

SOUTHERN NEW HAMPSHIRE UNIVERSITY

AND

THE OPEN UNIVERSITY OF TANZANIA

**MASTER OF SCIENCE IN COMMUNITY ECONOMIC
DEVELOPMENT (2007)**

**IMPROVEMENT OF COMMUNITY HEALTH CARE IN YOMBO
VITUKA WARD**

CASE STUDY OF YOKIDA

**Prepared and submitted by:
Lucas Jocelyne David
MSC.CED STUDENT**

**IMPROVEMENT OF COMMUNITY HEALTH CARE IN YOMBO VITUKA
WARD**


THE CASE STUDY OF YOKIDA.

BY LUCAS JOCELYNE DAVID

**A PROJECT PAPER SUBMITTED IN PARTIAL FULFILLMENT FOR THE
REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE IN
COMMUNITY ECONOMIC DEVELOPMENT IN THE SOUTHERN NEW
HAMPSHIRE UNIVERSITY AT THE OPEN UNIVERSITY OF TANZANIA.**

SUPERVISOR CERTIFICATION

**I, Felician Mutasa, supervisor of Jocelyne David Lucas, hereby confirm that I have
read the project and have found it acceptable for review.**

Signature: 
Date: 29/08/07

STATEMENT OF COPYRIGHT

No part of this project may be reproduced, stored in any retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without prior written permission of the author or the Open University of Tanzania/Southern New Hampshire University on that behalf.

DECLARATION BY THE CANDIDATE

I, Jocelyne David Lucas, hereby declare that this project paper is my own original work and that I have not submitted this paper in another university for a similar degree.

Signature: *Lucas.*

Date: *28th August, 2007.*

DEDICATION

**For the memory of my daughter JEMIMA ANGOLWISE KAHELO who passed
away on 23rd June, 2005.**

**And my husband JUSTINE BENJAMIN KAHELO who passed
away on 30th June, 2005.**

**The Lord gave and the Lord has taken away; may the name of the Lord be praised.
(Job 1:21b).**

ABSTRACT

Health facilities play a vital role towards health development of any country. It is particularly important in a country like Tanzania where resources and technology are more limited. The emphasis is on the need for increasing community involvement in health development and improve access and equity in health and health services.

The community Economic Development project is called Improvement of Community Health Care at Yombo Vituka ward. The situation is worse during the rain season as geographical location of the area allows floods causing the area to be like an Island, then there is poor sanitation and drainage system causing mosquito breeding and poor accessibility to the area.

Therefore, the community based organization called Yombo Kilakala Development Association (YOKIDA) decided to start up the plan of building a dispensary and improvement of sanitation in the area.

The community Dispensary Project at Kilakala locality will help in reduction of infant and maternal morbidity and mortality rates. Secondly, increase in life expectancy through provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases and treatment of

common conditions. Furthermore, the long distance walk to Temeke District Hospital will be shortened by having the dispensary in the area.

EXECUTIVE SUMMARY

Yombo Kilakala Development Association (YOKIDA) is a community based organization established in the year 2002.

It is a registered organization under the society's ordinance of 1954 and received the certificate of registration number SO. NO 11650 issued on 4th day of October 2002 under the Ministry of Home Affairs. It was established to improve living standard of the people through poverty reduction and needed appropriate intervention with diseases found in the area, long distance walk to Temeke district hospital and poor sanitation in the area. The target community is the people living within the community in the Yombo Kilakala locality and Yombo Vituka Ward at Mbagala Division in Temeke District in Dar es salaam region. Tanzania. According to the 2002 population census in Tanzania the ward has population of 59781, where women are 29680, Men 30101, with households numbered 14252. The people live in unplanned areas that are slums and are poverty stricken low class cadre. Most of population is self employed doing petty business and some are street vendors selling seasonal crops and substance cultivation.

The community members of the Yombo Kilakala ward made a collective – choice or decision to provide a community dispensary in their area, in order to enhance access to primary health care services. However, arrangements for the construction operation and maintenance of the facility are not yet in place. Facility construction requires

mobilization of adequate financial and human resources and undertaking the construction process either themselves or by contracting out the activity.

The project objectives are fulfilled like creation of better environmental sanitation at Yombo Vituka. There was proper disposal of garbage and potholes in the area. Two garbage disposal were created and the construction of community dispensary is under operation. There is improvement of community health status in the area.

Furthermore, once the construction process is completed, operating or running the dispensary and maintaining it, also requires adequate human resources as well as financial resources for the procurement of required inputs, equipments and staff remuneration.

The project will be accomplished by people themselves through community efforts and donor assistance from TASAF. In order to achieve community development people must be enabled to develop their capacity to identify their problems and plan ways of solving them. In addition, people must be helped to develop their capacity and enhance their desire to participate in decision making related to greater social and economic development. Government, donors, NGO's and other related organizations and institutions are most responsible in supporting the communities to achieve the envisioned capacity.

ACKNOWLEDGEMENT

I wish to express my sincere thanks to the administration of the Open University of Tanzania in collaboration with Southern New Hampshire University-USA who helped me to undergo this course.

Special thanks to Belgian Technical Co-operation for funding my studies and Ministry of Community Development Gender and Children for allowing me to study .

I would like to thank my supervisor, Mr Felician Mutasa and course tutors Mr. Michel Adjibodou for their professional guidance and commitment to the success of this study. Without their inputs and advice this study would not have been possible.

My sincere thanks to YOKIDA CBO leadership, Zarokii Jaffery and community members of Kilakala street lane and all the other staff for the support during the whole period of field research.

I am indebted to Dr Robert Mhamba, Mr. Gwamaka Bukuku, Mr. and Mrs. A. Ngude, Mr. and Mrs. Kiwayo, Blandina Mhina, Mariana Maziku, Mary Watugulu, Zainabu Ngonyani and Hussein Fandey for all the support extended to me for the success of this study.

Many thanks are extended to Madame Monica for her motherly love and care, Aunt Agatha Chuma for her wise words ever gives me new strength everyday. Madame Mary Magdalena and her family for encouraging and consoling me at that difficult time. And, for my daughter Eunice Monica Kahelo for giving me her time for my studies, the entire

Congregation of Upanga Assemblies of God church for their prayers and moral support for the whole period of my studies.

Last but not least, I would like to extend a word of thanks to my fellow classmates for their maximum co-operation extended to me during the whole period of my studies.

TABLE OF CONTENTS

Supervisor's certification	i
Statement of copyright	ii
Declaration by the candidate	iii
Dedication	iv
Abstract	v
Executive summary	vi
Acknowledgement	vii
Table of contents	viii
List of appendices	ix
List of tables	x
Abbreviations	xi

CHAPTER ONE

1.0 Community Need Assessment	1
1.1 Community Profile	1
1.2 Community Need Assessment	4

1.3 Reasons for community needs assessment	5
1.4 Research Methods for community Needs Assessments	5
1.5 Research Approach	7
1.6 Research Design	7
1.7 Sampling Techniques	8
1.8 Data collection techniques	9
1.8.1 Interview	9
1.8.2 Observation	9
1.8.3 Documentary Review	10
1.8.4 Questionnaires	10
1.8.5 YOKIDA meeting	11
1.8.6 Psychometrics characteristics	11
1.9 The limitations or problems encountered	12
1.10 Data analysis	13
1.10.0 Findings, analysis and discussion	13
1.10.1 Economic activities in the area	13
1.10.2 Major problems facing Yombo Vituka Ward	14
1.10.3 The disease which is of community concern	15
1.10.4 The willingness of the community to participate in the construction of the dispensary	16
1.10.5 The importance of sending children and other members of the family to the dispensary	17

1.10.6 The ways to improve sanitation in the area	18
1.10.7 The awareness of YOKIDA CBO	19
1.10.8 The impact of CBO on sanitation and health	20
1.10.9 Recommendations	21

CHAPTER TWO

2.0 Problem identification	22
2.1 Statement of the problem	22
2.2 The target community	24
2.3 Stakeholders	24
2.3.1 Stakeholders list	26
2.4 Project goal	27
2.5 Project objectives	27
2.6 Host organization	28
2.7 Study area	28
2.7.1 Vision of The YOKIDA CBO	28
2.7.2 Mission of the YOKIDA CBO	28
2.7.3 Goal of the YOKIDA CBO	28
2.7.4 Area of operation	28
2.7.5 Objectives of YOKIDA CBO	29
2.7.6 Main activities of the CBO	30
2.8 Assignment	31

2.9 Significance of the study	31
-------------------------------	----

CHAPTER THREE

3.0 Literature Review	33
3.1 Theoretical literature review	34
3.2 The Empirical literature review	40
3.3 Policy Review	48

CHAPTER FOUR

4.0 Project implementation	55
4.1 Products and outputs	55
4.2 Project planning	56
4.3 Implementation Plan	56
4.4 Inputs	59
4.5 Staffing pattern	60
4.6 Project budget	61
4.7 Project implementation	61
4.8 Resource mobilization plan	66

CHAPTER FIVE

5.0 Monitoring, Evaluation and Sustainability	69
5.1 Monitoring	69
5.1.1 Introduction	69

5.1.2	Inputs monitoring	70
5.1.3	Process monitoring	70
5.1.4	Output monitoring	71
5.1.5	Evaluation of outcomes and impacts of the project activities	71
5.1.7	Participatory Monitoring and Evaluation	73
5.1.7.1	Participatory Monitoring	73
5.1.7.1.1	Step one: reasons for monitoring	73
5.1.7.1.2	Step two: objectives and activities	74
5.1.7.1.3	Step three: Monitoring questions	74
5.1.7.1.4	Step four: Direct and indirect indicators	75
5.1.7.1.5	Step five: The information gathering tools used	75
5.1.7.1.6	Step six: Who will do the monitoring	76
5.1.7.1.7	Step seven: Analysis and presentation	76
5.1.7.2	Activities done	77
5.1.8	Participatory Evaluation	80
5.1.8.1	Step one: Review objectives and activities	80
5.1.8.2	Step two: Reasons for evaluation	80
5.1.8.3	Step three: Evaluation question	80
5.1.8.4	Step four: Who will do the evaluation	81
5.1.8.5	Step five: Direct and indirect indicator	81
5.1.8.6	Step six: Information sources for evaluation questions	81
5.1.8.7	Step seven: Skills and labor used to obtain information	82

5.1.8.8 Step eight: Information gathering and analysis	82
5.1.8.9 Step nine: Who will gather information	82
5.1.8.10 Step ten: Analysis and presentation	83
5.1.9 Sustainability	84

CHAPTER SIX

6.0 Conclusions and recommendations	86
Bibliography	90
Appendices	93

List of Appendices

Appendix A: Needs Assessment
Appendix B: Letters of introduction/Acceptance
Appendix C: Organizational chart
Appendix D: Project implementation Gantt chart
Appendix E: Staff job description
Appendix F: Project budget (Cost Analysis)
Appendix G: Project Power Point Presentation
Appendix H: Statistical Information

List of Tables

Table 1.10.1: Economic activities in the area	13
Table 1.10.2: Major problems facing Yombo Vituka Ward	14
Table 1.10.3: The disease which is of community concern	15
Table1.10.4: The willingness of the community to participate	
In the construction	16
Table1.10.5: The importance of sending children to the dispensary	17
Table1.10.6: The ways to improve sanitation in the area	18
Table1.10.7: The awareness of YOKIDA CBO	19
Table1.10.8: The impact of CBO on sanitation and health	20
Table 2.3.1 Stakeholders list	26
Table3.2.1: Health facilities in Tanzania since 1961-1991	42
Table 4.2.1: Project planning	57
Table 4.3.1: Implementation Plan	58
Table 4.7.1: Project implementation process	65
Table 5.1.6.1: The Monitoring and Evaluation of dispensary project	72
Table 5.1.8.71: Activities done	77
Table 1.1: Need Assessment	93
Table: 4.6.1 (a): Project budget Cost analysis- community dispensary	

Table 4.6.2 (b): Procurement of building materials for the dispensary

Table 4.8.1: Strategic action plan

68

List of Figures

Fig. 1: Health facilities in Tanzania since 2000- 2004

42

Fig. 2: Health facilities in Temeke Municipal 2000

43

Fig.3: Map of Dar es Salaam city council showing municipality

ABBREVIATIONS

AIDS	-	Acquired Immune Deficiency Syndrome.
CBO	-	Community Based Organization
CED	-	Community Economic Development.
HIV	-	Human Immunodeficiency Virus
HAPA	-	Health Action Promotion in Singida, Tanzania
IEC	-	Information, Education and Communication

MCH	-	Mother and Child Health.
MDGs	-	Millennium Development Goals
NGOs	-	Non-governmental Organizations.
NACP	-	National Aids Control Programme.
PSI	-	Population Service International
TASAF	-	Tanzania Social Action Fund.
UN	-	United Nations
VOLU	-	Voluntary Work Camps Association of Ghana.
VHCP	-	Valley Health Communities Program in Singapore.
WHO	-	World Health Organization
YOKIDA	-	Yombo Kilakala Development Association.

CHAPTER ONE

COMMUNITY NEED ASSESSMENT

1.1 Community Profile:

Location:

Temeke Municipality is one of the three Municipalities in Dar es Salaam city; the others are Ilala and Kinondoni. The Municipal under the jurisdiction of the council is the large in size compared to Ilala or Kinondoni Municipal. It covers an area of 656 km with a coastline of 70 km length. Temeke Municipality is located in the South of Dar es salaam city, borders coast region in the south, Ilala Municipality in the North and West while in the East it stretches the cost line of the Indian Ocean.

The Ecological Characteristics:

Temeke Municipality is divided into three ecological zones:

1. The northern upland zone of Mtoni Kijichi escapment, Keko, Temeke, Mtoni and Tandika.
2. The central zone of Mbagala, Chamazi, Yombo Dovya, Kongowe plateau and Kigamboni.
3. Southern low land parts of Kisarawe II, Amani Gomvu, Kimbiji, Chekeni Mwasonga and Kitunga.

Most of the area is covered by sand soil. The main natural vegetation area coastal shrubs, Miombo woodland, coastal swamps and mangrove trees.

Climate:

Temeke Municipality lies in the tropical coastal belt of Tanzania and therefore is influenced by two major climatic elements, namely rainfall and temperature. Rainfall pattern is that of bimodal type with erratic conventional rains. The rains occurring almost through out the Municipality between December and February. While the long heavy rains in the period from February to June. The amount of rainfall received ranges from 800 -1200mm per annum. Temperature like rainfall is also influenced by ocean. High temperature prevail throughout the year ranging from 25 c during the period of June to August up to 35 c in the period of January to March.

Population:

According the 2002 population census there are 768,451 inhabitants with 187,609 households; of whom 387,364 were male and 38,081 female with an estimated growth rate of 4.6% per year the current population (2007) is estimated to be 962,220 of whom 485,040 are male and 477,180 are female.

Administrative Structure;

Administratively Temeke Municipal is divided into three divisions namely Chang'ombe, Mbagala and Kigamboni. The divisions are further divided into 24 wards; which also are divided into 158 mitaa. There are 34 councilors of whom two are members of parliament.

Yombo Vituka Ward, the centre of my study, is among the 24 wards in the Mbagala division, in Temeke Municipality.

Yombo Vituka borders Kiwalani Ward in the North, Kitunda Ward in the West, Tandika Ward in the East, Makangarawe Ward in the South.

Education: In Yombo Vituka Ward the services range from pre-primary education, primary education, secondary education, vocational training and adult education in Yombo Vituka Ward.

Pre-schools: there are 27 pre-schools in Yombo Vituka Ward, 2 are government owned while 25 are private owned. There is total number of 718 children in all schools of whom 201 are boys and 317 girls.

Primary schools: there are 7 primary schools in Yombo Vituka Ward, 5 are government owned while 2 are private owned. There is total number of 13409 children of whom 5772 are boys and 7637 girls.

Secondary schools: there are 3 private secondary schools in Yombo Vituka Ward, the total number of children is 4114 of whom 2201 are boys and 1913 are girls.

Vocational Training: there is 1 vocational training in Yombo Vituka Ward, which is privately owned.

Total population of Yombo Vituka is 59,781 of whom 30,101 are men while 29,680 are women with 14,252 households, as per 2002 population census.

Income: the income of Yombo Vituka Ward is divided into, the people with low income who are situated at Kilakala and Barabara ya Ali Hassan Mwinyi and the middle income people are situated at Machimbo, Sigara and Vituka Juu.

Industry: there is 1 paper bag factory at Barabara ya Ali Hassan Mwinyi and milling machines these provide employment to the people of Yombo Vituka.

Socio-Economic status;

According to 2002 national population census 67% the population in the Municipality are engaged in formal and informal sectors especially industry and trade. Agriculture and livestock employees are about 13% of the population while 20% offer services in various government departments, public institutions and private organizations.

Strategy for social services has been based on equal opportunity and universal access to basic social services such as education, health and water.

Economic Structure:

Developments in the past few years have been geared towards improving Municipal capacity to generate more income and poverty alleviation more income in this case can be generated through agricultural production, livestock, natural resources, industries, trade, cooperatives and informal sector promotion.

1.2 Community Need Assessment

A needs assessment identifies the extent and type of existing problems in the community, the services available, and the unmet needs. In even simpler terms a needs assessment is a process to determine the need, which can be defined as the gap between the problem and existing efforts, resources and programs to deal with the need.(conducting community needs assessment;2005).

1.3 Reasons for community needs assessment:

To identify the existing problems in the community and a possible way to solve the most pressing need.

To identify who needs the health services and ways to extend the services to reflect the community needs.

To find out how the need community is facing problems related to health like poor sanitation in the area.

Community needs assessment was done through participatory approach that involved researcher and the community of Yombo Vituka. The community was able to identify the problems facing the area as follows, long distance walk to Temeke District Hospital due to lack of health services in the area. Poor sanitation and poor drainage system causing mosquito breeding for malaria and other diseases like, cholera, AIDS. And, poor accessibility to and from the area especially during the rain season. There are two deep water wells that cannot serve the whole area hence there is lack of water distribution. Lastly, there is lack of nursery school in the area of Yombo Kilakala.

There were 28 participants in total 21.4% which is the same as 6 participants were members of community dispensary project committee and 78.6% which is the same as 22 participants were members of the community.

1.4 Research Methods for Community Needs Assessment:

The information was gathered through focus group discussion and unstructured discussion was employed, to find out the root causes of the problem and the most

pressing need in the community. The purpose of focus group is to build a synergy of thoughts and ideas that can make projection in the community. It is easy to conduct and provide detailed information through stimulation of thinking and discussion.

The members of the community were highly involved because each member was given a chance to express their knowledge on the problems affecting their community. Through brainstorming several problems were mentioned and their priorities. The purpose of brainstorming is to generate ideas and prioritize issues. Key informants were used. Through interviewing key questions were used to guide the discussion between the researcher and the respondents. The purpose of interviewing is that it is useful when looking for in-depth information on a particular topic because it allows for clarification and follow up on questions.

Hence, from the problems identified, better understanding of the impressions of community need was obtained. For instance, construction of dispensary, maintenance of the road, then construction of water supply system and later construct a nursery school. Later ranking was done to ensure the core problem is well addressed and agreed with all stakeholders. At last the need for dispensary was recognized as a core problem because all members had looked on the priority list during ranking. See (Appendix E: 64).Inline with the above, the researcher had an opportunity to observe the community individual behaviors and response towards the needs assessment.

Documentary Review, the researcher used some data recorded in the previous years to know the allocation of information in relation to the problems facing the area. Documentary review is ease and fast to access because data already exists.

1.5 Research Approach

The study was conducted in Temeke District. Yombo Vituka was purposively selected for the study as it has a CBO. The reason behind was that Temeke is experiencing rapid development of new settlements that cause the need of health services. The need of a dispensary to meet the increasing demand in an area requires various strategies by different people and institutions to achieve the policy objectives by addressing community participation and the role of community based organization in the sustainability of the dispensary and delivery of health services.

The study is based on data collected from Yombo Vituka Ward, YOKIDA CBO staff, the selected community, Yombo Vituka construction committee, primary health committee and government staff. In the selected street lanes the researcher worked with various people, community leaders, YOKIDA staff and government staff and primary health and construction committee.

1.6 Research Design

The cross sectional survey was done. A cross sectional study involves asking questions to a representative sample of the population at a point in time where such instruments as questionnaires and interview guides are used. The design is most appropriate for descriptive purposes and determination of the relationships between variables.

Sample size is 150 people that is 10% of the total population of 1,506 in the Kilakala street lane representing the survey sample. The respondents were 134, YOKIDA staff¹² and Government staff 4.

This particular street lane was selected because it is one among four street lanes that initiated the idea of constructing a community dispensary and is situated at the centre of all the street lanes.

Response rate is the number of people who respond to a survey.

Sample size 200

People surveyed 150

$150/200 \times 100 = 75\%$ the response rate.

1.7 Sampling techniques

Random sampling for YOKIDA leaders and community in general was applied and cluster sampling to district officials were employed in the research.

Data collection was done at two levels namely primary and secondary. In primary level, first hand information was collected from the selected community, and CBO leadership.

While secondary data were collected from ward, district .Documentary sources also provide secondary data for the purpose of getting official and reliable information that were related to the study.

1.8 Data collection techniques

In order to obtain the required information the researcher used the following survey instruments as interview, questionnaires, documentary and observation.

1.8.1 Interview:

A set of prepared key questions were used to guide the discussion between the researcher and respondents. The interview was conducted in the form of questions and answers session. During interviews, conducive atmosphere was created for the respondents to express themselves freely. The interviews were conducted in the form of question and answer sessions. All questions were structured and unstructured.

1.8.2 Observation:

While conducting the survey, I had a chance to observe in the community what was happening such as individual behaviors and the response towards the project. I joined them in social activities to learn more about them and also to be accepted as part of them.

Aiming at finding out how the community- based organization is performing in the activities like community mobilization for the construction of the dispensary, community committees such as health, environment and sanitation, and their attitude towards participation in dispensary construction.

The researcher selected these methods because it is useful during the formative and summative phases of evaluation. For instance, during the formative phase, Observations can be useful in determining whether or not the project is being delivered and operated as planned .During the summative phase, observation is used to determine whether or not the project is successful. This is due to the reason that it provides direct information about behavior of individuals and groups and provides good opportunities for identifying out comes.

1.8.3 Documentary review:

Documentary is source of data collection which relay on data collected previous years and be recorded, mostly are available data which are relevant to the topic. The type of information mainly obtained from books, files, newspapers and journals to mention but few. The researcher used the information to know the names of places during sampling and to know the allocation of information in relation to the project activities.

1.8.4 Questionnaires: In accordance with the level of education of participants and the nature of activities performed. The number of questions are 22, for different respondents, were as follows:

In section 1 there are 19 questions are designed for the community members of Yombo Vituka.

In section 2 there are 19 questions are designed for the CBO leaders.

In section 3 there are 3 questions are designed for the district officials.

The questions were open-ended and closed, designed and used to guide the exercise of data collection in study. This kind of data collection technique was used due to the fact that, some people do not know how to read and write.

1.8.5 YOKIDA meeting

I attended two meetings with YOKIDA staff and leaders which was scheduled when I was undertaking my research. I got different views and suggestions regarding the importance of good health and the improvement to be done to the community. I got some clarifications on community attitudes towards community dispensary construction and the need to improve sanitation in the area.

1.8.6 Psychometrics characteristics:

Psychometrics is the branch of survey research that enables the researcher to determine how good the survey is. Psychometrics provides survey researchers with a way to quantify the precision of the measurement of qualitative concepts, such as program beneficiary satisfaction.

Scales.

The scale employed for the case of questionnaires include, category scale with various options such as yes or no and others were specific responses such as boiling water, use mosquito nets and proper disposal of waste for the case of improving sanitation of the area. Additive scales were used where the respondents were free to give the views.

Content.

The research is based on improvement of community health care at Yombo Vituka Ward. The contents for category scales were yes or no and the content for additive scales differed depending on knowledge and understanding of the respondents.

How questions are scored.

The category response in questionnaire was yes or no, the respondents were required to circle on the applicable options asked and some are required to fill the blanks. On the interview guide the researcher recorded the summary of responses from the respondents and categorize those that fall in the same category.

How questions are combined into scales.

The scales were used in yes or no responses. Therefore, one scale surveys the need of dispensary in the area and the other on practice of primary health care activity and improvement of sanitation in the area.

1.9 The Limitations or problems encountered

The study was confronted with the following problems during the whole process of data collection.

During the research period it was the agricultural season in Temeke District, so it was too difficult to consult the respondents at the right time. Since the community engaged in farming activities in the areas like Vikindu, Mbande and Mbagala, based on this problem the researcher frequently re-arranged the appointments for interview in order to be able to meet the respondents.

1.10 Data analysis

Data analysis in the project of improvement of community health care at Yombo Vituka was done by both quantitative using SPSS package and qualitative methods. I used descriptive analysis in presenting and discussing my findings. Also descriptive statistics such as, percentage, tables and figures are used.

1.10.0 Findings, Analysis and discussion

This chapter is concerned with the results obtained from the field survey. After, the researcher collected the data, the results were obtained as summarized below:

Table1.10.1: What are the economic activities in the area?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
Petty business	35.3% (24)	64.7% (44)	100% (68)
Subsistence cultivation	63.2% (36)	36.8% (21)	100% (57)
Others	36% (9)	64% (16)	100% (25)

Source: Field data 2006

From the study, the data indicated that major economic activities are petty business and subsistence cultivation to those who have farms outside the area like Mbande,

Mbagala and Vikindu within the Mbagala division. The area is densely populated so there is no farming practiced within except outside the area.

Most of people are self employed doing petty business and some are street vendors selling seasonal crops and cooked food. Others, are employed like teachers, nurses and civil servants but very few. People are not formally employed, thus are engaged in petty business and subsistence cultivation. As a result there is little contribution in terms of money, towards the community dispensary construction.

Table 1.10.2: What are the major problems facing Yombo Vituka Ward?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
Disease found in the area	57.14%	42.9%	100%
E.g. Malaria, Cholera, Aids and measles	(20)	(15)	(35)
Long distance walk to Temeke District Hospital and Malawi dispensary	47.44%	52.6%	100%
	(37)	(41)	(78)
Poor sanitation in the area	32.43%	67.6%	100%
	(12)	(25)	(37)

Source: Field data 2006

The table shows that out of 150 respondents 78 of the respondents indicated that long distance walk to Temeke District hospital and Malawi dispensary is a major problem,

while 37 responded to poor sanitation in the area and 35 respondents indicated diseases found in the area as problem.

From the information collected, it shows that long distance walk to Temeke district hospital and Malawi dispensary was highlighted as a leading problem in the area, for the vulnerable group were children and pregnant women who cannot walk long distance for health services. The distance is about one and a half kilometers away. Poor sanitation was also mentioned as a problem because it causes diseases in the area.

In line with diseases found like malaria, cholera, measles fever, and HIV/AIDS is also problem in the area.

Table 1.10.3: What Disease is the community most concerned about?

Disease	Response		
	Men	Women	Total
	69	81	150
Malaria	54.3% (38)	45.71% (32)	100% (70)
Aids	32.7% (17)	67.30% (35)	100% (52)
Cholera	44% (11)	56% (14)	100% (25)
Measles Fever	100% (3)	0% (0)	100% (3)

Source: Field data 2006

From the table above, it shows that malaria is the leading disease in the area then followed by AIDS and cholera. This is due to poor sanitation in the area. People do not follow the hygienic ways especially in the local drinking pubs. There is poor disposal of garbage and poor drainage of dirty water that cause high mosquito breeding area. Measles fever is very little due to government efforts to eradicate it by 100%.

Table 1.10.4: Is the community willing to participate in the construction of the dispensary?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
YES	44.5%	55.5%	100%
	(65)	(81)	(146)
NO	0%	0%	0%
DON'T KNOW	100%	0%	100%
	(4)	(0)	(4)

Source: Field data 2006

The table shows that 55.5% of the female respondents agreed that participation is very important for the construction of the dispensary while 44.5% male did agree and the rest is 4 male respondents do not know anything to do with project.

This implies that the respondents agreed that community participation is important and should be encouraged by the CBO leaders in order to ensure that the dispensary is

constructed in Yombo Vituka Ward. However, it is notified that, the community alone cannot accomplish some tasks due to limited resources. Then, there is a need of assistance from outside the community. Hence, TASAF supported the dispensary construction in the project of improvement of community health care in Yombo Vituka ward.

Table 1.10.5: Do you think the constructed dispensary is useful to the Yombo Vituka residents?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
YES	44.9% (66)	55.1% (81)	100% (147)
NO	100% (1)	0% (0)	100% (1)
DON'T KNOW	100% (2)	0% (0)	100% (2)

Source: Field data 2006

From the table above 81 of the female respondents agreed that it is important to take their families to be treated in the dispensary when they get sick while 66 male respondents agree on the importance of dispensary, then 2 male respondents do not know if the dispensary is important to them and 1 male responded on the negative that it

not important to send their families to be treated to the dispensary. This group believes on traditional treatment like the use of herbs for cure.

The study shows it is important to be treated in the dispensary for treatment, in case they get sick and provision of primary health care services. Then, may be able to fight against the diseases that affect the area, together with primary health care for prevention and control against the diseases. The problem of community on long distance walk to reach the Temeke district hospital would be solved because the dispensary will be constructed within the area of Yombo Vituka, which will meet the needs of the community.

Table 1.10.6: What are the ways to improve sanitation in the area?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
Sensitization on community in keeping clean Environment	46.6% (27)	53.4% (31)	100% (58)
Educating the community on prevention of diseases	42.30% (33)	57.7% (45)	100% (78)
Distribution of IEC Materials: brochures, posters etc	64.3% (9)	35.7% (5)	100% (14)

Source: Field data 2006

The table shows that 78 of the respondents indicated that educating on prevention of diseases is essential while 58 agreed on sensitization on community in keeping clean

environment is a solution and 14 respondents received the IEC materials and found that are useful. In fact, this is a permanent solution and has slowed down the rate of diseases with the use of mosquito nets, boiled water and proper disposal of waste.

Table 1.10.7: Are you aware of YOKIDA CBO?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
YES	46.2% (66)	53.8% (77)	100% (143)
NO	0% (0)	0% (0)	0% (0)
DON'T KNOW	28.6% (2)	71.4% (5)	100% (7)

Source: Field data 2006

Out of 150. Respondents 66 were males while 77 were females. Most of females and males respondents during field visits, showed to be well informed about the CBO activities. Such distribution among them helped to reduce gender bias decisions in the CBO and the presence and participation of both male and female was active. While 2 of males and 5 females do not know anything because have just moved in so are new to the area.

Table 1.10.8: What impact has the CBO on sanitation and health achieved?

Response	Number of respondents		
	Men	Women	Total
	69	81	150
YES	46.9% (68)	53.10% (77)	100% (145)
NO	0% (0)	0% (0)	0% (0)
DON'T KNOW	20% (1)	80% (4)	100% (5)

Source: Field data 2006

Primary health care is related to health and sanitation issues. Then, 150 of the respondents which is male 46.9% and female 53.10% agree that the CBO had made positive impact to the improved sanitation while 80% of women respondents and 20% of men respondents said they do not know anything on the impact.

Some of the cited reason was that since the primary health care committee mobilized on the need of keeping clean environment on the purpose of disease prevention. There was decrease of mosquito breeding in the area and a consequent decrease in malaria and cholera cases in the area.

1.10.9 Recommendations

a) The dispensary should be constructed in Yombo Vituka so that there will be no long distance walk to Temeke District hospital. Furthermore, with the provision of primary health care services there will be the decrease of diseases like malaria, cholera, HIV/AIDS, measles and fever.

b) The establishment of primary health care committee will mobilize on the need of keeping clean environment on the purpose of disease prevention.

It has to be a continuous activity on educating the community on prevention of diseases and keeping clean environment like the use of mosquito nets, boiled water, proper disposal of waste.

c) YOKIDA-CBO should work closely with District Council and act as a catalyst to the Government since the role of CBO is to supplement development activities in the area where Government has failed.

CHAPTER TWO

PROBLEM IDENTIFICATION

2.1 Statement of the problem

The need of community dispensary project at Yombo Vituka ward is a major community concern. Survey results done on Health Services by the Temeke Municipality Council-2000 concerning the people of Yombo Vituka ward attending Temeke District Hospital, are as follows: there were 33.3% of people suffering from malaria, 23.3% of children under five who suffer measles, fever and other diseases, 23.3% of people suffering from HIV/AIDS, 20% pregnant mothers who are due to deliver. Epidemic diseases like cholera, there were 20 people who suffered early January in 2005.

Between 2002 and 2004 three deaths were reported due to the problem of long distance walk to reach the hospital. The number of cases reported increased from 3 to 6 and there are many sick people who need hospital services for instance a day there is average of 30 people attending at Temeke District Hospital suffering from different diseases.

The vulnerable groups are children and pregnant women who cannot walk for a long distance for health services to Temeke District Hospital and Malawi Dispensary. Therefore, 95% of respondents in Yombo Vituka community members (men and women) are affected due to lack of dispensary service near the area.

The situation is worse during the rainy season as geographical location of the area allows floods causing the area to be like an island, and then there is poor sanitation and poor drainage system causing mosquito breeding and poor accessibility to and from the area.

Therefore, Community Based Organization called Yombo Kilakala Development Association (YOKIDA) decided to start up the plans of building a dispensary and improving sanitation of the area.

Needs identified for improvement of community health at Yombo Vituka ward were construction of the dispensary, road maintenance, construction of water supply system and construction of nursery school.

Government response ; in response to the threat of malaria, measles, HIV/AIDS, Cholera epidemic, the Government of Tanzania has planned for construction of dispensaries in every ward in country wide. Ministry of health started up Urban Control Malaria Projects in Dar es Salaam and Tanga and National AIDS Control Programme (NACP) to prevent the transmissions and spread of malaria and HIV/AIDS.

External initiatives in fighting against the diseases; Coca-Cola African Foundation in partnership with Population Service International (PSI) offered every 21/- Tz Shillings – per every bottle of Coca-Cola sold, to contribute on purchase of mosquito nets which are to be distributed at very low price of 2,750/=

Tanzania shillings to pregnant women and children under the age of five years in every mother and child clinics (MCH) in the country as per Nipashe News paper of 17/12/2005.

2.2 The target community; Target community comprises of the people living within the community in the Yombo Vituka ward. The area has a total population of 82062 people . Out of that 29468 are women, and 52594 are men. At the increasing rate of 2.4% with 14252 total number of households. Community participation is very important for the project because it is a community project, so it depends on community initiatives in terms of manpower, community contribution and collection of construction materials like sand and aggregates.

2.3 Stakeholders; the first stakeholders in the project are the members of the YomboVituka community (CBO members). Other members are the community leaders, Community development worker, the Temeke District Health Department as well as the Ministry of health and the donor known as TASAF.

- Yombo Vituka community is to be involved in every step of the project as manpower. And, are going to benefit from the health services that will be provided.
- Community Development Worker has experience on intervention of the project activities, monitoring and evaluation.

- Community leaders have skills and knowledge that would help in the project like implementation activities and follow ups.
- Temeke District Health Department would help in collaborating with the CBO in planning and advice on the project according to the Tanzania Health Guidelines.
- Ministry of Health will accomplish the cost sharing of the project as per health policy 2002 and the provision of health staff and salaries and working implements.
- TASAF the donor agency will provide all the preparation for construction like seminar and purchases of construction materials from the beginning of the project till the end.

Table 2.3.1: Stakeholders list

No	Stakeholder	Describe Participation	Evaluation	Impact of Participation	Rate	Plan
1	Community	Decision making. Implementing the project.	High	Problem to be solved.	Positive	Project to be established
2	Community leaders	-Create awareness. Mobilization Help in problem identification.	High	Greatly concerned with project as preliminary implementers.	Positive	Talk to the community on progress of the project.
3	Community Development worker	Shared a lot of experience on intervention of the problem.	High	Popular in the area so the society accepted her ideas. Project to be implemented.	Positive	Work with her closely as the whole of Yombo Kilakala ward is under her supervision
4	Temeke District Health Department.	Collaborate with the CBO on construction and maintenance of the dispensary.	High	Support implementation.	Positive	Project to be established.
5	Ministry of Health	Funding. Follow ups.	High	Project to be implemented	Positive	Project to be established.
6	Donor TASAF	Funding. Review of organization plan.	High	Project to be implemented	Positive	Project to be established.

2.4 Project Goal

The current condition of the target community is that Yombo Vituka ward is faced by diseases like malaria, cholera, AIDS, measles and fever, long distance walk to Temeke District hospital and poor sanitation environments.

The project will promote better health among the YomboVituka dwellers and improved sanitation through primary health care. The following are the project goals:

1. To improve access to primary health care services in the Yombo Vituka ward communities by constructing a community dispensary within the ward.
2. To free Yombo Vituka residents from epidemic diseases.

2.5 Project Objectives

1. Improvement of community health status in the area.

Indicator: Reduce number of patients from 30 to 6 a day by educating the community on prevention rather than treatment.

2. Creation of better environmental sanitation at Yombo Vituka.

Indicator: Proper disposal of garbage and potholes in every household in Yombo Vituka.

3. Construction of community dispensary at Yombo Vituka.

Indicator: One dispensary will be constructed within Yombo Vituka ward.

2.6 Host organization

The host organization is the Community Based Organization of Yombo Kilakala locality named “The Yombo Kilakala Development Association” (YOKIDA).

2.7 Study area:

2.7.1 Vision of the YOKIDA CBO

The people living in Yombo Kilakala Ward will be more aware, organized and be able to handle and deal with their felt needs and manage to improve their life condition.

2.7.2 Mission of the YOKIDA CBO

To prepare, train and enable the people, recognizing their own ability to identify their problems and use the available resources to earn and increase their income and build better lives for themselves.

2.7.3 Goal of the YOKIDA CBO

To build and improve the life conditions of the Yombo Vituka people through community initiatives.

2.7.4 Area of operation

The main area of operation of YOKIDA in Yombo Vituka ward is in the five street lanes as follows:

- a) Kilakala

- b) Vituka
- c) Barabara ya Ali Hassan Mwinyi
- d) Sigara
- e) Machimbo

The constructed dispensary will serve the above street lanes.

2.7.5 Objectives of the YOKIDA CBO

- a) To contribute in the economic development of the Yombo Vituka ward people by keeping good strategies for the community.
- b) To understand, help and co-operate in the use of appropriate technology for the community development of Yombo Vituka Ward.
- c) To rise up private and group activities in relation to environmental conservation, construction and road maintenance together with other activities concerned with community development.
- d) To extend health services, economic agriculture and community development through poverty alleviation.
- e) To start up, to develop various projects together with programmes linked with women and youth.

2.7.6 Main activities of the CBO

Health;

- a) Create awareness to communities on the importance of good health.
- b) Sensitize the community on the importance of using toilets, proper disposing of gabbage,boiled water,the use of mosquito nets and good sanitation ways.
- c) Provide health education through seminars, workshops and role plays and drama.
- d) Distribution of IEC materials in the community like posters on transmitted diseases and prevention such as cholera,malaria,HIV/AIDS,measles and diarrhoea.
- e) Mobilization on construction of dispensaries and health centres.

Education;

- a) Create awareness to communities on the importance of education.
- b) To mobilize parents on ensuring that the children are going to school.
- c) Collaborate with District education department for provision of facilities.

Environmental conservation;

- a) Educate the communities on environmental protection and natural resources.
- b) Reforestation and protection of water sources.
- c) Educate the community on land carrying capacity.
- d) Educate the community on revised land act.

2.8 Assignment

This project paper explores the contribution of local CBO particularly YOKIDA in the efforts of promoting health through community dispensary construction and improvement of sanitation in the area.

The other assignment of the project is to design a resource mobilization plan for the construction of a dispensary in the area.

To enhance capacity building among the community as apart of the resource mobilization strategy.

To give feedback from the research results, by informing the community on the real situation and what is to be done.

To disseminate information to other stakeholders dealing with health so as to ensure that support is provided to the community where the level of health is still low compared to other areas in the district.

2.9 Significance of the study

Improvement of community health at Yombo Vituka depends on basic health Services that are provided by dispensaries and health centres. They represent the minimum level of health services that should be available to the majority of the population. The project is based on “prevention” which is primary health care and “Treatment” for availability of the dispensary. On prevention there is health Education for the whole community, distribution of IEC materials in the community for example, brochures on prevention of diseases like cholera, malaria, HIV/AIDS, measles and diarrhea. Primary

health care committee mobilize on the need of keeping clean environment on the purpose of disease prevention. There should be a continuous activity on educating the community on prevention.

On treatment there is diagnosis and management of the common and less severe illness, with referral to hospital for severe ill or problem cases. Maternal and child health (MCH) services, nutrition and child spacing are provided in a constructed dispensary. Therefore the successive project will have beneficial impact to the targeted group in the community. And, hence people in the community will have solved the problems of diseases found in the area, long distance walk to Temeke District Hospital and poor sanitation in the area.

CHAPTER THREE

LITERATURE REVIEW

Introduction

The literature review entails theoretical, empirical and policy reviews of various literatures used by the researcher. The readings have helped to verify the findings compared to what others have found.

Public services have to be provided, produced and maintained to ensure a sustainable flow of services to the public. Ostrom et al. (1993) have distinguished between provision and production in the public realm as follows:

Provision refers to decision made through 'collective-choice mechanism about: the kind of goods and services to be provided by a designated group of people; the quantity and quality of the goods and services to be provided; the degree to which private activities related to these goods and services are to be regulated; how to arrange for the production of these goods and services; how to monitor the performance of those who produce these goods and services. Whereas production refers to the more technical process of transforming inputs into outputs, making a product or in many cases rendering a service (Ostrom et al, 1993:75)

Community members of the Yombo Vituka have made a collective-choice or decision to provide a community dispensary in the area, in order to enhance access to primary health

care services, whereas community participation is important to contribute for the services needed in their community.

3.1 Theoretical literature review.

Community participation:

Participation is not only a matter for the community; it is a reciprocal process in which the development workers and change agents at all levels of implementation must take part.

Community based organization gears towards people's active participation through which a community identifies its needs, rank them develops the confidence and will to work at them, finds the resources (internal and external) to deal with these needs, takes action in respect of them and develops co-operative and collaborative attitudes and practices in the community (Iceberg,2003).

As development strategy, empowerment entails the design and implementation of appropriate programmes to raise and increase capacity and ability of the target communities to address their current as well as future changing needs. The corner stone of this approach is active participation of target communities in problem identification, problem solving and project planning and implementation process as opposed to doing things for them (Paul, 1986).

Community based participatory approaches seems to be advocated in many parts of the developing world. The informal sector usually extends services or goods that the government has not made widely available, that this can be offered to cater for the needs of the poor or that are not yet extended to new areas of settlement.

Different writers define popular participation differently depending on the social economic environment they are, their academic background, cultural setting, and professional inclinations.

Popular Participation is defined as:

- i. Pateman (1970), defines popular participation as a process where each individual member of a decision making body has equal power to determine the outcome of decisions.
- ii. Leonard (1983), The Israel and the French define the concept as, a process in which two or more parties influence each other in making plans policies and decisions. It is restricted to decisions that have further effects on all those making the decisions and on the represented by them.
- iii. Popular participation is a process through which (...the people in any given locality should be allowed to determine for themselves on their own initiative what are the things they feel they need most (Tavanlar, 1983).
- iv. Thomson (1970), confines, popular Participation to activities associated with the selection of political leaders and the procedures for influencing the activities by them.
- v. According to Kalabaka (1989; 262) Popular participation increases efficiency in development activities by involving local resources and skills and making better use of expensive external costs.

It can also increase the effectiveness of such activities by ensuring that, with people's involvement, they are based upon local knowledge and understanding of problems and will therefore be more relevant to local needs.

It helps to build local capacities and develop abilities of local people to manage and to negotiate development activities.

Therefore, popular participation still remains the best strategy for community development. There are various self help projects initiated by the people themselves, developers are beginning to believe that the solution to poverty rests with those who are poor. The people at the grassroots level, create a self supporting system with a low level of outside resource support, depending on local leadership and local responsibility.

Health, Poverty and Development link:

Health and development go together, villagization and other development policies aim to bring rural people together to participate in their own development. Improved health must be a part of this development.

The government has emphasized that health services, education and water supplies are high priorities for rural development, as well as enough food and proper housing. This is why better nutrition and good environmental health are such important aspects of village health services.

Also the development of a cash economy, improved agricultural methods, a fair sharing of the land, better educational levels, high adult literacy rates and improved roads all

lead to improved health. Raising living standards through the people's participation in development will lead to healthier communities. (Wood et al, 1981).

Vicious Cycle of Health and Poverty; It is recognized that there is a strong relationship between health and poverty which works in both ways; income poverty leads to poor health outcomes and adverse health outcomes contribute to income poverty. A number of factors typically associated with income poverty are also determinants of ill health. These include high level of female illiteracy, lack of access to clean water, unsanitary conditions, food insecurity, poor household caring practices , heavy work demand, lack of fertility control as well as low access to preventive and basic curative care. Opposite, unfavorable health outcomes, which contribute to income poverty, include ill-health in general, HIV/AIDS, malnutrition and high fertility. These reasons cause poverty through diminishing productivity reduced household income and increased health expenditures (WHO, 2003).

Poverty, health and the poor:

Health and poverty are inextricably linked. Poverty is often associated with ill health, while ill health is lead to poverty. More importantly, however, good health can lead people out of poverty. And that alone is sufficient reason for global efforts to focus on this area.

Around 1.3 billion people in the world live in extreme poverty, surviving on less than US\$ 1 a day for all their needs. These people have little or no access to health services

and education and limited prospects for a better life. They are far removed from decisions that affect their day to day lives.

Meanwhile, there is a critical need to focus on the ability of the poor to voice their concerns and participate in making decisions that affect their lives. Health and development programmes have a poor record of ensuring that this participation is both effective and sustainable. Mechanism to enable the poor and the vulnerable to be involved and work towards a better future for themselves are central to overall health and development.

The global community should recognize that good health is a way out of poverty. It results in a greater sense of well-being and contributes to increased social and economic productivity. The impact of ill-health on productivity affects not only the poor but societies and economics as well. The issue of health and poverty is not just a moral issue; it is an economic issue as well. It is more cost-effective in the long run to reduce poverty by improving health and development interventions for the poor than to face the heavy costs of poverty on the community as a whole (Global Forum for Health Research: 1999).

Poverty and Sustainable Development:

A perspective on poverty and health within the larger context of health and socio-economic development was also essential. This explored issues that directly affect the nature of the poverty/health relationship. Some of the concerns addressed include:

- a) Institutional frameworks of government institutions that may hamper or assist health development.
- b) Explicit consideration of the poverty impact of health policies and the health impact of poverty reduction policies.
- c) Public/private partnerships for reducing inequities in health and increasing the welfare capital of vulnerable groups.
- d) The cause/effect relationship between internal (within country) and external (international) migration on poverty and health.
- e) Inter-sectoral approaches that utilize the most appropriate strategies from a wide array of discipline for poverty reduction and health gains.

Although the above list is by no means exhaustive it illustrates the complexity of the health/poverty relationship and its influence on a large number of other factors.

Other critical factors in the relationship between poverty and health are population and environmental health issues. 80% of the poor in Latin America, 60% in Asia and 50% in Africa live on marginal lands of low productivity and high susceptibility to degradation. Similarly, in the world's cities more than one billion people live without facilities for garbage disposal or water drainage and breathe polluted air.

These are mostly the poor, especially in urban or peri-urban slums. It is important to recognize this complex interaction between poverty, population, health and the environment and study potential interventions (Health Research: 1990).

Poverty should thus be tackled on two fronts: one to ensure that the poor have access to primary health care (especially families with young children and vulnerable groups such as the elderly), the other to enhance the health potential of the current workforce and future workforce (school children).

Poverty reduction need not be a long term process. Many development countries have demonstrated that the worst forms of poverty can be rapidly reduced or eliminated. In a relatively short time with determined, well-designed and efficiently implemented strategies. (WHO: 1995).

In summary, the larger foundation on which health development and poverty alleviation are built must not be forgotten. The potential for change differs greatly among the world's people and the systems in which they live. Although these differences need to be recognized, it is also becoming clear that there is a common vision of health and social development that includes equity, elimination of poverty employment, social justice and the basic needs for human welfare such as health, education, shelter and food (Global Forum for health Research: 1999).

3.2 The Empirical Literature:

The empirical literature is based on the problems facing Yombo Vituka ward. The problems facing Yombo Vituka ward are diseases found in the area like malaria, cholera, aids, measles, and fever, long distance walk to Temeke District hospital and poor sanitation environment.

The community is aiming objectively at enhancing the community to participate in construction of a dispensary at Yombo Vituka ward within one year. To ensure that the constructed dispensary is operative and well maintained. And as well to improve sanitation of Yombo Vituka ward.

Need and demand for health services:

A useful way of looking at a community is to consider both their needs and demands for health services. The demand for health services comes from the various problems for which the people seek help, whether they treat themselves, see a herbalist or witch doctors and attending the health centre.

These problems are first diagnosed by the people themselves when they say “I do not feel well” or ‘I am weak, I cannot go to the shamba field’ when their illnesses have already progressed as far as producing symptoms.

The need for health services comes from all the health problems that actually exist in a whole community of about 50,000 people (Wood et al, 1981).

The resources for the development of the health services are limited and health services must compete with other priorities like education, agriculture and water. The problem is how to use these limited resources so that everyone in the population gets some benefits.

Dispensary services: this is the first formal health unit of level one health services. It is a primary health facility which offers out –patient services including reproductive and

child health services including reproductive and child health services including reproductive and child health services, and diagnostic services. A dispensary caters for between 5000 to 10,000 people and oversees all the village health services a health centre shall cater for 50,000 people (Tanzania:2002)

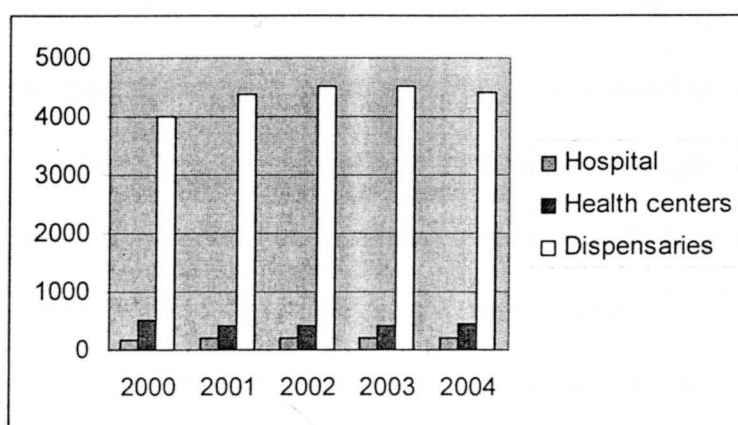
A Significant increase in the number of health facilities between 1961 and 1991 are as follows:

Table 3.2.1: Health facilities in Tanzania since 1961-1991

	1961	1991	TOTAL
Hospital	98	175	273
Health centers	22	276	298
Dispensaries	875	3,0149	3,1024

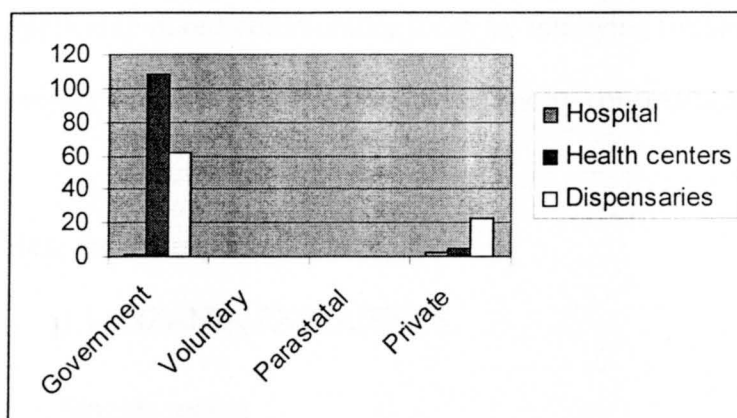
Source: Guideline standards for health facilities. Tanzania.

Health Facilities in Tanzania Since 2000- 2004



Source: National Bureau of Statistics President's Planning and privatization June, 2005.

Figure 2: Health Facilities in Temeke municipal -2000



Source: Temeke Municipal Council 2006.

Partnership with the private sector:

Poor people make heavy use of private, for-profit and not-for profit services (NGO and religious). The public sector in many developing countries does not have either the capacity to deliver health services itself to the entire population or to ensure that health services delivered by the private sector promote health objectives.

The type of partnership that government can develop with private providers will vary according to patterns of use and their relative strengths and qualities. Government may choose to contract out particular services to NGOs or seek to improve the quality of services available in the private-for-profit sector.

For instance the following experiences show how the community projects at the grass-root level can be built through community efforts, international volunteers, NGOs by using local resources within the community and the resources outside the community

like donor funding and government itself providing construction materials. This can be applicable in our communities today by following the same procedures and a community project like that of YomboVituka dispensary construction can be successfully achieved.

Here are the experiences:

i) TANZANIA EXPERIENCE

Singida region

Currently, the ward is served by one dispensary in Ghalunyangi, which is about ten kilometers from Matumbo. The villagers usually walk at least 8 kilometers to health services at Mtinko Hospital.

Matumbo, Mkenge and Mpoku villages receive a mobile clinic services once a month from Mtinko Hospital. Normally pregnant women walk long distance of 8-10 kilometres to Mtinko Hospital for ante and neo natal health services.

HAPA is a non-governmental Organization in the area. HAPA carried out a Needs Assessment of the villages in the Makuro ward where these villages located. It was found that a dispensary is the highest priority identified followed by medical staff housing (in Tanzania the government provides housing for medical staff and teachers in rural areas).

HAPA intends to support the community of Matumbo with provision of building materials for one dispensary, provision of technical and management of the project

implementation support. The community contribution in this project include local villagers manpower during the implementation processes, collection of local available materials such as sand , rocks and aggregates , raising funds to pay village masons and carpenters. In addition the international volunteers worked alongside villagers building project they have initiated themselves such as the construction of village dispensaries (health centers) , school classrooms, pit latrines and staff houses for teachers and medical staff at Singida region.

The health service will be improved and health education easily provided. People will be encouraged to adhere to good hygiene and sanitation practices. With more easily accessible healthcare the health of most of the village population will improve. Hygiene and sanitation practices will improve in the village.

ii) GHANA EXPERIENCE

Near Assin Fosu in the central region

The Assin Fosu village has no health services and are receiving the services once a month by rural medical aiders. Major diseases in the villages include the following , malaria, diarrhea, stomach diseases, there are incidences of malnutrition and eye diseases.

The voluntary work camps Association of Ghana (VOLU) co-operate with the villagers and volunteers these are Ghanaian and international volunteers come together for Community – building projects like health centers (dispensaries), school, organize an HIV/ AIDS awareness campaign, help replenish the local rain forest,

community development. The volunteers and villagers live, learn and work voluntarily, mainly by manual labor, for the benefits of the Community. That is help poor communities to do work which the villagers of Assin Fosu would otherwise be unable to do, by using the local available materials like stones, aggregates and some help from the government like iron sheets for roofing, cement, paints etc.

It is rather to assist the villagers in helping themselves by working with them on the project. The common issue is that the community development work of VOLU, in addition to being self help, is sustainable and grass roots – local communities decide which project are needed and feasible.

iii) SINGAPORE EXPERIENCE

Mat-su Communities

Valley Hospital Association created the Valley Health Communities Program (VHCP) which is a non – governmental organization . The purpose of this initiative was to work closely with Mat–Su valley residents to raise the health status of Mat-su Communities by identifying and meeting community health needs.

The Valley Health Communities Program has envision a community where communities and citizens come together to develop and maintain physical, mental, economic and environmental health. That is need areas are community health centers, water safety, school health, suicide prevention, senior health issues etc.

The Mat-su Communities had a dispensary built by community initiatives and improvement have been done is now a health center serving the Mat-su communities.

The aim is to continue to work closely with Mat-su valley residents to raise the health status of Mat-su Communities via Community -lead project and programs.

The dispensary services, this is the first formal health unit of level one health services. It is a primary health facility which offers out-patient services including reproductive and child health services and diagnostic services, (National Health Policy, 2002:17).

Through the experience for Tanzania, Ghana and Singapore the various constructions of health facilities like dispensary through non-governmental organizations and from people initiatives will enhance the development of areas without services. This is done by getting idea on resource mobilization within the society and outside the society.

The rural people have been involved in some decision – making, they have participated in communal work , and most of all have become aware of the problems inherent due to lack of health centers or dispensaries in their areas.

The experiences are relevant to Tanzania situation because the establishment of health services do promote the provision of health education that encourages adhering to good hygiene and sanitation practices. Thus, accessibility of health care may improve the health of the people.

The situations do differ in the practice depending on environmental conditions, economic condition and even attitude of the people, but all aim at provision of good health for all.

The government of Tanzania has decided to put greater emphasis on preventive medicine and the basic health services that all people need. This means organizing the services to provide more primary and secondary prevention for the whole population. This is being achieved by building more dispensaries and health centre so that most of the people of Tanzania will be living within about 10 kilometers of a dispensary, health centre or hospital and also by a programme of training village health workers and encouraging community participation in health activities (Wood et al,1981).

3.3 Policy Review:

Yombo Vituka is facing problem of diseases like malaria, cholera, typhoid, measles fever. The long distance walks to Temeke District hospital. Poor sanitation in the area. All these need to be solved by, enhancing community to construct a dispensary and to ensure that the constructed dispensary is operative and well maintained. Therefore all this need policies and guide lines to operate effectively and for the dispensary construction at Yombo vituka ward to be successful.

According to the Government reform policies, the health sector is one of the priority sectors. In the health sector, health policies should clearly identify the roles that all health actors including NGOs, community-based organizations and the private-for-profit sector have to play in improving health outcomes for poor people. Partner

countries planning and health ministries and development agencies, moreover, should take concerted action to ensure that the importance of health is recognized across government as central to reducing poverty and attain broader development objectives and that this goals is reflected in poverty reduction strategies.

Strengthening the capacity of the public sector to carry out the core functions of policy maker, regulator, purchaser and provider of health services is central to the development and implementation of health systems. Strong institutional and organizational capacity, moreover, is necessary to track the use of resource strategies. These key issues go beyond the health ministry alone and reflect the necessity of placing health-sector reforms within the context of broader governance reforms (WHO, 2003)

In the Tanzania Development vision 2025, health is mentioned as one of the priority sectors. Among its main objectives is achievement of high quality livelihood for all Tanzanian. This is expected to be attained through strategies, which will ensure realization of the following health service goals.

1. Access to quality primary health care for all.
2. Access to quality reproductive health service for all individuals of appropriate ages.
3. Reduction infant and maternal mortality rates by three quarters of current levels.
4. Universal access to safe water.
5. Life expectancy comparable to the level attained by typical middle income

Countries.

6. Food self sufficiency and food security.
7. Gender equality and empowerment of women in all health parameters.

Policy Vision: The vision of the Health policy in Tanzania, is to prove the health and well being of all Tanzanians with a focus on those at risk and to encourage the health system to be more responsive to the needs of the people.

Policy Mission: To facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status.

Policy Objectives:

The objectives of the Policy are to:

1. Reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services facilitate the promotion of environmental health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions.
2. Ensure that the health services are available and accessible to all the people in the country (urban and rural areas).
3. Train and make available competent and adequate number of health staff to manage health services with gender perspective at all levels. Sensitize the

community on common preventable health problems, and improve the capabilities at all levels of society to assess and analyze problems and design appropriate action through genuine community involvement.

4. Promote awareness among Government employees and the community at large that, health problems can only be adequately solved through multisectoral cooperation involving such sectors as Education , Agriculture , Water , Private Sector including Non Governmental Organization, Civil Society and Central Ministries such as Regional Administration and Local Governmental, Finance and Community Development , Women Affairs and Children.
5. Create awareness through family health promotion that the responsibility for ones health rests in the individuals as an integral part of the family, community and nation.
6. Promote and sustain public – private partnership in the delivery of health services.
7. Promote traditional medicine and alternative healing system and regulate the practice.

The above is the policy review for Tanzania Ministry of Health where it insist on basic health services that are provided by dispensaries and health centers to represent the minimum level of health services that should be available to the majority of the population. Also dispensaries belong to the village/community more than to the

government health services, although the whole health programmer in a district is under the professional supervision of the district medical officer.

Policies from the UN-SYSTEM and the Millennium Development Goals (MDG)

In developing countries, breaking the vicious circle of poverty and ill health is an essential condition for economic development. The fact that three of the eight Millennium Development Goals are specific to health is across the international development community.

Achieving better health for poor people requires going well beyond the health sector to take action in related areas such as education, water and sanitation.

Health is now higher on the international agenda than ever before, and concern for the health of poor people is becoming a central issue in development. Indeed, three of the Millennium Development Goals (MDGs) call for health improvements by 2015, reducing child deaths, maternal mortality and the spread of HIV/AIDS, malaria and tuberculosis.

Achievement of the three health related MDGs, for instance, all hinge strongly on reaching the MDGs of gender equality and universal primary education. Female education, in particular is strongly linked to improved health care for children, families and communities and to lower fertility rates. Education is also one of the most effective tools against HIV/AIDS (WHO, 2003)

The diseases like , HIV /AIDS , tuberculosis and malaria come to be discussed in a variety of forums at the UN as well as outside the UN, and Commitment to address the three disease were made for example , by the G 8, the world Bank , the world Economic Forum and the European Commission.

Millennium Development Goals (MDGs) are a product of consultations between international agencies, but were also adopted by the United Nations (UN) General Assembly as part of the road map for implementing the substantially broader Millennium Declaration, which it had adopted in September 2000. The MDGs have eight goals, three of which are health – focused, namely those on child mortality, maternal health and HIV/AIDS, malaria and other diseases.

The UN – led Millennium Project has the objective of ensuring that all developing counties meet the MDGs. The whole UN system has since been requested to adapt to addressing the MDGs, and to report to the secretary General on their achievements in that direction.

For health policies, this has meant, for example pressures from some of the member states, such as the UK, for the WHO to refocus its work on the MDGs, most notably to the goal concerning HIV/AIDS, Malaria and tuberculosis.

The MDGs have become an important tool to steer both the UN system towards a narrower agenda with more emphasis on selected interventions and country presences, but more recently increased attention has been placed on the need for addressing development – including health policy issues and systems, more comprehensively.

By 2015 all United Nations Member States have pledged to do the following in health sector:

1. Reduce child mortality.
2. Improve maternal health.
3. Combat HIV/AIDS, malaria and other diseases.

An emphasis on innovations and innovative approaches encourages the use of new technologies and the building of new structures both at global, and national levels up to grass root levels (ollila:2005).All this is aimed at good health for all.

Therefore the nations of the world have agreed that enjoying the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, and political belief, economic or social condition. Beyond value to individuals, health is also central to overall human development and to the reduction of poverty. (Health, education and poverty, 2002)

CHAPTER FOUR

PROJECT IMPLEMENTATION

Introduction

The implementation of this project is under sponsorship of TASAF and the Community of Yombo Vituka ward under supervision of YOKIDA CBO. TASAF has contributed 15,899,050/- Tanzanian shillings and the community has contributed 5,776,175/- Tanzanian shillings. YOKIDA is responsible for mediating between The donors and community.

4.1 Products and outputs

The important products and output of the CED project in Yombo Vituka will be as follows:

Product:

1. The dispensary Building: having the dispensary building will provide the availability of community dispensary services because people who are already sick will get treatment from the dispensary. And, primary health care services will be provided with emphasis on prevention than cure. Educating the community on nutrition and prevention of diseases.

Output:

2. Training: training the community on prevention of diseases, keeping clean Environment and distribution of IEC materials: after training the community, the output is, people will keep clean environment by creation of proper disposal of

waste in every household, drink boiled water, use mosquito nets and wash their hands after every toilet visits.

4.2 Project Planning (See planning table 4.2.1) with designation of responsibility for undertaking each activity, resources required and planned delivery timeline.

4.3 Implementation Plan (See Implementation Plan table 4.3.1) a list of activities needed is generated to accomplish each objectives including people responsible, time frames and resource requirements.

Table 4.3.1: Project Planning

Activity	People Responsible	Resource Requirements	MONTHS																	
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Creation of community awareness on the problem	YOKIDA, Technical Advisor CED,	Stationery																		
Training the community	Health officer, YOKIDA, Primary health committee	Stationery, Allowance for trainer																		
Strategic Action Plan	Technical advisor CED, YOKIDA																			
Resource Mobilization plan	Technical advisor CED, YOKIDA, the construction committee and Donors	Financial and Human Resources																		
Building the Dispensary	Technical advisor CED, YOKIDA and the construction committee	Financial and Human Resources																		
Starting to Operate	Technical advisor CED, YOKIDA, the District Health Department and the Ministry of Health.	Financial and Human Resources.																		

Table 4.3.1: Implementation plan

[illegible]

4.4 Inputs

1. Funds for construction of the dispensary was contributed by TASAF and community of Yombo Vituka. TASAF contributed 15,899,050 /- and the community contributed 5,776,175 /-.
2. Community mobilization on creation of awareness on implementation of project activities. This was undertaken by CMC, TASAF and the local government.
3. Capacity building, during the training stationeries was provided to the participants and allowance was provided to the Health worker who facilitated the training. This was contributed by YOKIDA CBO, the amount was 60,000 /-. This was done through ten cell leaders informing the people and each house hold heads were invited in the training.
4. Human Resources
 - a. For construction there must be skilled and unskilled workers

The skilled workers were engineer 1, designer 1, construction technicians 8.

The unskilled workers like labourers who are available depending on the need.
 - b. For operating and maintaining the dispensary there must be medical staff.
5. Construction materials: in the construction of dispensary there is a need for construction materials like nails, ironsheets, sand, steel bars, bricks, cement, binding wires and timbers (see appendix F: table 4.6.1 a)

6. YOKIDA CBO in co operation with Temeke District Health Department which is a government body will provide the medical staff and staff salaries, dispensary supplies like medicines, medical equipments, water and power,

4.5 Staffing pattern: according to the United Republic of Tanzania Guideline standards for health facilities, medical staffs that are required in the dispensary are as follows below. All in all, the request must be done to Temeke District Health Department for provision of staff for the dispensary, as the government is responsible.

Clinical Cadre

- i) Assistant Medical Officer 1 (Supervisor)
- ii) The supervisor should spend at least two hours twice per week at the dispensary.
- iii) Clinical officer (MA) 1
- iv) Clinical Assistant (RMA) 1

Nursing Cadre

- i) Registered Nurse Midwife 1

- ii) Public Health Nurse (PHNB) 1 or trained nurse at all time the clinic is open
- iii) Mother and child Health (MCH) aides 1

Paramedical

1 trained laboratory Assistant

4.6 Project Budget – cost analysis for community dispensary at Yombo Vituka Ward (See Appendix F: table 4.6.1a and 4.6.2 b).

4.7 Project Implementation

During the actual project implementation began with:

1. Seminar on 28/8/2006 -3/9/2006. The people involved were, construction and mobilization committee (CMC), TASAF staff and the local government leaders of Yombo Vituka. The seminar is on preparing the budget for the construction of the community dispensary at Yombo Kilakala. People were involved in all stages of the planning process from the initial point of problem identification, project design, decision making. This will help them be responsible for their project and feel that the project belongs to them.
2. Mobilization meeting was done on 5/9/2006 - 8/9/2006. People involved were 700 community people, CMC, TASAF and local

government leaders. Mobilization was on the construction of community dispensary that everybody has the right to know about it. And, the TASAF people were to see if the people did agree on the project as well turn up of the people through talking to them implies acceptance.

3. Building set out was done on 14/3/2007 – 17/3/2006. People involved were CMC,TASAF, local government and the community manpower. This is the initial stage of construction.
4. Foundation excavation was done on 15/3/2007 -18/3/2007. People involved were CMC,TASAF and local government and the community manpower.
5. Pouring of reinforced concrete foundation was done on 19/3/2007 - 30/3/2007. People involved were CMC,TASAF and local government and the manpower.
6. Building setting foundation was done on 1/4/2007 – 4/4/2007. People involved were CMC,TASAF and the local government and the manpower.
7. Soil ramming was done on 5/4/2007 – 8/4/2007. People involved were CMC,TASAF, the local government and the manpower.
8. Concrete floor pouring was done on 17/4/2007 -20/4/2007. People involved were CMC, TASAF, the local government and the manpower.

9. Evaluating meeting was done on 21/4/2007 - 22/4/2007. People involved was CMC, TASAF, the local government leaders and the community of Yombo Kilakala. Evaluation is done for the construction of the community dispensary, to see to what extent the work has been covered.
10. Building wall was done on 27/4/2007 – 6/5/2007. People involved were CMC, TASAF, local government and the manpower.
11. Pouring concrete for lintel was done on 7/5/2007 – 9/5/2007. People involved was CMC, TASAF, local government and the manpower.
12. Column was done on 13/5/2007 – 26/5/2007. People involved was CMC, TASAF, local government and manpower. End of reporting is here. The researcher ended up here in reporting during her research period.
13. Roofing is expected to be done on mid June after the release of third phase funds from TASAF and other stages will be completed as follows below:
14. Doorframes and shutters.
15. Progress meeting.
16. Window frames.
17. Ceiling installation.
18. Wall plastering.
19. Floor.

- 20. Window shutters.
- 21. Electrical installation.
- 22. Sitting bench.

The third phase will end up here where the building is completed and will start to operate on late December 2007. In the operation of the dispensary the health education activities will be provided daily as primary health care services.

TABLE 4.7.1: PROJECT IMPLEMENTATION PROCESS: COMMUNITY DISPENSARY AT YOMBO VITUKA WARD

No	Activities	Supervisor	Resources	Comments	Time frame	
					Planned	Actual implementation
1.	SEMINAR	CMC /TASAF Local government	Note book Pen Flip chart Drinks/bites Trainer Marker pen Maskin tape Allowance	The activity went as fixed date.	28/8/2006 - 3/9/2006	-
2.	MOBILIZATION MEETING	CMC/TASAF Local government	700 people	The activity went accordingly.	5/9/2006 - 8/9/2006	-
3.	BUILDING SETTING OUT	CMC/TASAF Local government	Labourers Artisan String Pegs Foreman nails	There was a delay from TASAF in releasing funds For construction.Begining of phase one.	15/9/2006 - 18/9/2006	14/3/2007 - 17/3/2007
4.	FOUNDATION EXCAVATION	CMC/TASAF Local government	Artisan Labourers		9/10/2006- 14/10/2006	15/3/2007- 18/3/2007

			foreman			
5.	POURING OF REINFORCED CONCRETE FOUNDATION	CMC/TASAF Local government	Cement Sand Gravels Water Artisans Labourers Reinforcing steel bars Binding wire Saw foreman		23/10/2006 - 2/11/2006	19/3/2007 - 30/3/2007
6.	BUILDING SETTING FOUNDATION	CMC/TASAF Local government	Sand Cement bricks Artisans Cement build Brick making Machine Mason Labourers Water Sand to build foreman		3/11/2006 - 6/11/2006	1/4/2007 - 4/4/2007
7.	SOIL RAMMING	CMC/TASAF Local government	Sand Labourers		7/11/2006 - 10/11/2006	5/4/2007- 8/4/2007

			Water Foreman Artisan			
8.	CONCRETE FLOOR POURING OF	CMC/TASAF Local government	Sand Cement Gravels Water Timber Nails Artisans Labourers Foreman		20/11/2006 - 24/11/2006	17/4/2007 – 20/4/2007
9.	EVALUATION MEETING	CMC/TASAF Local government	700 people		27/11/2006- 28/11/2006	21/4/2007- 22/4/2007
10.	BUILDING WALL	CMC/TASAF Local government	Cement Sand Artisan Water Brick making Machine Cement/build Labourers		1/12/2006 - 11/12/2006	27/4/2007 – 6/5/2007

11.	POURING CONCRETE FOR LINTEL	CMC/TASAF Local government	Reinforcing steel bars Gravels Sand Cement Binding wire Rings Nails Water Labourers Artisans Foreman		12/12/2006 - 14/12/2006	7/5/2007 – 9/5/2007
12.	COLUMN	CMC/TASAF Local government	Gravels Reinforcing steel bars Rings Timber Nails Sand Cement Water Labourers Artisans Foreman	End of phase one and two in the construction, about 17,185,451.25 Tanzanian shillings have been used.	20/12/2006 - 2/1/2007	13/5/2007 – 26/5/2007
13.	ROOFING (Treated timber)	CMC/TASAF Local government	Timbers Binding iron	Beginning of phase three the funds will be	7/1/2007 - 11/1/2007	

			Strips Nails Timber Caps Iron sheets nails Artisans Labourers Bolts Foreman	Released on the beginning of June 2007 to continue with the construction.		-
14.	DOORFRAMES & SHUTTERS	CMC/TASAF Local government	Frames Shutters Door locks Hinges Screws Labourers Artisans Foreman		10/1/2007 - 30/1/2007	-
15.	PROGRESS MEETING	CMC/TASAF Local government	700 people in the ward		27/1/2007 - 17/2/2007	-
16.	WINDOW FRAMES	CMC/TASAF Local government	Window frames Artisans Labourers Foreman		23/2/2007 - 5/3/2007	-
17.	CEILING	CMC/TASAF	Hard board		6/3/2007 -	

	INSTALLATION	Local government	Ceiling nails Cornices Artisans Labourers Foreman		13/3/2007	—
18.	WALL PLASTERING	CMC/TASAF Local government	Sand Cement Lime Water Labourers Artisan Foreman		6/3/2007 - 13/3/2007	—
19.	FLOOR	CMC/TASAF Local government	Sand Cement Water Labourers Artisan Foreman		14/3/2007 - 16/3/2007	—
20.	WINDOW SHUTTERS	CMC/TASAF Local government	Window shutters Labourers Artisan Foreman		24/3/2007 - 30/3/2007	—

21.	ELECTRICAL INSTALLATION	CMC/TASAF Local government	Electrical conduits Switch boxes Main switch Wire Circuit breaker Earthrod Earthwire Copper wire Bulbs Connectors Labourers Artisans Foreman Switch		3/4/2007- 7/4/2007	-
22.	SITTING BENCH	CMC/TASAF Local government	Bricks Reinforcing steel bars Mm16, mm12, mm10. Binding wire Wire kashata Gravels Labourers Artisan		17/4/2007 - 22/4/2007	-

CMC=Construction and Mobilization Committee formed from the community where the dispensary construction is taking place.

4.8 Resource mobilization plan

TASAF have contributed 15,899,050/- towards the project while the community

Of YomboVituka have contributed 5,776,175/- on their own initiatives.

The project has started on 14/3/2007 and is expected to end on later 2007.

When planning a community development project, it is important to have a clear idea about needed resources, resources available in the community, resources that need to be Obtained from outside, ways of making maximum use of such resources.

The resources needed is in form of cash,manpower,building materials,building ground and capital working.

Seeking funds for building materials and construction are obtained from TASAF donor.

Resource mobilization planning:

Phase one: Create awareness of the community in the construction of community dispensary and the problem faced.

Phase two:

a) Look for plot, sketch map and cost analysis for construction.

a) Create awareness of the community in the construction of community dispensary and the problem faced.

b) Secure funds for construction of community dispensary

Internal donor –community and external donor-TASSAF

c) Mobilization of manpower like masons, laborers, construction engineer, stakeholders.

This is done in the community where people can volunteer to work in the construction activities.

There is skilled labor that is to be paid salaries like foreman, masons and engineers.

There is an unskilled labor that is laborers and is paid wages daily.

Phase three:

Procurement of building materials where TASSAF is the purchaser and the community is to receive, cross checking and storing them. (See Appendix F: table 4.6.2 b)

Phase four:

Construction begins (see Appendix F: table 4.6.1 a)

Phase five:

Provision of dispensary service, working materials, staffing, patients to be attended.

Table 4.8.1: STRATEGIC ACTION PLAN

[illegible]

CHAPTER FIVE

MONITORING, EVALUATION AND SUSTAINABILITY

5.1 Monitoring

5.1.1 Introduction:

Monitoring refers to the ongoing assessment of the program's progress in Implementation and in achieving its stated goals and objectives.

Monitoring starts with the problem identification and assessment of Process, outputs and outcome and impacts of the project.

Evaluation refers to the use of social research methods to systematically investigate a program's effectiveness. Monitoring assess what is being done, whereas evaluation assesses what has been achieved or what impact has been made.

Over the past few years, one largely agreed upon Monitoring and Evaluation M&E framework has emerged, i.e. the input-process-output-outcome-impact framework.¹ Accordingly, *Inputs* refer to such things as human and financial resources and time committed to the program or project. *Outputs* refer for instance to such things as stocks (e.g. buildings) of goods and delivery systems for health care. This includes things like drugs and other essential commodities, new or improved services, trained staff, information materials, etc. These outputs are often the result of specific *processes*, such as development of the strategic plan for the dispensary construction, development of the resource mobilization plan, mobilizing resources, constructing

¹ World Health Organization. The World Bank, UNAIDS. USAID, CDC. The Global Fund (2004) Monitoring and Evaluation Toolkit HIV/AIDS

the dispensary and providing the primary health care services at the dispensary. *Outcomes* refers to short term or intermediate results of the program's activities (such as increased number of people accessing health care services at the Community Dispensary by age groups), while impact refers to the long-term effects of the programme that can be attributed to the program or project, e.g. reduced infant mortality rates in the community' etc.

5.1.2 Inputs Monitoring

Inputs to be monitored in this project includes availability of human Resources within the YOKIDA for the development of the Strategic action Plan, the resource mobilization plan and undertaking the resource Mobilization activity. This will also include availability of seed money for Purchasing of stationeries, communication and other incidentals. Besides, inputs monitoring will also be undertaken during the construction process and eventually when the dispensary starts to operate.

5.1.3 Process Monitoring

This constitutes monitoring of all the process at each stage of the project implementation. In our case, the processes to be monitored will include, the strategic plan development process, the resource mobilization proposal designing process, the resource mobilization process, the dispensary construction process, the dispensary operation and maintenance processes

5.1.4 Output Monitoring

This the assessment of whether the processes are delivering the required Outputs in the desired quantity and quality. Monitoring in this case will Constitute assessment of the outputs designated to achieve each of the Objectives in our project.

5.1.5 Evaluation of Outcomes and Impacts of the Project activities in the Community.

This is done during the formative and summative phase of evaluation.

This however is done after the facility has been in operation for a considerable long period of time (formative phase). This will probably be undertaken after the CED project technical support has ended. But the important areas to be assessed are as follows (summative phase):

1. Whether there is an improvement in access to primary- health care services by all members of the community after establishment of the dispensary within the community.
2. Whether there is an improvement in the status of health in the community as indicated by the reduction in infant and child mortality rates, decreased incidences of epidemics such as cholera, malaria and measles etc.

TABLE 5.1.6 : THE MONITORING AND EVALUATION
COMMUNITY DISPENSARY PROJECT AT YOMBO KILAKALA IN
VITUKA WARD.

EVALUATION
(Effective Evaluation)

<i>INPUTS</i>	<i>PROCESS</i>	<i>OUTPUT</i>	<i>OUTCOME</i> <i>(Short-terms and Intermediate Effects)</i>	<i>IMPACT</i> <i>(Long-terms Effects or)</i>
<ul style="list-style-type: none"> • Staff • Funds • Facilities • Supplies • Community 	<ul style="list-style-type: none"> • Strategic Plan Designing • Resource Mobilization Plan Developing • Resources mobilization activity • Dispensary construction activity • Operating and maintaining the dispensary • Dispensary providing the required primary health care services in the community. • Training on prevention of diseases and keeping clean environment. 	<ul style="list-style-type: none"> • Existence of the Strategic Plan for Dispensary construction, operation and maintenance • Existence of the resource mobilization plan • Resources mobilized • Primary Health care services provided by dispensary 	<ul style="list-style-type: none"> • Reduced infant and child mortality rates. • Reduce maternal mortality. • Diseases are controlled in the area. • Clean environment due to introduction of primary health care. 	<ul style="list-style-type: none"> • Improved life expectancy in the community • Improved sanitation in the area.

5.1.7 PARTICIPATORY MONITORING AND EVALUATION

5.1.7.1 Participatory Monitoring:

Participatory Monitoring is the systematic recording and periodic analysis of information that has been chosen and recorded by insiders with the help of outsiders.

The main purpose of participatory monitoring is that it provides information during the life of the project, so that adjustments and / or modifications can be made if necessary.

Project Selected: Improvement of Community Health at Yombo Vituka Ward. Case Study of Yokida Community Based Organization.

Introduction: The community of Yombo Kilakala is faced with various problems such as poor sanitation, women and children walk long distance from Yombo Vituka to Temeke District Hospital to find health services, and the community is affected by malaria, measles fever, HIV/AIDS, and cholera.

Steps to participatory Monitoring:

5.1.7.1.1 Step one.

Reasons for monitoring:

The reasons of monitoring community dispensary project in Yombo Vituka are as follows:

- a) It provides information related to problems faced by the community.
- b) Obtained information can adjust or modify the problems faced the project.
- c) It help to track of activities by recording the information on daily, weekly, monthly on seasonal basis. Such as poor sanitation in the area.

d) When monitoring the group members will analyze, discuss and integrate information. For example, water born diseases like cholera, malaria. The community can discuss to find the solution to the problem.

5.1.7.1.2 Step two: Objectives and activities reviewed are as follows:

Objectives:

- a) Improvement of community health status.
- b) Creation of better environmental sanitation at Yombo Vituka.
- c) To ensure that the dispensary is constructed within the next one year.

Activities:

- a) Creation of community awareness on the problem faced.
- b) Training the community on prevention of diseases and keeping clean environment.
- c) Distribution of IEC materials.
- d) Resource mobilization of community dispensary construction.
- e) Building the dispensary.

5.1.7.1.3 Step three: monitoring questions developed as follows:

- a) Is the community trained? Here we want to know if 100 people will be trained.
- b) Is the distribution of IEC materials done? Here we want to monitor if the 100 brochures are distributed.
- c) Is the creation of disposing garbage done? Here we want to monitor the creation of disposing garbage in the area.

d) Are the resources available for the construction of the dispensary? Here we want to monitor if the proposal for resource mobilization is accomplished.

e) Is the dispensary going to be constructed within the next one year? Here we want to monitor the preparation of construction materials such as bricks,sand,iron sheets, aggregates and cements.

5.1.7.1.4 Step four: To establish direct and indirect indicators.

Direct Indicator

a) To reduce number of patients from thirty to six a day.

b) One dispensary will be build within a year.

Indirect indicator

a) Number of planned activities implemented in the operation.

b) Number of people using mosquito nets, clean environments and boiled water will increase.

5.1.7.1.5 Step five: The following are the information gathering tools used

a) Focus group meetings: discuss issues relevant to the community through gathering the opinions, ideas from small targeted group of people. Focus group meeting is ease to conduct and stimulates thinking and discussion because allows for issue probing.

b) Observation: this occurs were there is to observe the community, participatory observation involves seeing the degree of implementation and expectations through participating in project monitoring. Observation can help to obtain hidden information that cannot easily be expressed by the community like non-participants observation, the researcher used bird watching.

- c) Interview: the researcher asked questions with a purpose to gather information about monitoring and implementation of activities in the community.
- d) Documentary review: the researcher reviewed data that already exists to get insight about emerging trends or issues from the initial point of project implementation and monitoring.
- e) Encourage thinking about creating opportunities, considering strengths and weaknesses and limitations that might be present.

5.1.7.1.6 Step six: To decide who will do the monitoring.

- a) Monitoring will be done by CED technical advisor and the dispensary construction committee members.
- b) Primary health committee.
- c) Representatives of the Community Based Organization (CBO).

5.1.7.1.7 Step seven: Analyze and present results.

- a) The information monitored will be analyzed by CED technical advisor and will be discussed in community meeting.
- b) Analysis will be done quarterly.
- c) The presentation will be done through written reports and oral presentations to project beneficiaries.

After participatory monitoring the results are as follows:

Table 5.1.7.2: Activities done

Activities	Number of respondents		
	Men	Women	Total
	69	81	150
1.Sensitization on community in keeping clean Environment	46.6% (27)	53.4% (31)	100% (58)
2.Educating the community on prevention of diseases	42.3% (33)	57.7% (45)	100% (78)
3.Distribution of IEC Materials: brochures, posters etc	64.3% (9)	35.7% (5)	100% (14)
4.Resource mobilization for construction Of the community dispensary.	-	-	-

Source: Field data 2006

Activity 1: Sensitization on community in keeping clean environment.

From the table above, number of men attended the sensitization activity in keeping clean environment is 46.6% of 58 = $46.6/100 \times 58$ = that is 27 men while number of women are 53.4% of 58 = $53.4/100 \times 58$ = that is 31 women.

Indicator: Proper disposal of garbage and potholes in the area.

From the table above, men have responded low for about 27 than 31 women. Because women do domestic activities and petty business around home and are majority of the population so attend more in

community activities. Having the community create disposal of garbage in every household and fill in the potholes in the area will keep clean surroundings, there will be no littering and stagnant water.

Activity 2: Educating the community on prevention of diseases

From the table above, number of women attended the training is 57.7% of 78 = $57.7/100 \times 78 = 45$ women while Number of men attended the training are 42.3% of 78 = $42.3/100 \times 78 = 33$ men.

Indicator: Reduce number of patients from 30 to 6 a day.

From the table above, women have responded more for 45 women than men who are 33. Women are more than men in attendance because women are doing petty business near home then it was easy for them to attend. Furthermore, educating a woman is educating the whole family, because will pass the information to the rest of the family. Having the people educated on prevention of diseases will drink boiled water and use mosquito nets. Therefore, this training will help to reduce the patients from 30 to 6 a day which is the indicator of the objective.

Activity 3: Distribution of IEC materials: 150 brochures

From the table above, men received 64.3% of 14 men = $64.3/100 \times 14 = 9$ while women received 35.7% of 14 women = $35.7/100 \times 14 = 5$ women.

From the above analysis, people are not interested in reading the materials distributed, the number of people received the material is low

for men for about 9 and even worst for women for about 5. Despite of the fact the efforts done has helped to reduce diseases and promote clean environment (use of mosquito nets, boiling water to control cholera, proper disposal of waste)

Activity 4: Resource mobilization for construction of the community dispensary.

Needed resources for construction are: cash 15,899,050 /- from TASAF and 5,776,175/- was contributed by the community of Yombo Vituka, land / plot, capital working and building materials (See appendix F: Procurement of building materials).

Human resource: manpower (skilled and unskilled).

Indicator: The dispensary will be constructed within one year.

Since the resources were mobilized and available so the construction was performed accordingly with exception of a little delay in the beginning of the construction process. The construction started on March, 2007 there was a delay of TASAF in releasing money so the actual beginning of construction was supposed to be on 15th September, 2006. The construction is behind the schedule because of the World Bank proceedings in financial monitoring and evaluation but surely it will be completed at the end of 2007.

5.1.8 Participatory Evaluation:

Participatory Evaluation is an opportunity for both outsiders and insiders to stop and reflect on the past in order to make decision about the future.

5.1.8.1 Step one: To review objectives and activities.

- a) The objectives and activities will be reviewed by group meeting.
- b) The group members will plan and review the activities such as proper disposal of garbage and creation of new garbage disposal, train the community, creation of awareness, distribution of IEC materials, collection of sand and aggregates.

5.1.8.2 Step two: Review reasons for evaluation.

Evaluation is done in order:

- a) To find out if we did what we set out to do by checking if the activities are done as planned.
- b) To find out if we make better for our efforts such as proper disposal of waste, brick making, sand collection and stones.
- c) To ask our selves if our objectives still make sense.

5.1.8.3 Step three: To develop evaluation question.

- a) How many people were trained?
- b) How many brochures were distributed?
- c) How many garbage disposals were created?
- d) Are the people participating in the community activities?
- e) Is the dispensary constructed as planned?
- f) Are we doing the right thing as planned?

g) Are people using mosquito nets, pit latrines and boiled water?

5.1.8.4 Step four: To decide who will do the evaluation.

- a) The first meeting will decide on who will do the evaluation.
- b) The evaluation team will include CED technical advisor and dispensary construction committee.
- c) Primary health committee.
- d) Representatives of Community Based Organization (CBO).

5.1.8.5 Step five; To identify Direct and Indirect Indicator.

Direct indicator:

- a) Reduce number of patients from thirty to six a day.
- b) One dispensary will be built within one year.

Indirect indicator:

- a) Number of planned activities implemented in the operation.
- b) Number of people using mosquito nets, clean environments and boiled water will increase.

5.1.8.6 Step six: To identify the information sources for evaluation questions.

- a) The source of information for people participating in community activities will be obtained from daily attendance register to those who participate.
- b) The source of information that dispensary is going to be constructed as planned will be obtained in the quarterly report.
- c) The source of information that people are using mosquito nets will be obtained in the near by dispensary.

5.1.8.7 Step seven: To determine the skills and labour that are required to obtain information.

- a) The evaluation team must decide which skills and resources are available to them.
- b) The resources needed: money, manpower, land, construction materials, skilled labour and transport.
- c) The resources have are: manpower, land, sand and aggregates, skilled labour.
- d) Other resources needed to get: money, transport, cements, iron sheets, building equipments, hospital equipments.

5.1.8.8 Step eight: To determine when information gathering and analysis can be done.

- a) It is important to assure that information will be gathered and analyzed within the time frame which is given to the evaluation team.

5.1.8.9 Step nine: To determine who will gather information.

- a) The information will be gathered by CED technical advisor and dispensary construction committee.
- b) Primary health care committee.
- c) Community resource persons.
- d) Community Based Organization (CBO).
- e) Methods used in gathering information are:

Interviewing, observation and documentary review and SPSS package was used.

5.1.8.10 Step ten: To analyze and present results.

After Evaluation the achievements are as follows:

Summative Evaluation:

- a) 150 people were trained on prevention of diseases and keeping clean environment and 150 brochures were distributed. There were 69 men and 81 women who participated. In keeping clean environment sensitization women attended were 53.4% while in training 57.7% attended and in receiving IEC material 35.7% responded. This was done in the training. Men response in keeping clean environment was 46.6% while in training was 42.3% and in receiving IEC materials it is about 64.3%. Many women had good attendance than men.
- b) Proper disposal of garbage was done in every household in the area.
- c) In Participation, 10 people are required but attendance is 7 people a day that is $7/10 \times 100 = 70\%$ this indicates that, participation in the construction of the dispensary was good because is more than a half. The participation is 2 women while for men are 5 a day, which implies that 20% is women participation and 50% is men participation. This shows the importance of the dispensary as women and children are most vulnerable group mostly in need of medical services like MCH services.
- d) The construction of the dispensary is on third phase where as the first and second phase is completed this May, 2007 because of the delay extra effort and time was applied to cover the two phases simultaneously. The evaluation of the construction went

on well. TASSAF has given funds for the third phase; this will be for roofing and door frames and shutters and other stages to be covered.

e) Upon completion of the construction process i.e. having the dispensary building in place, surely the construction will be completed in the end of 2007.

Formative Evaluation:

a) The dispensary starting to operate in a considerable long period of time as planned and the medical services are being rendered.

b) The dispensary providing the required primary health care services to the community as planned.

5.1.9 Sustainability:

Community health care committee is to be active to ensure proper sanitation like garbage and potholes should be maintained, training the community on prevention of diseases and keeping clean environment and the distribution of IEC materials concerning proper sanitation.

Dispensary will be jointly owned with the community people and the government. Community people will pay small contribution for the services received in order to have a sense of ownership and commitment. This is due to health sector reform of 1994. The community must be involved in taking care of its own dispensary and improvement of health care in all levels.

The government provides Medical staff, working medical implements, staff salaries and medical kit distributed by Medical Stores Department (MSD) monthly through Temeke District Health Department.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

A) Results:

The results of improvement of community health care at Yombo Vituka is as follows:

The goals and objectives have changed over the life of the project because there is,

i) Objective 1:

Improvement of community health status in the area: This objective is fully achieved due to the fact that, there is reduction of diseases like malaria, cholera, with the efforts done in provision of training and sensitizing the community on keeping clean environment and educating the community on prevention of diseases. People can now boil water for drinking and use mosquito nets.

ii) Objective 2:

There is creation of better environmental sanitation: This objective is fully achieved through proper disposal of garbage in every household and fill in potholes so there is no stagnant water around this have reduced mosquito breeding areas and diarrhea in the community.

iii) Objective 3:

Construction of community dispensary within one year 2007: This objective is partially achieved because the dispensary is under construction on third phase and is expected to be completed soon this 2007 and be in operation within this 2007.

Unexpected occurrence that greatly affected the ability to complete the project was the delay of TASAF releasing money in time have caused the project to be behind the schedule. Then, the project is still under construction.

iv) The goals:

Have been achieved because the dispensary is under construction and surely will be completed soon this 2007. Therefore, the community of Yombo Vituka will have access to primary health care services. Hence, will be free from epidemic diseases.

v) Expected Outcome if the project is successfully completed:

Availability of dispensary will lead to improved health service and health education will be easily provided.

People will be encouraged to adhere to good hygiene and sanitation practices.

People will have improved health due to easy accessibility of health care.

Community people now know more about health services that are available.

People are satisfied with the increased availability and decrease cost of drugs through health centres as the drugs are given free for children. Hence, increase utilization of health services.

Although the project is partially self-sustaining financially, it needs the facilitative support of district level health workers, medical kit that is provided monthly, medical working implements, staff salaries so as to continue to meet the needs of the community.

B) Recommendations:

- i) The Government and the voluntary sector manage about equal number of hospital facilities in Tanzania. However, Government health centres and dispensaries account for most of the care provided at local levels. Ensuring wide access to basic, affordable, quality health services in an environment undergoing reforms is a major challenge in Tanzania. There is a serious need to translate policy changes into improved and sustained health outcomes, with specific attention to focus on the poor rural and urban people.
- ii) Sensitization towards the community on the importance of local contribution to support development project should be the highest priority for any CBO in the area. This will create a sense of ownership and belonging in the project development as community has contributed towards implementation of the project.
- iii) There is a need to seek for assistance for the communities, by encouraging NGOs and other Donor Agencies to support CBOs in their initiatives so that they can complete the community project that has failed to be completed by the community.
- iv) If the project is donor funded, the donor should ensure that the funds given out in time in order to cop up with the planned construction activities. Hence there should be no delay.
- v) The impact of user fees and cost sharing mechanisms needs better understanding and further independent analysis. While, opinions on their adoption remain divided, there is clear evidence that many of the poor and other marginalized groups are

unable to afford basic services. There should be exemption especially to those known by the community that are poor and can not help themselves.

vi) There should be an insistence to strengthen community participation in the development activities by promoting broader accountability in problem identification, planning, Implementation and monitoring of basic social services.

vii) The involvement of women in the project is a strong factor in building community support and has raised the status of women as community leaders.

viii) To improve the health conditions of the poor, more resources must be allocated to remote areas and the orientation to costly interventions are to be addressed and increasing preventive programs by constructing more dispensaries to cater the population.

BIBLIOGRAPHY

Eeva Ollila (2005) Restructuring global health Policy making:

The role of global public – private partnership.

In commercialization of Health care: Global and local Dynamic and
Policy responses.

Policy related to community Health in UN system.

Global Forum for Health Research (1999): Promoting Research to improve the health

Of poor people. WHO. Switzerland.

Goggle Rural Health Project in Tanzania

<http://www.volunteer africa.org/green/about?>

Health Research (1990): Essential link to equity and development.

Commission on Health Research for Development.

Kalabaka J.W. (1989; 262) People's participation in rural Development in Tanzania
Planners handbook. The Hague.

Leonard D.K (1983:54): Rural Administration in Kenya. East Africa

Literature Bureau.

OECD (2002) : Health, Education and Poverty Reduction. OECD

Development Centre. Policy brief no 19. Paris.

Ostrom et al (1993): Institutional incentives and sustainable

Development. Infrastructure policies in perspective.

West view press.

Pateman C (1970; 69): Participation and democratic theory. Cambridge

University Press.

Policy related to community Health in WHO

[http:// valley health communities.org/about.php](http://valleyhealthcommunities.org/about.php)

Valley Health Community Program.

Tavanlar E.J (1970:34); Quoted in Leonard D.K,Rural Administration in

Kenya. East Africa Literature Bureau.

Thomson D (1970:34): The democratic citizen. Cambridge University

Press.

United Republic of Tanzania (2002: 17); National Health policy. Ministry of Health.

United republic of Tanzania (1996: 1+ 2); Guideline standards for health facilities Dar

es Salaam

UNICEF (2001): Situation Analysis of Children in Tanzania.

VOLU – The voluntary Work camps Association of Ghana. Working to build Ghana.

<http://www.volu.org>

WHO (2003) : Poverty and Health.DAC Guidelines and references series.

WHO (2005) : Human rights, health and Poverty Reduction Strategies.

Issue no 5.

Wood C.H et al (1981): Community Health. Rural Health Series12.AMREF.

World Health Organization (1984): Glossary of Terms used in health for all series.
Geneva.