Technical Report 3: An Assessment of the Potential of Health Attendants for Family Planning and Reproductive Health Expansion in Tanzania

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Abbreviations

AIDS	Acquired Immunity Deficiency Syndrome
BP	Blood Pressure Machine
CBD	Community Based Development
CPR	Contraceptive Prevalence Rate
CTT	Central Training Team
DAPP	Diagnostic Assessment for Performance and Potential
DBL	Distance Based Learning
DHS	Demographic and Health Survey
DHMT	District Health Management Team
DMO	District Medical Officer
DMCHCo	District Maternal and Child Health Coordinator
DNO	District Nursing Officer
FP	Family Planning
FPU	Family Planning Unit
FGD	Focus Group Discussions
HA	Health Attendant
HC	Health Centre
HIV	Human immunodeficiency virus
HRD	Human Resource Development
IEC	Information, Education and Communication
INTRAH/RON	Program for International Training in Health, Regional Office, Nairobi
IST	In-Service Training
IUCD	Intra Uterine Device
MA	Medical Assistant
MCH	Maternal and Child Health
MCH Aide	Maternal and Child Health Aide
MIS	Management Information System
MNCEB	Mean Number of Children ever born
MOH	Ministry of Health
PCS	Population Communication Services
RH	Reproductive Health

RHMT	Regional Health Management team
RHU	Reproductive Health Update
RMA	Rural Medical Aide
RMO	Regional Medical Officer
RMCHCo	Regional Maternal and Child Health Coordinator
RNO	Regional Nursing Officer
SMI	Safe Motherhood Initiatives
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TKAP	Tanzania Knowledge, Attitude and Practices survey

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I. Executive Summary

1. Background and Purpose

Prior to 1994, the Tanzania Family Planning Policy Guidelines and Service Standards and the Tanzania Family Planning Training Strategy, which were developed to guide family planning service delivery and training, identified Nurse Midwives, Public Health Nurses, MCH Aides and Medical Assistants as the primary MCH/FP service providers. At a 1994 meeting of Regional Medical Officers to obtain their input to develop a five-year (1994-1999) strategy for family planning training, it was learned that the expansion of family planning services particularly in peripheral rural health units was severely restricted because of the limited numbers of these staff in each district available for training. Therefore, to increase the number of health workers eligible for FP training, Health Attendants were proposed as a new and suitable cadre to fill this service need. As a result, the 1994 revised Tanzania National Policy Guidelines and Standards for training and service delivery now identifies Health Attendants as among the priority cadres for FP training alongside MCH Aides, Nurse Midwives, Public Health Nurses and Medical Assistants to provide service at dispensaries, health centers and within communities.

The FP functions of Health Attendants that are stipulated in the guidelines are similar to those of MCH Aides. They range from providing information, education and counseling to FP clients to providing a variety of FP methods including IUCDs. MCH Aides and Health Attendants are also expected to screen clients for STDs and to refer clients with STDs for treatment. However very little is documented about this cadre of Health Attendants in terms of who they really are, what they do, and what they are capable of doing. Thus, it would be difficult to formulate a strategy for their effective participation in the expansion of FP/RH services.

In response to this lack of information, and the demand and expressed need for their training, a three-phase pilot project was designed to address these questions. The first phase consists of three parts. Part One was this Needs Assessment Study, whose findings and recommendations will form the basis of Part Two (the developing and refining of the training materials and approaches) and Part Three (the field testing of the training strategy). In the two later phases, Health Attendants in Tanzania will be trained using the developed training materials (Phase 2), and the effectiveness of the training will then be evaluated (Phase 3). The primary purposes of this needs assessment study were to:

- Explore the potential of Health Attendants to provide FP/RH services;
- Obtain data to guide development of a strategy to enable Health Attendants to participate in the expansion of FP/RH services in Tanzania.

2. Methodology

Kigoma region was selected as the site of the needs assessment study because it is one of the most under-served regions in Tanzania. It is poorly accessible geographically and reports a low contraceptive prevalence rate (CPR)—below 5 percent as of 1991. The study was conducted in Kasulu and Kibondo, two of the four districts in the selected region. A cross-sectional and qualitative approach was used to obtain baseline information on the deployment, working environment, knowledge and skills of all Health Attendants in the two districts. Information was also sought from their supervisors and instructors with regard to preferred training approaches for this cadre. Perceptions of MCH clients and members of the community concerning services provided at local health facilities were also obtained.

The following nine instruments were used to collect the required information by the study team:

I1 Health Attendant questionnaire
I2 Health Attendant pre/post test
I3 Health Attendant Instructor questionnaire
I4 MCH Clinic Supervisor and District Health Management Team questionnaire
I5 Health Facility questionnaire
I6 Health Attendant MCH/FP Skills Assessment questionnaire
I7 Focus Group Discussion guide for Health Attendants
I8A Focus Group Discussion guide for MCH clients in health facilities
I8B Focus Group Discussion guide for the community

The study team was comprised of three supervisors (one INTRAH consultant, one Tanzanian research person, one representative from the Family Planning Unit/Ministry of Health), eight data collectors (all from Kigoma and trained in comprehensive clinical skills), and the study manager (INTRAH Regional Research and Evaluation Officer).

Several activities were carried out by the study team before the actual data collection. The activities

preceding data collection were: organization of an orientation workshop for the Regional and District Health Management teams and data collectors, training of the data collectors and pretesting and revision of the instruments.

The data collection activities included interviews with Health Attendants' Instructors in Kigoma Urban and the organization of two data collection workshops for Health Attendants. Each workshop lasted two days during which time several instruments (*I1*—Health Attendants questionnaire, *I2*—Health Attendants' knowledge test questions and *I7*—focus group discussion guide) were administered by the data collectors. Data collectors also interviewed individuals who were responsible for formal training of Health Assistants (*I3*). Site visits to selected health facilities provided an opportunity for assessing Health Attendants' skills (*I6*), conducting interviews with MCH supervisors and In-Charges at the clinics (*I4*), collecting observational data at the site (*I5*) and carrying out the focus group discussions for MCH clients and the community (*I8A*, *I8B*).

By the end of the one month data collection period, 109 Health Attendants had responded to instruments *I1* and *I2*; (55 from Kasulu and 54 from Kibondo), 39 supervisors and managers had responded to instruments *I4*; 33 health facilities were visited, and 36 of the 109 Health Attendants who participated in the data collection workshops had their skills assessed at their work site using instrument *I6*. Focus group discussions were conducted with ten MCH client groups, nine Health Attendants groups, eight male community groups; and eight female community groups (see Table 2).

The data collected were reviewed in the field by the supervisors for accuracy, completeness, consistency and legibility. The study manager performed the quantitative analysis using Epi Info (Version 6.0). The qualitative analysis was performed by the INTRAH consultant and the Tanzanian resource person.

The Needs Assessment produced some important findings from which two categories of implications were drawn. The first set of implications concern the potential of Health Attendants for the provision and expansion of FP/RH services and the second set identifies factors which will guide the formulation of a suitable training strategy for this group. These implications are summarized below.

3. Positive implications regarding Health Attendants' potential

A) Health Attendants provide a stable and dependable work force

Health Attendants live in the communities in which they work, and the majority work in dispensaries in rural areas. Their long duration of employment as Health Attendants and at their present health facility imply that not only are they experienced but also very stable. The group also expressed satisfaction with their work environment.

B) FP/RH training efforts are feasible and desirable

There already exists a one-year formal training course for Health Attendants which is financed and managed at regional level. Forty percent of Health Attendants have attended this one year course. This indicates the existence of an established institution that can sustain a training intervention. Health Attendants expressed a desire to receive formal training which implies that they would look forward to attend an FP training course.

C) Male and female Health Attendants can deliver FP services

Both males and females are represented in this cadre of health service providers and both sexes are currently providing many FP/RH services and are capable, with additional training, of providing more and better services. Clients and the community do not show any gender preferences for service providers.

D) Health Attendants have MCH/FP/RH experience, and a knowledge and skills base

The Health Attendants already have the rudiments of FP/RH knowledge and skills. In particular they have demonstrated a well-developed skill in administering intra-muscular injection. This skill can be enhanced for providing Depo Provera to clients (since they currently provide FP services). A well designed FP training course can build on this and other skills.

E) Opportunity for integration of FP/RH with MCH services

Over 80 percent of Health Attendants reported they provide child care services, such as immunization, and growth monitoring. At least 70% give health education talks and perform deliveries, while 60% offer FP services. This provides an opportunity for integrating FP/RH into other MCH Services using Health Attendants.

F) Health Attendants are valuable community motivators/educators

As long term community members who are literate, with elementary school education and with years of health services experience, Health Attendants are potentially excellent community motivators and educators in the area of FP/RH. A high proportion (77%) are within the reproductive age group (15-49 years) and over half have used contraceptives at sometime in their lives. Thus they are FP users and FP providers and therefore have the potential to serve as positive community motivators/educators

G) Health Attendants are favorably recommended as FP providers

Health Attendants are favored as FP service providers by the instructors of their one-year formal training course and by their MCH supervisors. Among other attributes, Health Attendants are described as easily accessible to clients and as communicating effectively with them.

H) Existence of a local FP/RH infrastructure

The basic environment for FP services expansion is already in place. Most In-Charges of health facilities indicated the existence of a system for maintaining some form of inventory or supply management records and a mechanism for storage of supplies.

4. Negative implications regarding Health Attendants' potential

A) Structural shortcomings related to supplies management and essential commodities supplies management

All facilities report the lack of private rooms/space for FP client counseling and history taking and almost all health facilities report an acute/perennial shortage of drugs and other essential commodities. It is observed that there is a shortage of contraceptives supply in all the health clinics visited. The mean number of pill cycles available to FP clients in all 33 clinics on the day of the visit is 11, the corresponding means for condoms and foam tablets are 752 and 151 respectively, while Depo Provera is absent in all clinics. This finding contradicts reports from In-Charges of the health facilities, who indicate that they have no problems getting FP supplies and that the supplies get to the facility in good condition. In addition to the problem with contraceptives and medical supplies, almost half of the clinics

reported serious water supply problems. This shortage of water has implications on maintenance of

asepsis and other infection control measures

B) Transportation limitation

The In-charge of most facilities report that there are severe transportation problems, coupled with poor conditions of roads especially during the rainy season. These problems may hinder regular and timely supply of commodities and essential drugs and thus affect service expansion and access to these rural communities.

5. Implications for formulation of a training strategy

A) The fact that all Health Attendants can read and write in Kiswahili has a bearing on the:

- medium of instruction;
- language of the training materials;
- processes to be used in developing the materials from the initial stages.

B) The relatively low educational background of Health Attendants implies that :

- the use of training approaches and techniques that will be more suitable for trainees of low educational level (i.e., more practice, less theory, use of training media and methodologies that are locally familiar, for example song , poems that are sung - ngonjera, mashairi- drama, stories etc.);
- training should not necessarily be of long duration but perhaps phased, with specific skill areas to be attained at each phase;
- a training strategy should address a set of simple content areas at a time;
- training aids should be visual/audio and simple enough for easy interpretation;
- the possibility exists to use non-traditional learning approaches, which maximize adequately supervised on-the-job practice opportunities.
-

C) The FP curriculum developed for the training of Health Attendants should:

- be performance based;
- reinforce those aspects of client centered interpersonal and communication skills that currently exist and develop missing aspects;

- aim at enhancing quality of care and building strong client-provider professional relationships.

D) In designing the FP curriculum, the strong preferences of clients should be considered to enhance Health Attendants' ability to reach clients.

E) The perspectives of the community, clients, supervisors, instructors and Health Attendants imply that the curriculum content for Health Attendants should address the following essential areas in addition to the services they are currently providing:

- client provider interaction and work ethics and client rights;
- counseling and educating clients on FP and RH, pre-natal and other safe motherhood services;
- screening clients for high risk factors
- FP services for all including special groups, for example adolescents, males, post-partum women etc.;
- infection prevention and control ;
- record keeping and reporting;

- supplies management in relation to quality of care;
- how to use audio visual materials for client and community education/motivation.

F) Given that 72 percent of Health Attendants work in dispensaries in rural areas, the training should take place in either their own sites or sites that are similar to their work environment.

G) The training strategies developed for Health Attendants will need to include training in FP/RH training for both instructors and supervisors.

H) Lack of regular contraceptives and other supplies in health clinics have negative implications on:

- performance of the trained service provider;
- access to quality services that encourage continuation of FP use ;
- provision of less effective, less appropriate, or less preferred methods of contraception.

I) In preparing to implement the training strategy that will be formulated, the need to address the supplies and supervision problems identified must be considered.

In summary, Health Attendants working in the MCH clinic setting offer a potentially useful cadre for the expansion of FP service delivery. They possess suitable personal characteristics which can be relied upon for reaching potential FP clients, especially in peripheral areas. Given the existence of an established training system which is regionally based and managed, an investment in the training of this group can be sustained with minimal resources. However, in order to maintain and improve the quality of FP services acquired through such training, FP commodities, equipment and supplies should be made available and be properly cared for at all service delivery points.

II. Introduction

1. Background

A) Demographics, Health and Medical Care

The average number of children born to a Tanzanian woman in 1992 was 6.3 and the annual population growth rate was 2.8 percent. Although the national fertility rate is slowly decreasing and knowledge of contraceptive methods is high, only ten percent of men and seven percent of women were using any contraceptive method at the time of the 1991-92 Tanzanian Demographic and Health Survey. Thirty percent of married women were defined as having their need for family planning services unmet, and only one-quarter of the total demand for services was being met. Contraceptive use varied greatly by region and was particularly low in rural areas (Tanzanian DHS 1991-92).

While infant and child mortality rates are high (92 and 141/1,000 live births respectively), over 91 percent of women receive antenatal care and 71 percent of children received all recommended vaccinations—with over 95 percent of children having received a BCG vaccination (Tanzanian DHS 1991-92). As with other countries in the Sub Saharan region, Tanzania also has high rates of HIV and STDs.

Medical care is organized regionally, with mainland Tanzania's 20 regions subdivided into at least 106 districts. The country has an extensive network of health facilities and MCH services are offered in MCH clinics staffed primarily by MCH Aides, Health Attendants, Nurse Midwives and Public Health Nurses. Nurses receive four years of formal training, MCH aides receive two years, and Health Attendants are trained on the job with some later selected for a year for formal training. Health Attendants are located primarily in rural health clinics, mainly in under-served and remote districts. However, staffing patterns vary greatly and health posts may be staffed solely by one or more Health Attendants. Communities are also served by Village Health Workers and Trained Birth Attendants.

B) Family planning and Health Attendants

Prior to 1994, the Tanzania Family Planning Policy Guidelines and Service Standards, developed to guide the implementation of family planning service delivery and training, identified Nurse Midwives, Public Health Nurses, MCH Aides and Medical Assistants as the primary MCH/FP service providers. However, at a meeting of the Regional Medical Officers (RMOs) held in 1994 for the development of a five year strategy for FP training, there was overall consensus on the limited number of MCH Aides and Nurse Midwives available in the regions and districts, particularly in the under-served areas for training as service providers. This limitation will influence meeting the targeted number of potential trainees required for the expansion and acceleration of family planning services to the community level. The Health Attendant cadre of health worker whose number far exceeded that of MCH Aides in under-served areas was therefore proposed as a suitable group to be trained for FP provision in addition to MCH Aides, Nurse Midwives and Public Health Nurses and Medical Assistants.

As a result of this recommendation, the 1994 revised edition of the Policy Guidelines and Standards identifies Health Attendants as among the priority cadre for FP training for the provision of services at the health centre, dispensary level of the health care system as well as within the community. The FP functions of this cadre stipulated in the guidelines is similar to the functions assigned to MCH Aides. The functions range from providing information, education and counseling to FP clients, to providing a variety of FP methods including IUCDs. MCH Aides and Health Attendants are also expected to screen clients for STDs and to refer clients with STDs for treatment.

Even though the current status and mandate given to Health Attendants in the Policy Guidelines fulfills the RMOs' request, very little else is documented about this cadre. The background information available on Health Attendants is related to basic information on training status. It is known that there exists two categories of Health Attendants. The first category of Health Attendants has received a one-year structured training course in general nursing conducted at the regional hospital by instructors who are not necessarily qualified tutors. The syllabus utilized for this training was developed nationally with provision for modification at the regional level. This category of trained Health Attendants is referred to as Nursing Assistants by the Ministry of Health. The second category of Health Attendants has not received any formal training but they do provide services using skills acquired on the job. They are referred to as Nursing Attendants. What else is known about both Nursing Assistants and Nursing Attendants in terms of "who they really are", "what they do", and "what they are capable of doing" is not

sufficient to enable the identification of factors which will influence the formulation of a strategy for their effective participation in the expansion of FP/RH services.

More detailed information is therefore required to support the assumption of their potential and ability to provide reproductive health services, including a variety of FP methods, prevention and management of STDs and AIDS in addition to other health services. The information would also be useful for the identification of training approaches appropriate for the group. To address this assumption, a three-phase project was conceived. The first phase included a needs assessment study, the development and refining of a family planning curriculum to train Health Attendants, and a field testing of the training materials and approach. In the subsequent two phases, Health Attendants would be trained using the training materials developed (Phase 2), and the effectiveness of the training would then be evaluated (Phase 3). The content of this report is limited to the Needs Assessment study (Part 1 of Phase 1) whose main purposes are outlined below.

2. Purposes and objectives of the needs assessment

A) Purposes

The purposes of this needs assessment study were to:

- Explore the potential for Health Attendants to provide FP/RH services;
- Obtain data that would guide the formulation of a strategy for enabling Health Attendants to participate in the expansion of FP/RH services in Tanzania.

B) Specific objectives

The specific objectives of this needs assessment study were to:

- Provide the Tanzania Ministry of Health with descriptive information on Health Attendants employed in MCH clinics;
- Identify the personal characteristics of Health Attendants with potential for providing FP services in community clinics;
- Assess the working environment of Health Attendants for the purpose of strengthening it for FP service delivery;

- Identify the levels and gaps in FP knowledge and FP-related skills of Health Attendants;
- Identify factors that would contribute to the formulation of a training strategy.

III. Methodology

1. Diagnostic Assessment for Performance and Potential Approach (DAPP)

The methodology used for implementing this needs assessment follows the Diagnostic Assessment for Performance and Potential (DAPP) approach developed by INTRAH to conduct an in-depth analysis to assess a cadre's performance and potential for providing FP/RH services, as well as the environmental factors that will influence that cadre's performance. Data gathered using this approach provides information necessary to decide whether to train a cadre, what to train about, how to train, by whom and with what materials.

Specifically the DAPP approach has the capacity to address the following issues:

- Describe or answer some questions and concerns about the personal and potential characteristics about an identified cadre of trainees;
- Justify, confirm or reject the cadre's potential to provide services;
- Give an opportunity to examine a cadre's work environment, evaluate their sustainability at the worksite, and investigate their acceptance by potential clients, the community and other health personnel;
- Allow for assessment of the potential of adding new skills to already existing skill to achieve the expansion of FP/RH programs;
- Contribute to host country human resource development (HRD) by yielding scientifically sound information facilitating expansion of available human resource and maximizing untapped human resource in country.

2. Study locations

The following four criteria were used to select the study region:

- Low contraceptive prevalence rate (CPR)—below five percent as of 1991;
- Poor geographical accessibility;
- Fewer MCH Aides than Health Attendants;
- Substantial number of Health Attendants currently providing MCH and other services.

Two predominantly rural regions of the country, Shinyanga and Kigoma, satisfy these four criteria. As

of 1991-92, only 1.2 percent of married women in Shinyanga region were using modern methods of birth control and an additional 4.2 percent were using traditional methods. In Kigoma, the proportion of married women using modern methods of contraception during the same period was 2.8 percent, while 2.1 percent were using traditional methods. Less than six percent of women in both regions were using any method of contraception, compared to the national average of 10 percent for currently married women. Although both of these regions were appropriate for the study, Kigoma, which is in the far western part of the country, was selected as the study site because of the expressed support for the study by the Regional Medical Officer in that area. This support was considered an important ingredient in successfully completing this study.

There are four districts in the Kigoma region: Kigoma Urban, Kigoma Rural, Kasulu and Kibondo. As the Kigoma Rural district lies along Lake Tanganyika and has many health clinics that are not accessible except by water and as the Kigoma Urban district does not contain many MCH clinics, the two districts selected for the study were Kasulu and Kibondo.

3. Study design, sample size and selection of the study

The design for this needs assessment was cross-sectional and descriptive, designed to provide baseline information on the deployment and working situations of Health Attendants as well as a variety of related information to be utilized by those designing the training. Rather than sampling Health Attendants throughout the country, it was decided to survey all of the 112 Health Attendants working in MCH clinics in each of the two selected districts.

Thirty-three of the 63 health facilities in the two districts (52%) which were represented by a Health Attendant at the centralized meeting were selected for a site visit to interview supervisors and to observe the FP-related skill level and actual working situations of the Health Attendants. The number of health facilities visited (33) was determined primarily by the time allotted to data collection, the desire to have approximately equal representation of formally and informally trained Health Attendants, and the accessibility of the site.

4. Study population

Information on personal characteristics and on family planning knowledge was collected from 109 Health Attendants working in MCH clinics in the two districts. This figure constitutes 97 percent (109 of 112) of all Health Attendants working in MCH clinics and 31 percent (109 of 348) of the total number of Health Attendants in the two selected districts (Table 1). In these districts, 33 of the 113 health facilities (29%) were visited and information about FP-related skill levels and Health Attendants' working conditions was gathered observationally and from interviews with 33 on-site supervisors. The three instructors who train Health Attendants during the one-year training course were also interviewed, as were 39 MCH Supervisors and In-Charges (Table 1).

5. Data collection instruments

The following nine instruments were used for data collection. The major study objectives addressed by each questionnaire are listed in parentheses following each instrument:

- I1 Health Attendant questionnaire (Objective 1 and 2)
- I2 Health Attendant pre/post test (Objective 4)
- I3 Health Attendant Instructors questionnaire (Objective 1, 3 and 5)
- I4 MCH Clinic Supervisor and District Health Management Team questionnaire (Objective 1, 3 and 5)
- I5 Health facility questionnaire (Objective 3 and 5)
- I6 Health Attendant MCH/FP skills assessment questionnaire (Objective 4 and 5)
- I7 Focus Group Discussion guide for Health Attendants (Objectives 1, 2, 3, and 5)
- I8A Focus Group Discussion guide for clients in health facilities (Objective 5)
- I8B Focus Group Discussion guide for the community (Objective 5)

Drafts of Instruments I1 to I6 were developed jointly by a Tanzanian resource person, a representative of the INTRAH regional office in Nairobi (INTRAH/RON) and a consultant from INTRAH, Chapel Hill. The drafts of the Focus Group Discussion guides were developed by representatives from the INTRAH regional offices in Nairobi (INTRAH/NAIROBI) and the Program for Appropriate Technology in Health (PATH/NAIROBI). All instruments were translated from English into Tanzanian Kiswahili by a Tanzanian resource person and then translated back into English to ensure that the translations were

accurate. Both the Kiswahili and English versions of the instruments were finalized by the study team after pretesting in the field.

6. Study team

The needs assessment study was planned and implemented by a team made up of supervisors, data collectors, and the Study Manager.

The Supervisors —Three persons served as supervisors: a Tanzanian resource person, a representative of the Tanzania Ministry of Health, Family Planning Unit (MOH/FPU), and an INTRAH consultant from Nairobi. The supervisors participated in the finalization of the project protocol, and of both the English and Kiswahili versions of the data collection instruments. They provided leadership in the training of data collectors and the data collection. Supervisors also participated in the analysis of the data, as well as in the preparation of the report for the Needs Assessment study.

The Data Collectors— Eight family planning service providers with Comprehensive Clinical Skills (CCS) training based in Kigoma region performed the data collection. Six of the data collectors were Maternal and Child Health Aides (MCH Aides), and remaining two were Nurse Midwives.

The Study Manager—The Research and Evaluation Officer based at the INTRAH Regional office in Nairobi, served as the Study Manager and had the overall responsibility of providing leadership and coordinating all stages of the study.

7. Activities prior to data collection

A) Planning (April 26, 1995; May 3-5, 1995)

The training of data collectors and pretesting of the instruments developed for the Needs Assessment study was facilitated by a team of four members consisting of the three supervisors and the Study Manager. Planning for the training and field testing activities was carried out partly in Nairobi and partly in Dar-es-Salaam. The INTRAH team in Nairobi (The INTRAH consultant and the Study Manager) supervised the production of the draft instruments and developed draft training plans for an orientation workshop and training of data collectors. The plans outlined the objectives, content, duration, methodology, the trainer(s) and evaluation method for each session. In Dar-es-Salaam, the draft training

plans were finalized, and the corresponding schedule of activities was developed through collaborative efforts between the INTRAH team, the FPU and the Tanzanian resource person.

B) Orientation workshop (May 9, 1995)

Eighteen persons from Kigoma Region attended the orientation workshop which was held in Kigoma. Among the participants were the members of the Regional Health Management Team (RHMT) including the acting Regional Medical Officer (RMO), the District Medical Officers (DMOs), the District Nursing Officers (DNOs) and District Maternal and Child Health Coordinators (DMCHCos) representing Kasulu and Kibondo districts respectively. The eight data collectors also participated in the orientation workshop.

The orientation addressed the background, justification, rationale, and the components of the three phases identified for the implementation of the project. The emphasis nevertheless was on the first phase (needs assessment and development of training materials and curriculum) and the purposes, objectives, methodology and data collection procedures proposed for this needs assessment study within the first phase.

Based on the information provided and the discussions that followed, four groups of key actors for the implementation of the Needs Assessment study were identified and categorized as: *Regional Team*, *District Team*, *Data Collector*s and *Kigoma Study Planning Team*. In group sessions, the four teams outlined their perceived roles and responsibilities as well as their expectations from the other teams during the planning phase, and the actual data collection process. The perceived roles, responsibilities and expectations were presented in a plenary session and discussed by other groups members. A consensus was reached on expected roles and responsibilities for planning and in collecting the data required for the needs assessment study.

C) Training of data collectors and field testing of instruments (May 10-16, 1995)

The training of the eight data collectors on the use of the nine instruments took place immediately after the orientation activity. The training activities were conducted in Kiswahili by the supervisors and lasted for six days. During this time, the supervisors who served as facilitators ensured data collectors' understanding of the purpose, content and use of the nine instruments. The first day of the training was dedicated to providing detailed descriptions and encouraging discussion on the purpose and content of

each instrument. The remaining five days were scheduled for practical training. Facilitators utilized role playing in a workshop setting to enhance participants understanding of the use of the Health Attendant questionnaire (*I1*), the test questions (I2), and the focus group discussion guide questions for Health Attendants (*I7*). Health Attendants working in Kigoma Urban played the role of respondents, whilst the data collectors served as facilitators. For the interview schedule for Health Attendant instructors (I3), data collectors played the roles of both interviewer and instructor.

Three field visits to MCH clinics in Kigoma Urban served as practice on the use of the interview schedule for MCH supervisors and clinic in-charges (*I4*), the health facility observation schedule (*I5*), the checklist for the assessment of Health Attendants' skills (*I6)* and the focus group guide questions for clients (*I8A*). Practice in leading a focus group discussion of community members (*I8B*) was also carried out within two community settings in Kigoma Urban. For each focus group discussion session, one data collector acted as the facilitator of the group and the others as note takers. The supervisor also recorded detailed notes to serve as the standard in judging data collectors' skills in note-taking and guided the discussions as and when necessary. At the end of each group discussion both the data collectors and the trainers provided feedback based on their observations during the discussion.

The data collectors' overall understanding of the practical use of the instruments was assessed daily during process review meetings and reflection sessions. In particular, data collectors competence in assessing Health Attendants skills in the provision of basic MCH services was judged by consistency in scoring between raters. At the end of the training, data collectors were judged by the supervisors as competent in the use of Instrument *I1* to *I6*, but considered to need more practical exposure on the use of the Focus Group Discussion Guides (Instrument *I7*, *I8A*, and *I8B*).

D) Revision of the instruments (May 17-27, 1995)

From the daily experiences gained through role playing and use of the instruments in the field, participants and facilitator reached a joint agreement on questions to be modified or deleted and on new questions to be added in each instrument. The Tanzanian team (the Tanzanian resource person and the FPU representative) were assigned the responsibility of incorporating the suggested changes into the Kiswahili versions of the instruments in Dar-es-Salaam, whilst the INTRAH team (the INTRAH Consultant and the Study Manager) held the identical responsibility for the English versions.

E) Re-orientation of the Data Collectors to revised instruments (June 3-6, 1995)

Before the data collection started, the eight data collectors were gathered in Kigoma Urban for a three-day re-orientation activity whose main aim was to acquaint them with the updated content and procedures. During this re-orientation, the content of all the nine instruments was again discussed. Practice sessions were held at Maweni hospital to ensure that all the data collectors were capable of administering all nine instruments and would use them correctly to obtain valid and reliable data. As part of the re-orientation, focus group discussions were again conducted using samples of MCH clients, community groups and Health Attendants.

To maximize the quality of information collected from the actual focus group sessions, a decision was made by the study team for the supervisors and three competent data collectors to take over full responsibility for facilitating and hand-recording the sessions. It was also decided to audio-tape record the sessions for future reference.

8. Data Collection (June 6-July 3, 1995)

At the end of the re-orientation period, data collectors interviewed the three Health Attendant instructors based in Kigoma Urban using instrument I3. The data collectors were divided into two groups of four members. Each group was assigned a supervisor who was to lead them in data collection activities in their respective districts. One supervisor led the Kasulu data collection team and the other the Kibondo team. Data collection took place from June 8th to 28th in Kasulu district and between June 12th to July 3rd in Kibondo district.

Two 2-day data collection workshops were held separately in Kasulu and Kibondo districts, attended by 56 and 54 Health Attendants working independently or assisting in MCH clinics. During the first day of each workshop, the Kiswahili version of instrument *I1* was administered to all present Health Attendants. Each question was read out and explained in Kiswahili by one of the data collectors. Health Attendants, all of whom were literate in Kiswahili, indicated a response by using a tick or by writing in the appropriate space(s) provided. The other three data collectors offered individual assistance to Health Attendants if required but were careful not to bias the responses. Health Attendants also completed the Kiswahili version of *I2*, designed to measure their knowledge of family planning methods, risks, and benefits.

On the second day of the workshop, focus group discussions were conducted with groups of Health Attendants (five groups in Kasulu and four in Kibondo). The group discussion sessions were facilitated by supervisors using instrument *I7*. The purpose of the discussion was to obtain more information about Health Attendants preferences with regard to learning approaches, trainer characteristics and training setting attributes. The uses of visual aids in their working environment and perceived client material preferences were also discussed. Three groups of key informants were also surveyed in order to gather more information that could inform the design of the training curriculum and materials. These were the two project district health management teams—District Medical Officers, District Nursing Officers and District MCH Coordinators—(*I4*), the supervisor of each MCH clinics (*I4*) and the In-Charge of each facility (*I5*). The two latter interviews were carried out at the site and therefore represent a sample of the total population.

Using information gathered at the centralized meeting of the Health Attendants in each district, the final selection of 15 facilities to be visited was made. The facilities were selected purposely to have as close as possible equal representation of Health Attendants trained on-the-job and trained formally through the one year training course. During the site visits, the information for *I4* from the MCH supervisor was collected through interviews, information for *I5* on the facility itself was gathered through observation and through interview with the supervisor of the Health facility. A visual assessment of the activities of the Health Attendant in the MCH clinic was performed by two data collectors and the team supervisor independently, using instrument *I6*. Assessment by three raters was necessary in order to obtain a more accurate judgment of the skill levels of the Attendants in whichever of their daily activities they performed during the visit. The final skill level was the consensus score jointly agreed upon by the three raters.

A focus group discussion session was also conducted for clients in five of the fifteen health facilities visited. At eight of the ten remaining sites in each district, focus groups of community residents were held. Four were male only and four female only. Group discussants recruited from the clinic and community settings discussed issues related to utilization of health facilities, preferred attributes of service providers and preferred content and type(s) of visual aids. The facilitators for these group discussions used instruments I8A and I8B to guide the discussion groups for clients and the community respectively. The proceedings of all Focus Group Discussions were recorded both by hand and on tape.

At the end of the one month data collection period in both districts, 109 Health Attendants responded to

instruments *I1* and *I2,* a total of 39 people responded to instrument *I4*, 33 health facilities instead of the 30 originally planned were visited, at each of which the In-Charges responded to *I5*. Thirty-six Health Attendants who had participated in the data collection workshops had their MCH/FP-related skills assessed using Instrument *I6*. Focus Group Discussions were conducted with ten MCH client groups, nine Health Attendant Groups, eight male community groups and 8 female community groups (Table 2).

9. Data management and analysis

Team supervisors were responsible for reviewing the instruments at the time of data collection for completeness, consistency, and legibility. The Study Manager brought all of the completed *I1* (Health Attendant Questionnaire), *I2* (Health Attendant test questions), *I7* (Focus group discussion for Health Attendants) and *I3* (interview schedule for Health Attendants' instructors) to Nairobi for coding, data entry, and analysis. The INTRAH consultant in turn, hand-carried the remaining five completed questionnaires after data collection in the field to Nairobi for processing and analysis. All data entry, computer editing, and analysis of the quantitative and qualitative data were carried out between June and August 1995.

Using the Epi Info (Version 6) program, standard descriptive analyses (frequencies and cross-tabulations) were produced. While the major interest was in the entire group of Health Attendants and health facilities, the data were also stratified to view possible differences between:

- formally and informally trained Health Attendants;
- the two selected districts;
- types of health facilities.

Due to the need to generate results as quickly as possible for use by the designers of the curriculum and training materials, the qualitative data were translated into English by the INTRAH consultant and the Tanzanian resource person and organized by questions and responses to bring out the main themes.

IV. Results

The chapter is organized into 6 subsections. In the first three subsections (1, 2, 3) the results obtained from the analysis of all instruments developed for Health Attendants are presented. In the next two subsections (4, 6) data from other sources are examined which describe different aspects of the working environment that influence Health Attendants' performance as FP service providers. In the final subsection (6), the perspective of clients and the community on the provision of health services and the availability and use of educational materials is presented.

1. Health Attendants' personal characteristics and work environment

A) Introduction

In this subsection, the information obtained from the analysis of *I1* (Health Attendant questionnaire) is presented. It includes a description of Health Attendants' age, sex, marital status, educational attainment, literacy levels, and training status. It also presents the Health Attendants' perspective on their work environment in terms of the range of services provided in the clinics in which they work (including the availability of FP services) and past and current use of contraceptives by this study group.

B) Personal characteristics of Health Attendants

Of the 109 Health Attendants who participated in the data collection workshop, 66 percent were females (72 of 109) compared to 34 percent males. Marked gender differentials were observed between districts (Table 3a). About 52 percent of Health Attendants in Kibondo districts were males in comparison to only 16 percent of those in Kasulu district (Figure 1).

Male Health Attendants were slightly older than their female counterparts (Table 3b, Figure 2). Nearly two thirds (61%) of the females were in the 30-39 year age group while less than half (43%) of the male respondents were in that same age group. The mean age for males was 40 years old and for female Health Attendants, 31 years.

All Health Attendants were asked for their highest level of educational attainment within Tanzania's formal education system. Respondents are grouped in five educational categories, those who have not completed up to Standard 7, those who have completed Standard 7, completed Forms 1-2, completed

Forms 3-4, and any other. In response to this question it was learned that 89 percent completed Standard 7 (Table 3a). There was virtually no difference in educational achievement between the districts, between male and female health attendants (Table 3b) or between those formally-trained Health Attendants and those trained on the job (Table 3c, Figure 3). All Health Attendants demonstrated an ability to read and write in Kiswahili (Table 3a).

The distribution by religion shows that there are substantially more Christians among the Health Attendants interviewed (89%) than Muslims (11%) with only minor differences between the two districts(Table 3a). Sixty-three percent of the Health Attendants who practice the Christian faith in Kibondo are Roman Catholics whilst the Christians in Kasulu are equally divided between the Roman Catholic (40%) and Protestant denominations (46%). Also there were almost three times as many Muslims in Kasulu (15%) as in Kibondo (6%).

Most of the Health Attendants were currently in marital unions (71%), with slightly more in unions in Kibondo (76%) than in Kasulu (66%)(Table 3a). There was a marked gender differential with 95% of the men and only 58% of the women reporting a current union (Table 3b).

C) Training status

There were relatively few differences between the formally trained HAs and those trained on-the-job (Table 3c, 4a, 4b). Forty percent of Health Attendants attended the one-year formal training course in general nursing and the others were trained on the job. The formally trained HAs were slightly younger (18% over 40) than the others (28%), but the sex distribution, educational achievement and distribution by district were all very similar for these two groups.

D) Work experience

The data show that the large majority (73 percent) of Health Attendants were recruited in the local area by the district committee, and the remaining minority by the regional committee (17%) and by private agencies(9 %) (Table 5, Figure 4). There were slightly more HAs recruited by the District Committee in Kasulu (76%) than in Kibondo (70%), but the general pattern clearly favors locally recruited individuals in both districts. The mean duration of employment as Health Attendants for the entire study sample is 13.5 years, with little differences between Kasulu (13%) and Kibondo districts (14%). As might be expected due to employment mobility, the mean duration of working in their present health facility (7.8

years) was shorter than their duration of service as Health Attendants. Nonetheless, these results suggest that there is relative stability in work location among this cadre of health workers, most of whom were recruited in their home district.

E) Work environment

Overall, 72 percent of the HAs work in dispensaries, 20 percent in health centres and 8 percent in hospitals (Table 6). There were marked differences between districts with the proportion of Health Attendants working in dispensaries substantially higher in Kibondo (87%) than in Kasulu district (56%). One-third of Health Attendants interviewed in Kasulu districts work in health centers and another 11 percent in hospitals. For both districts, the majority Health Attendants lived in the community in which they work, and 19 percent actually lived within the health facility complex.

The range of health services provided was similar in all health facilities and did not vary by district (Table 6). According to the vast majority (over 90%) of Health Attendants' responses, a wide range of services are available to clients including child growth monitoring and development, antenatal care, immunizations, health education and family planning, and deliveries. Home visits are only slightly less frequently offered with 85 percent of Health Attendants reporting this service in their health facility .

In both districts, Health Attendants were apparently most frequently utilized for the provision of curative care, immunizations, and child growth monitoring as indicated by over 85 percent of the respondents (Table 6). Almost 80 percent give health education talks, 71 percent perform deliveries, and 66 percent offer FP services. Antenatal care (63%) and home visits (53%) are the least common activities performed by Health Attendants. There are only small differences observed in the services provided by Health Attendants by district (Figures 5, 6).

Supervision of Health Attendants is carried out by a variety of people. For almost two-thirds (63%), supervision is by Medical Assistants or Rural Medical Aides (Table 6). One-third (28%) also reported that supervision by a nurse or nurse midwife is common. If they are absent from work, another Health Attendant (49%) or MCH Aide (41%) takes over their responsibilities in the clinic.

F) Workload and job satisfaction

Based on the number of clients seen daily, a slight majority of Health Attendants from both districts generally perceive their present workload in the health clinic as "just about right" (59%), and the remaining minority view it as "too heavy" (41%) (Table 7). In spite of their seemingly busy schedule, fully 42 percent reported to be totally satisfied with the job and the remaining 58 percent expressed only partial satisfaction. The reasons most frequently cited by those who were totally satisfied with their job include:

- Good working relationships;
- Feel needed by the employer for the job;
- Feel needed by the community;
- Self confidence in performing the job;
- Good working conditions;
- Good training and supervision.

Those Health Attendants (58%) who expressed only partial satisfaction with the job identified the following causes for their dissatisfaction:

- Low salary;
- No allowances when on-call;
- Difficult working environment;
- Too few health workers, therefore heavy workload;
- Lack of opportunity for further training;
- Lack of materials and equipment.

G) Availability and provision of FP services at Health Attendant sites

With the exception of only one of the 109 Health Attendants interviewed, all confirmed the provision of some type of FP service in the facilities in which they work (Table 8). The three most widely available modern contraceptive methods in both districts, according to the Health Attendants responses, were oral contraceptives (96%), condoms (86.1%), and Depo Provera (77%). The availability of these methods varies only slightly between the districts with the notable exception of Depo Provera which is more widely found in Kibondo ((85%) than in Kasululu (69%). Intra Uterine Devices (IUCDs) and diaphragms are only available in 20 percent of Health Attendants' clinics, while 27 percent of Health Attendants indicate the provision of natural family planning methods in their clinics *(*Figures 7. 9).

Health Attendants are FP service providers in those health facilities in which these services are available (Table 8). FP services provided by Health Attendants include: counseling (64%); giving health education talks on the benefits of FP (59%); resupplying pills (50%); community motivation (36%); providing pills to first acceptors (35%), providing barrier methods (17%) and referring clients for other methods (28%) (Figures 8, 10).

Some district variations in the pattern of FP services provided by Health Attendants were observed. More Health Attendants in Kasulu district counsel clients for the use of family planning, refer clients for other methods and carry out community motivation for FP. Health Attendants in Kibondo provide barrier methods more often to clients than their counterparts in Kasulu district (Figures 8 and 10). No notable differences in the pattern of FP services provided were observed by Health Attendants' training status.

Over 95 percent of Health Attendants in both districts report that clinics are open for an average of eight hours daily Monday through Friday and that family planning is provided daily for a minimum duration of seven hours (Table 8). Family planning services are available in Kibondo clinics for an average of 7.8 hours daily as compared to 7 hours in the Kasulu clinics.

H) Health Attendants' fertility patterns

Although data are not available to make a statistically valid comparison, the fertility pattern of the Health Attendants appears to be similar to that of the general population. The mean number of children ever born(MNCEB) to all the Health Attendants interviewed was 4.8, with males reporting more than twice as many children ever born (MNCEB=7.3) as females (MNCEB=3.6) (Table 9). Data from the Tanzania Demographic and Health survey (1991/92) reported the MNCEB for women 20-49 as 4.0. This slightly higher fertility among women of the in the general population as compared to female Health Attendants is probably due to the different age distributions of the two samples, the general population sample likely being slightly older. The sex differential in fertility level also accounts for the marked difference in MNCEB between Health Attendants in Kasulu and Kibondo districts. Due to the male dominance among the group in Kibondo district, the MNCEB is higher for this district, (MNCEB=5.5) than for Health Attendants in Kasulu district (MNCEB=4.2) (Table 9).

I) Contraceptive use

Contraceptive use was relatively high among the Health Attendants interviewed. Fifty five percent of them have used a method of family planning at some time in their lives (Table 10). Contraceptive use was notably higher among Health Attendants in Kasulu district (67%) as compared to those in Kibondo (43%) and among females (69%) than males (27%) (Table 10, Figure 11). Although this rate of ever-use of contraception is considerably higher than was reported in a recent KAP survey in Tanzania, it is important to note that because the samples were very different in these studies (one was a national random sample of people, and the other all the Health Attendants in a selected group of health facilities), their rates are not strictly comparable (Tanzania KAP Survey 1994).

Of the 60 Health Attendants who have ever used contraception, 56 responded to the question on present use. Of these, 66 percent are currently using contraceptive. This indicates an overall difference of 21 percentage points between ever-use (55%) and current use (34%) of contraceptives among all Health Attendants interviewed. The reasons cited for discontinuation, listed according to the frequency of the responses, are:

- breast-feeding;
- desire to become pregnant;
- objection by partner;
- secondary sterility;
- abstinence;
- past child-bearing age.

The pill was the most common contraceptive ever used by Health Attendants (70%) and the condom the next most common (17%) (Table 10, Figure 12). The current contraceptive mix among Health Attendants indicates continued use of those methods and the marked increase of injectibles (Depo Provera). Among the Health Attendants currently using contraceptives, 53 percent are using pills, 21 percent use condoms, and 16 percent are on injectables (Table 10 and Figure 13).

2. Health Attendants' FP training, knowledge and skills

A) FP training

None of the 109 Health Attendants interviewed have ever received any formal FP training, although over two thirds claim to provide some form of FP services in their health facilities.

B) FP knowledge

Health Attendants in the study population were tested on their general knowledge of family planning in ten areas. Scores indicate the percentage of correct answers and a cut-off of 60 percent was selected to indicate a passing score. The overall mean score attained by all 109 Health Attendants was 50 percent, which is 10 percent below the passing score. The average score for Health Attendants in Kibondo district (54.2%) was only slightly higher than the corresponding score for those in Kasulu district (46 %) (Figure 14). Even smaller differences were observed between the scores for Health Attendants formally trained (52%) and those trained on the job (49%), and between males (52%) and females (49%).

Similar analysis was done for each of the following test items to reveal Health Attendants' relative strengths and weaknesses in specific FP content areas:

- Categories of women at risk from complications due to pregnancy;
- Meaning of FP;
- Women to whom FP use is recommended;
- Three reasons why FP is good for mothers;
- Three reasons why FP is good for fathers;
- Three reasons why FP is good for children;
- Three reasons why FP is good for community;
- Knowledge of FP methods;
- Knowledge on Pills, Depo Provera, IUCD, condom;
- Attitude towards FP based on the policy guidelines.

Results from these tests for both districts combined shows that Health Attendants scored below the cut-

off score of 60 percent in seven out of the ten test items (Figure 15). The questions for which responses were at or above the cut-off score when examined by district, sex and training status are listed below in descending order :

- Attitude towards FP based on the policy guidelines (91%);
- Knowledge of FP methods (77%);
- Knowledge of condom and eligibility for use (70%);
- Meaning of family planning (62%).

Mean scores were highest on questions related to Health Attendants' attitude towards FP. On the other hand, relatively weak responses were given on questions related to :

- Categories of women at risk from pregnancy complications, childbirth and delivery (28%);
- Categories of women recommended for use of FP (33%);
- Benefits of FP to mothers, fathers and the community (43%, 38%, 28%).

In addition to this general pattern, there were also some notable differentials by sex and training status observed. As is shown in Figure 16, females responded more accurately to questions on meaning of FP (T2) and demonstrated better knowledge of FP methods (T8) than males. Alternately, males scored higher than females on why FP is good for the community (T7) and knowledge of the pill (T9-OC) and of Depo Provera(T9-Depo). Although there were only few and minor differences between formally trained and on-the-job trained Health Attendants, the formally-trained did score higher in knowledge of FP methods (T8), and the benefit of FP to fathers and the community (T5, T7) than those trained on-the-job (Figure 17).

C) FP related skills

The mean scores by district obtained from the assessment of Health Attendants skills in performing seven FP related jobs is shown graphically in Figure 18. The graph compares the mean scores attained for each job against the cut-off (passing) score. Cut-off scores are set at 65 percent for all seven jobs listed below:

- Establishing and maintaining rapport with clients;
- Leading and conducting an MCH or FP Health Education talk;
- Explaining FP to clients;
- Counseling clients for FP;
- Physical examination of antenatal clients;

- Adherence to practices that reduce infection;
- Injecting patients.

The figure shows that Health Attendants average scores for six of the seven jobs were below the established cut-off score for Kibondo, and for two of the six jobs for Kasulu. The lowest scores were in the areas of family planning counseling (Job 4), physical examination of antenatal clients (Job 5), and injecting clients (Job 7). Health attendants scored highest in infection control practices (Job 6), establishing and maintaining rapport with clients (Job 1), conducting health education talks (Job 2), explaining FP to clients (Job 3), and, for the Kasulu cadre, injecting patients (Job 7). Scores between the two districts were similar except in the case of giving injections and in doing physical exams for antenatal patients where the Kasulu Health Attendants were notably more proficient. It should be noted that only 6 Health Attendants were observed giving injections to patients. On that job skill the four in Kasulu district obtained an overall score of 70 percent as compared to 33 percent for the two assessed in Kibondo. No notable differences in competency were observed by sex or training status.

3. Health Attendants' perspective on suitable FP training approaches and educational support materials.

A) Introduction

The information presented in this section about Health Attendants preferences with regard to learning approaches and educational support materials was obtained from the nine focus group discussion sessions organized in Kasulu and Kibondo districts. Information about Health Attendants' actual FP training experience is presented below, followed by their preferred learning approaches.

B) Previous FP training and interest in future training

Health Attendants who indicated having attended any formal health training course referred only to their one-year Health Attendant training course, which had no FP content. Indeed, all of the focus group participants expressed a desire to attend a course in family planning. In their own words, the main reasons for this desire are to:

- "understand how to provide FP services more accurately";
- "be able to provide FP services with confidence and earn trust from clients";

- "be able to provide community FP education and counseling."

C) Preferred training site

All courses attended by Health Attendants in the past were conducted in the Kigoma region. This was also the unanimous preference of Health Attendants for any FP training course. There were however diverse views as to the specific training location within the region. Those Health Attendants favoring the regional headquarters have identified the availability of practicum sites and adequate teaching materials as the reasons for their choice. The district headquarters towns, according to the majority, have added advantages of being more cost effective and providing closer proximity to families. As a rule, Health Attendants favor training sites with adequate classroom space and teaching materials. Similarly, they prefer training sites at which they do not have to rely on their own resources for food and accommodations.

D) Preferred methods of presentation and FP content areas.

The method of presentation predominantly used in previous training courses for Health Attendant were lectures with few demonstrations. However, in the focus group meetings Health Attendants expressed interest in demonstrations and group discussions as well as lectures.

The Health Attendants also expressed interest in a range of content for any FP course. In their words and order of preference this content included the following:

- "client education and countering rumors about FP";
- "FP methods: how they are provided and how they work";
- "benefits and risks of FP";
- "counseling of clients for FP";
- "physical assessment of clients";
- "management of side effects and complications arising from FP use";
- "community FP motivation strategies";
- "insertion of IUCDs".

E) Preferred training structure

In the view of Health Attendants, past courses in which the structure was biased either towards practice

or theory at the expense of the other, had some inherent disadvantages. These courses, for example, were

structured as three months practice with nine months theory or ten months theory with two months practice. The Health Attendants focus groups perception of these disadvantages are summarized below:

Courses with less theory and more practice:

There was less time to assimilate the content, especially since Health Attendants were only standard seven graduates. Also there was no in-depth coverage of content due to the shortage of time allocated for theory.

Courses with more theory and less practice:

These courses did not allow enough time to practice what was learned in class.

Apparently Health Attendants were interested in a better balance of theory and practice in a FP course, allowing sufficient time for each part and their integration.

F) Preferred trainer attributes and qualities

In their discussion of a trainer's qualifications most Health Attendants said that the trainer's work setting (urban or rural) and gender were not important considerations, but they did identify the following attributes and qualifications as requisite:

i. Preferred attributes:

- patient and attentive,
- polite and respectful,
- calm and composed,
- mature (middle-age),
- well-disciplined /not alcoholic.

ii. Preferred qualifications:

- trained and experienced in FP,
- Kiswahili speaking,
- health professional (District Medical Officers, Nurse Midwives, MCH coordinators,

experts from MOH/FPU).

G) Educational support materials

Health Attendants expressed the view that educational materials and visual aids for FP clients were a very important part of their efforts to provide quality RH services. They indicated that while there were some visual aids at their places of work, they would nevertheless like to have additional materials to assist them in educating and counseling clients on FP. Their preference is for posters, leaflets, and booklets showing:

- how different FP methods are used;
- benefits and risks of FP to both father and mother;
- men as clients and beneficiaries of FP services;
- real photographs of families/mother, contrasting those who have been using FP services versus those who have not;
- visual aids that counter rumors about FP.

4. Health facility site information

A) Introduction

Thirty-three health facilities were site-visited during their regular hours of operation on weekdays to:

i. Assess Health Attendants' level of competency at performing seven MCH/FP-related jobs or skills;

ii. Make observations on:
   - the availability and use of visual aids with clients;
   - FP client load and client flow;
   - available contraceptive types;
   - record-keeping procedures;

iii. Interview the person in charge of the facility on staffing pattern, FP equipment and supplies and on provision of FP services in the clinic.

The data collection teams spent an average of two to three hours in each facility in carrying out the observational assessment and the interviews. The next three sections (B, C, D) describe the

observational findings from these site visits, while the subsequent two sections (E, F) are based on

interviews with the person in charge of the site. Information on record keeping collected by observation and interview is described in section H.

B) Types and locations of health facilities

Of the 33 health facilities site visited, 18 were in Kasulu and 15 in Kibondo. Twenty-five of the 33 health facilities (76%) were dispensaries, six were health centers (18%) and the remaining two were hospitals (6%).

C) Availability and use of visual aids

Twenty-nine health facilities (88%) were displaying some type of family planning posters on the day of the site visit (Table 11a). There were only minor differences between districts in the proportion of health facilities with visual aids, but the mean number of visual aids displayed in health facilities was markedly greater in Kibondo (12.7) than in Kasulu (5.4). There were also notably more visual aids in hospitals and health centres (18) than in the dispensaries (6). Visual aids were found to be most frequently displayed in the MCH/FP section of the health facility, but they were also not uncommon in the curative and waiting areas.

The Ministry of Health, Tanzania is the main source from which the displayed visual aids were obtained (Table 11b). In addition, many of the health facilities, particularly those in Kasulu district, had visual aids designed by international organizations. Only three health facilities (one in Kasulu and two in Kibondo) displayed visual aids that were locally made (Table 11b).

The site visitors reported observing the use of visual aids with clients in all the facilities visited (Table 11c). They were observed being used with individual clients during counseling session in 20 of 29 clinics (69%) and during educational sessions at 24 of the 29 clinics (83%). Clinic staff report that the use of visual aids seem to support clients' understanding of the content of the FP session.

It is also noted by the site visitors that, in addition to posters, all 15 of the health facilities in Kibondo district and 10 in Kasulu district stock client materials in the form of leaflets and pamphlets (Table 11d).

These materials were obtained from the same sources as the posters. The Tanzania Ministry of Health supplied client materials to 25 of the 29 clinics (86%) and 17 clinics (59%) had client materials from international sources. However, in only about half of the health facilities visited (eight in Kasulu and 9 in Kibondo) were clients actually observed taking home FP leaflets (Table 11d).

D) Client flow, client load, provision of services, and available contraceptive types

Most of the health facilities visited were designed so that clients use a common entrance and exit (Table 11e). In two-thirds of the clinics clients are served on a first-come first-served basis, regardless of the service they seek. On the day of the site-visit almost 85 percent of the clinics were offering MCH services, about 70 percent curative care and health education, and about half were offering FP. These observational data on services available are consistent with the information provided by the Health Attendants indicating that curative care, MCH services and health education are provided regularly in the health facilities in which they work.

The types of contraceptives offered or recommended at health clinics covers a range of modern methods, however not all of these methods are universally offered or available. Oral contraceptives and condoms were the only methods offered in all the clinics visited (Table 15a). IUCDs, DepoProvera and foams were the next most common methods offered by 80 percent or more of the clinics. Diaphragms were offered in slightly more than half of the clinics (55%), and tubal ligations, vasectomies and Norplant were offered in less than half the clinics.

Apart from the limited range of contraceptive types offered, there were also extreme variations in the actual number of each contraceptive type available to clients on the day of the site visit (Table 12). Oral contraceptives, for example, were available in all of the clinics but the average supply in stock was only 11 cycles. Contraceptive types which were least available were IUCDs, DepoProvera and Norplant. IUCDs were only available in 13 health facilities and even they only averaged two IUCDs in stock. Not a single health facility had DepoProvera and only one facility had Norplant in stock on the day of the site visit. Clearly this shortage or unavailability of contraceptives in the health facilities limits the quality of family planning services that can be provided.

E) Characteristics of the In-Charges and other health care personnel

There was considerable variation found in the type of health care personnel serving as the In-charge and

in the staffing patterns in the clinics (Table 14). Rural Medical Aides (RMAs) were the most common personnel (39%) in charge of the clinics visited. Medical Assistants and Health Attendants were the next most common In-charges, each of whom was found in 21 percent of the clinics. MCH Aides and a medical doctor were In-charges in only a minority of the clinics (15%).

The information provided by the In-Charges of the health facilities visited also indicates marked differences in the staffing patterns of dispensaries as compared to hospitals and health centers. Differences were particularly noted in the distributions of Health Attendants, RMAs, Nurse Midwives/Nurses, and Clinical officers (Table 14a). In general, and as expected, health care centers and hospitals have higher numbers of the above-cited cadres than do the dispensaries. On the other hand, there appears to be shortage of MCHAs, Public Health Nurses, and RMAs in most facilities, particularly in dispensaries which made up the majority (78%) of the sample of health facilities.

F) Provision of services in the health facility (including FP)

There are many aspects of the provision of FP services that affect the quality of those services, and ultimately the satisfaction of the client population. In this section data are presented on some of those aspects. The number of hours that health facilities are open is an important aspect of the health service system. The majority of health facilities are open five days a week, Monday through Friday. According to the In-Charges interviewed hours of operation vary according to the type of health care facility. For instance, dispensaries are open about 12 hours daily on the average as compared to about 20 hours for hospitals and health centers.

While all the clinics visited offered FP services, they do so on different schedules. During regular hours of operation, the vast majority of clinics (73%) indicated that MCH and FP services were available during the same hours, which facilitates women's use of both services during the same visit (Table 15d). In the remaining clinics (27%), FP was provided at a special time when other MCH services were not offered.

In-Charges report that due to shortages of nurses, nurse-midwives, or public health nurses, FP services were offered in most facilities (about 70%) by MCHA or Health Attendants (Table 15b). Nurse-midwives provided these services in less than one-fifth (18%) of the clinics. In-Charges revealed that were few clinics (16% or less) that had a separate room set aside for FP counseling, history taking,

physical examination, or the giving of instructions to FP clients (Table 15c). This lack of privacy is undoubtedly a barrier which inhibits many women from making use of these clinic services.

According to In-Charges, the waiting time for FP services was usually short. In over 90 percent of the facilities visited, it was reported that FP clients waiting time was less than one hour. In half of the facilities (55%), waiting time for FP is said to be less than one- half hour (Table 15c).

The availability of FP supplies in the health facilities may be affected by a range of factors. While the vast majority of In-Charges (79%) staffing clinics reported that they have no problems getting FP supplies, some did report problems (Table 16c, 15d). The major problems reported affecting FP supplies were transportation related. Poor road conditions and lack of appropriate vehicles -often bicycles have to be used- sometimes causes a delay in obtaining supplies and also result in damages to supplies (Table 15d). Interestingly, and surprisingly, the views expressed by In-Charges concerning the regular availability of supplies were not supported by observations made at the clinic sites where low and generally inadequate supplies of many contraceptives were found.

G) Availability of clinic equipment and storage

The In-charges reported many inadequacies in basic equipment and supplies in their health facilities (Table 16a). For instance, one-half or more of the health clinics reported that they did not have a scale (weighing machine) (79%), an examination bed (64%) or a blood pressure machine (52%). Additionally, while most clinics relied on boiling water to sterilize equipment, almost all (94%) reported an unreliable supply of kerosene (to heat water) and many (42%) reported unreliable water supplies. Some of the clinics (21%) even reported having inadequate sitting facilities for waiting patients.

All of the In-charges gave assurance that their FP supplies were protected from rain and sun (Table 16c) and most indicated that they were kept in secure storage, under lock and key (73%)(Table 16b). A few facilities also keep their supplies in cartons and in locked wooden boxes.

H) Record-keeping

It was observed that some system of record-keeping exists within each health facility setting. With the exception of two dispensaries in Kasulu district which have no registers, the remaining health facilities have provisional, self-devised MCH and FP registers (Table 13, 16d). The standard FP register designed

by the Tanzanian Ministry of Health requests information on the client in the following categories:

- registration number,
- current date,
- date of first attendance,
- name of client,
- address,
- age,
- gravida,
- parity,
- number of living children,
- age of first child,
- client's level of education,
- client's occupation, and
- type of contraceptive.

Most of the health facilities (82%) record information on at least 50 percent of the above items for their FP clients. Health Attendants and MCH Aides were the two categories of staff observed completing the information required for the MCH and FP registers at the time of the visit. All the clinics indicated that they also submit monthly reports and a majority of them maintain an inventory book (85%), delivery notes (70%), and keep all the necessary stock (inventory) and supply-management records (about 60%)(Table 16c).

5. Characteristics and perspectives of Health Attendants' instructors and supervisors

A) Introduction

This section reports the personal characteristics of the instructors and supervisors of Health Attendants and their views on key factors that have a bearing on the development of FP training materials, and the structuring of FP curricula for Health Attendants. The section begins with the following information from instructors:

- Sociodemographic and background information;
- Views on FP training programs for Health Attendants;
- Views on suitable qualities for Health Attendants, FP training sites, and Health Attendants family planning trainers;
- Views on family planning services and how they could be improved.

It is followed by information from supervisors:

- Sociodemographic and background information;
- Information on family planning services
- Views on FP training and training programs for Health Attendants;
- Views on suitable qualities for Health Attendant trainers and training settings;
- Recommendations on what FP services Health Attendant should provide, methods of communication between supervisors and Health Attendants and discussion of problems previously encountered;
- General comments on what needs to be done to expand FP services to the community using health attendants as service providers.

B) Sociodemographic and background information on instructors

The three instructors interviewed were from Kigoma and were all 45 years old or above (Table 17a). Two of the instructors were female and one was male. All of the instructors have only a primary school education but all are registered nurses. Only one of the instructors has ever attended formal courses on family planning. One instructor has more than 16 years experience as compared to the others who have only 23 years and four months respectively. Two of the instructors have served in the present site for only 13 years while the third instructor has been at his present worksite for over eight years.

C) Instructors' perspectives on Health Attendants' FP training

Instructors indicated that FP was included in the content of the current one-year HA training course (Table 17b). They reported that the FP content varied somewhat according to the instructor. For instance, anatomy of the reproductive system, FP counseling, all FP methods, side effects of FP, and the advantages and disadvantages of FP were all mentioned by two of the three instructors as part of their course. Breast feeding, objectives of FP, and physical examination were only mentioned by one of the instructors as being a part of his course.

All three instructors indicated that family planning training could be included in the current one-year course or as a separate in-service course for Health Attendants (Table 17b). The reasons are different in each case. If additional materials were included in the current one-year course, the instructors felt that Health Attendants would help increase FP knowledge to the community and hence expand FP services. On the other hand, the instructors were also of the opinion that Health Attendants will understand the FP content better if they receive separate in-service training since there is not sufficient time in the formal HA training course to focus on FP. They also expressed the view that Health Attendants who attend an in-service FP course would gain more confidence in providing the FP services.

The instructors suggested that an in-service FP course should include the following FP topics (Table 17b):

- anatomy of the reproductive system,
- FP counseling,
- all FP methods,
- physical examination,
- side-effects of FP usage,
- indications and contra-indications of FP.

Two of the instructors recommended 6 to 8 weeks as the duration necessary to cover all the suggested subject areas. This length of time would also give instructors enough time to evaluate and monitor Health Attendants progress. As to the appropriate structure for an in-service FP course, two of the instructors indicate that the course should have equal amount of theory and practice because they are so closely interrelated.

D) Instructors' perspectives on suitable qualities of FP trainers, training setting and facilities, and Health Attendants as FP service providers

With regard to the desired qualities for trainers of Health Attendants, all of the instructors indicated that the trainers need to be experienced or trained in FP (Table 17c). In addition, two instructors thought the ability to teach and communicate was an important criteria. Only one instructor thought it would be important for the instructors to be female, so they could more easily discuss sexual issues with the female

Health Attendants.

With regard to the most suitable training setting, the instructors offered the following suggestions (Table 17c):

- The training location should be close to health facilities with sufficient patients and should be accessible to trainees so that transportation is not a problem. Practical sessions should also be easy to arrange;
- The training site should be at the regional headquarters to allow access to communication facilities such as telephone, and fax;
- Classroom and practicum sites should be well equipped in order to facilitate proper learning.

According to the instructors Health Attendants had certain qualities that would serve them well as providers of FP services (Table 17d). The qualities included:

- Health Attendants understand their working environment well and are well-known by most of the families to whom they might be providing FP services;
- Health Attendants are able to communicate well in a manner that is culturally acceptable so that they will be easy understood by potential customers;
- Health Attendants are experienced in the provision of health services since they provide health services daily;
- Health Attendants are clean, well-disciplined, and easily accessible to patients and can therefore satisfy client needs (Table 17d).

On the other hand, the instructors also identified personal characteristics that are not suitable for FP providers (Table 17d):

- People who have no desire or drive, do not care, and hence do not work well;
- People who are very rough-looking or acting and present a bad image to the clients;
- People who do not understand what they are doing and hence they become very defensive at times

E) Instructors' perspective on FP services that Health Attendants might provide

With regard to the types of FP services that Health Attendants might provide, the instructors suggested (Table 17e):

- Group health talks on FP and community outreach missions;
- Explanations FP methods to clients, identification of at risk clients, and client counseling;
- Instructions on the use of condoms, IUCD, pills, foam and foam tablets, and Depo Provera;
- Recording activity registers, FP supplies, and client histories

F) Instructors' comments on the provision of FP services

Instructors made the following general comments regarding the provision of FP services (Table 17e) :

- FP clinics should be provided with adequate equipment and supplies;
- Health Attendants should be trained to carry out home visits and provide health education in order to expand FP services;
- Enough FP trainers should be trained so that they can meet the demand of training Health Attendants and other FP service providers;
- All service providers at MCH clinics should be trained in FP with annual updates provided.

G) Sociodemographic and background information on MCH supervisors

Sociodemographic and background information on MCH supervisors are presented in Table 18a. Female supervisors (79.5%) outnumber male supervisors (21%) about four to one
and the mean age for all of them was about 36 years old. Like the Health Attendants themselves, most of the supervisors (82%) were either Catholic or Protestant with only a few being Moslem (18%). A majority of the supervisors (74%) have attained primary level education while only a minority (20%) have some secondary education. It appears that majority of the Health Attendant supervisors are relatively well experienced as supervisors. The mean length of time that they had been in their present capacity was about 10 years in both districts. They have also stayed at the same work site for a relatively long time, about 8 years in both districts.

H) Supervisors' information on FP services offered by Health Attendants

Supervisors report that Health Attendants were offering the following MCH/ FP services in their health facilities (Table 18b):

- Health Attendants primarily offer family planning services, curative care, immunizations, child growth monitoring, and health education (75% or more) ;
  A majority of Health Attendants also provide antenatal care and do deliveries (about 65%)

and about half (49%) of the supervisors indicate that the Health Attendants in their facilities do home visits;

- There appears to be no differences between the two districts in any of the services offered by Health Attendants.

I) Views of supervisors on FP training of Health Attendants

When asked if they would recommend that FP training for Health Attendants be provided in a separate in-service FP training course, almost all (95%) of the supervisors responded positively. The reasons they gave included the following:

- Health Attendants would understand such an FP course more easily since it will be a separate program designed for them and there would be more time devoted solely to FP;
- During a separate in-service FP training, there would be enough time to go into subjects in-depth and instructors will have adequate time to monitor and evaluate the knowledge and performance of the Health Attendants;
- Most of the Health Attendants have a low educational level and thus require more time to understand FP content, which would be possible in a separate course.
- FP clients will trust Health Attendants more if they know that they have attended a specific in-service FP course;
- Health Attendants will put more effort into their training since they will understand that the course is specially prepared and organized for them;
- Such a course would motivate Health Attendants to perform their other duties diligently so that they could be nominated for the in-service course.

J) Supervisors' suggestions as to the content of an in-service FP training course for Health Attendants

Supervisors indicate that an in-service FP training course for Health Attendants should include the following key subjects:

- All family planning methods: how they work and how to deliver them,
- FP client counseling,
- Natural family planning methods,
- Advantages and disadvantages of FP,

- Identification of high risk factors to mother,
- Physical examination/assessment of FP clients,
- How to motivate/recruit FP clients from the community,
- Anatomy & physiology of the reproductive system,
- AIDS and STDs,
- How to produce/provide FP reports,
- Benefits and risks of FP usage,
- How to refer clients with side effects.

K) Supervisors' recommendations on training duration and training structure

About one-third of the supervisors (12 out of 39) indicated that four weeks would provide adequate time to cover the FP content described above. Nine supervisors thought the duration should be between five and eight weeks, and six supervisors indicated that the duration for the training should be over 12 weeks. The mean duration was about 6.5 weeks. It is important to point out that almost all (95%) of the supervisors also said they would support FP training for the HAs within the one year training course (Table 18c).

Supervisors were asked to suggest how an in-service FP training course might best be structured for Health Attendants.

- A majority of supervisors (62%) indicated that equal amounts of theory and practice would be desirable to allow for better understanding and integration of both elements. Such a balance would better enable them to compare what was learned in class with what is practiced in the clinics. Health Attendants would have adequate time to apply classroom learning to practical settings, and practical sessions will remind Health Attendants what they learned in theory.
- A large minority (36%) of the supervisors expressed the view that less theory and more practice were desirable for the Health Attendants since this would allow them to gain more FP experience through adequate practice in the clinic.

L) Views of supervisors on suitable qualities for Health Attendants trainers, FP training setting and on characteristics that Health Attendants possess that are suitable as FP service providers

When asked to identify the important qualities that the trainers of Health Attendants should have, the supervisors cited the following:

- Should be an FP expert so as to be able to teach accurately, comprehensively, and confidently;
- Must be patient and considerate so that Health Attendant do not fear to ask questions, especially given the fact that they have little formal education;
- Must be polite and able to communicate so that Health Attendants will understand FP subjects without many problems;
- Must be clean, sober, cheerful so as to act as good role model for the students;
- Must be attentive, mature, and healthy

When asked about the training setting for a Health Attendant FP course, supervisors cited the following qualities as crucial:

- The setting must be close to a hospital or health institution so as to allow Health Attendants to have access to clients for practice sessions.
- The setting should have a well prepared and equipped classroom complete with all teaching materials to enable students to learn better.
- The setting should be within a town centre where essential services (food, telephone, vehicles, stationery, etc.) are easily available. Regional or district headquarters were most favored for the training setting since they are readily accessible and would have enough practicum sites.
- There should be adequate space and boarding facilities so that students can be comfortable and thus concentrate on their studies.
- There should be enough instructors to provide comprehensive training to the Health Attendants and to have time to monitor and evaluate their progress

When asked to identify characteristics of Health Attendants that make them particularly suitable FP providers, supervisors listed the following :

- Health Attendants are usually experienced and very cooperative, which helps them to get along with others, to perform their duties diligently, and be liked by clients.

- Health Attendants are trustworthy and cheerful, which makes clients perceive them positively.
- Health Attendants are hardworking, disciplined, reliable, polite and are good listeners, characteristics that are crucial for the proper provision of health services.
- Both coworkers and clients appreciate Health Attendants' role since they are on good terms with them.

As to the characteristics that Health Attendants possess that are not suitable for FP providers, supervisors indicated that:

- Most of the Health Attendants have a low education level; few have finished or gone beyond Standard 7;
- Some Health Attendants are lazy at work, some are troublesome, and others are undisciplined and alcoholic. This causes them to be poor providers of services;
- Some Health Attendants are untrustworthy, ignorant, corrupt, careless, carefree, disobedient, alcoholic, and some are even bad-tempered. These characteristics affect service provision and oftentimes discourage clients/patients from seeking FP services.

Table 18d provides a summary of supervisors' views on the type of FP activities Health Attendants should provide in a health facility. All the supervisors agreed that Health Attendants should provide a wide range of FP services including counseling, individual and group health education, identifying at-risk clients, taking client histories, giving instructions on all FP methods, keeping records and maintaining FP supplies.

M) Supervisors' perspectives on supervision and communication in their health facility

Data presented in this section illustrate some supervisory practices and the supervisors' perspectives on how well Health Attendants would cope with additional FP service responsibilities. A majority of supervisors indicated that they provide supervision to their Health Attendants on a daily basis (61.5%) (Table 18e). At the other extreme, about 15 percent of the supervisors indicated that they never

performed any supervision of their Health Attendants. The remaining one-quarter of supervisors indicated a frequency of supervision which ranged from weekly to once a month.

As to whether Health Attendants could cope if FP services were added to their present responsibilities, all the supervisors except one indicated that the Health Attendant could readily fulfill these additional responsibilities for a variety of reasons (Table 18e). The major reason given for their probable success with the added responsibility of FP was that many Health Attendants already have FP service responsibilities, and they are coping with that work even though they have not had any special FP training. Indeed, some expressed the view that with FP training the Health Attendants would cope even better than currently because they could more easily fulfill their FP service responsibilities.

With regard to how information is passed from Health Attendants to the supervisor and vice versa (i.e., communication channel and process), the supervisors indicated that:

- Communication is largely (80%) face-to-face (*i.e.*, talking/communicating orally;
- Others indicated that the communication process is through the MCH In-Charge;
- The DMOs indicated that they communicated through writing and visiting the clinics.

On problems that are encountered with the present communication channels, the supervisors indicated that the lack of transportation and vehicles is a serious problem, especially during the rainy season. The DMOs indicated that they needed vehicles for their health care facilities to maintain regular and frequent communication with their clinics. Communications are also hampered because of lack of telephones. As to what problems are encountered with regard to supervision of junior staff, the supervisors indicated that:

- Lack of transportation especially during rainy season makes supervisory visits impossible;
- Lack of discipline among some service providers;
- Alcoholism among some service providers;
- Lack of discipline and disappearances during working hours;
- Some junior staff are disobedient and do not follow instructions given to them by their seniors.

N) Supervisors comments on expanding FP services to the community levels through use of Health

Attendants

The supervisors were asked to comment on what needs to be done to expand FP services to the community and indicated that:

- Health Attendants should be offered FP training in large numbers so that they can conduct community recruitment of FP clients, home-visit missions, and providing group health education;
- Health Attendants should be provided with transportation means (e.g., bicycles) to help them to travel to villages for community FP awareness campaigns;
- FP service providers should be adequately supervised to ensure that they are providing proper FP service;
- Radio programs, FP film shows, FP drama etc. should be organized and provided;
- Community motivational and educational programs should be stepped up;
- The Ministry of Health should provide enough FP reading materials (*e.g.*, leaflets, booklets, visual aids) and FP equipment;
- Posters, leaflets, and FP materials should be freely distributed to the community.

6. Client and community perceptions of FP services and materials

A) Introduction

Focus group discussions were carried out with ten client groups (N=105) and 16 community groups (N=170). Clients were selected from those present at the health care facility on the day of the site visit. Community group members may also have been users of the facility but were not seeking services that day. The aim of these group discussions was to determine client and community views, opinions and perceptions on key areas that were deemed crucial for FP training and material development, FP services utilization, and FP service providers.

The following items were used as a guide for the client focus group discussions:

- Perceptions about services provided;
- Desired/preferred attributes for a health facility;
- Perceptions about health workers and their desired attributes;

- Perceptions about visual aids, particularly FP-related aids;
  - how are they used and what is their utility value
  - how can they be improved
  - whether they would like to take them
- Strategies and methods of communicating FP messages;
- Preferred strategies;
- Preferences as to the personnel needed to provide FP information.

The following items were used to guide the community member focus group discussions:

- Perceptions about services provided;
- Types of services usually sought;
- Attributes of an ideal health facility;
- Attributes of an ideal health worker;
- Experiences and concerns regarding health services received by the community;
- Suggested strategies and methods of reaching those who do not seek FP services;
- Community experiences with visual aids and suggestions for improvement.
  - community understanding of visual aids
  - community preferences on materials and visual aids

B) Client perceptions with regard to health services, health facilities and health workers

From the focus group discussions held with client groups (ten groups with a total of 105 participants), the following observations were made:

- On the day of the visit, a majority of the clients participating in the discussion indicated that they had attended the facility to seek child health services (child curative treatment (32%), or MCH preventive care for children (48%)). Only five of the clients were seeking FP services.

- The number of clients who reported that they were satisfied with the services they received (24%) was lower than those who reported that they were not satisfied (57%). Those who were satisfied cited good MCH services as their reason, while those who were not satisfied indicated lack of drugs (57%), long waiting times (24%), shortage of work materials and equipment (19%) and shortage of staff (30%) as the major reasons for their dissatisfaction.

- Clients indicated that missionary, private and district hospitals, at which many of the clients occasionally sought care, were well stocked with drugs (31%) provided a wider array of services (25%) which were also viewed as better.
- Most of the clients (67%) indicated that they would like to receive services from facilities in their localities provided that the facilities possess the following attributes:
    - Adequately stocked with drugs and essential commodities;
    - Able to provide a wide range of services (e.g., laboratory, surgical, dental, in-patient etc.);
    - Enough disciplined and competent health workers;
    - Reliable transportation means;
    - Adequate working materials and equipment.

As to health worker, many clients (76%) mentioned that a shortage of trained health workers exists particularly in the dispensaries. Most of the clients (67%) indicate they are free to discuss their problems with any health worker and it does not seem to matter whether services are provided by male or female provided he/she is competent. Clients prefer a health worker with the following attributes:

- Sharp and competent in service delivery;
- Polite, patient, cheerful and compassionate;
- Disciplined, trustworthy and not corrupt;
- Non-alcoholic (sober), non-temperamental, and upholding confidentiality.

C) Community perceptions with regard to health services, health facilities and health workers

During the focus group discussions carried out with 170 individuals (eight groups of males and eight of females), the following observations were made:

i. Both males and females indicated similar preferences as to the type of facility from which they would like to receive health services. These attributes included:
    - nearby location;
    - well-staffed with competent personnel;
    - able to provide a wide array of services;
    - well-supplied and stocked with drugs and other essential commodities;

- reliable transportation available;
- an uninterrupted supply of clean water and lighting.

ii. Both males and females also indicated similar preferences as to qualities that health workers should have which included:
    - kind and caring;
    - patient and friendly;
    - competent, hardworking;
    - devoted, compassionate;
    - not corrupt, disciplined and non-alcoholic;
    - trained and experienced in FP.

iii. As for their own experiences with health facilities, both males and females pointed out that**:**
    - health services are good only when there is a good supply of drugs;
    - there is shortage of staff which leads to delayed services;
    - there is rampant corruption among health workers resulting in unauthorized sale and theft of drugs, the asking of favors or bribes before rendering services, and, in some cases, under dosage of drugs to clients;
    - comparing public to private health facilities, both males and females indicated that private facilities (e.g., missionary hospitals) were well stocked with drugs, have adequate and competent staff, provide wide range of services, and have better facilities for inpatient services.

iv. The major concerns cited by both males and females regarding their local health facilities are:
    - perennial shortage of drugs and essential commodities;
    - corrupt and undisciplined health workers;
    - lack of working materials and equipment at the facilities;
    - services starting late;
    - lack of uniforms for health workers;
    - poor management of government health facilities.

v. Both males and females indicate the visit to the health facilities is to seek a variety of services which include:
    - MCH services;
    - curative services;
    - family planning services;
    - health education and counseling.

vi. The reasons cited by both males and females as to why some people did not use health facilities as often as they should are:
    - the fact that some people seek traditional remedies first;
    - some people are disappointed by the perennial shortage of drugs and poor conduct of some health workers.

vii. The reasons stated by both male and female groups as to why some people do not seek FP services included:
    - false beliefs and prevailing rumors about FP;
    - religious and cultural restrictions and constraints;
    - ignorance about FP on the part of some fathers and mothers.

viii. Some suggestion provided by both males and females on ways of reaching people who do not seek FP services include:
    - continued FP education and motivation through the use of various mass media campaigns;
    - involvement of village leaders and known FP acceptors;
    - planned home visits by health worker;
    - the development and implementation of FP programs targeted at males.

D) Clients' perceptions with regard to visual aids

Nearly all of the clients (103) have seen visual aids in the health facilities. Many of those visual aids related to family planning, AIDS prevention, MCH services, and prevalent diseases such as TB, leprosy, measles and malaria. Most clients indicate that they liked the pictures, illustrations and explanations on the visual aids since they are educational. Clients suggest that visual aids can be improved by having detailed and comprehensive messages written on them so that their meaning could be well understood.

As for FP-related visual aids specifically, most clients (103) have seen them in dispensaries and health centers being used by health workers during education and counseling sessions. Most of the FP visual aids seen by clients related to child spacing, benefits of FP, breastfeeding, and FP methods and how they are used. Clients suggested that the FP-related visual aids could be improved by having more comprehensive instructions and directions on what to do and how to act after having read the FP message on the visual aid

Clients indicated that they would like to see real life photographs and illustrations contrasting these families that have successfully used services versus those who have not. As to the best ways to reach men and women with FP-related messages, most clients suggested that the following strategies/methods be employed:

- educational public meetings,
- special FP seminars at the health facility,
- FP film shows in the villages and towns,
- special FP educational radio-broadcast programs,
- home-visits by health workers,
- use of FP acceptors to educate others.

All participating clients express the desire to take visual materials home, particularly those relating to child care, AIDS prevention and family planning so that they could to read and share them with others.

E) Community perceptions with regard to visual aids

In general, a majority of the community members participating in the focus group sessions had seen visual aids about health. Both males and females reported that the type of visual aids they see most frequently are about:

- family planning;
- AIDS prevention;
- maternal and child care;
- commonly occurring diseases, such as diarrhea, rabies, malaria, leprosy and tuberculosis.

Community members suggest that the visual aids can be improved by:

- enlarging the pictures and illustrations so that they are clearly visible;
- putting sufficient instructions and directions on visual aids;
- designing FP-related cartoons in pamphlets and newspapers.

All females and most males report that the meaning of visual aids have been explained to them. Both males and females indicate that they could get FP information from anyone (male or female) so long as that person have been trained in FP. Both male and female community groups indicated that they would like to take some visual aids home. They prefer to take pamphlets, leaflets and booklets related to family planning, child health, and nutrition, AIDS prevention, and management of diarrheal diseases. Generally both males and females acknowledge that they would read and share them with others.

V. Major Implications

The results presented in the previous section have been interpreted to have the following major implications:

1. Positive implications with regard to Health Attendants' potential for FP provision and expansion

A) Health Attendants provide a stable and dependable work force

Health Attendants are recruited locally, live in the communities in which they work, and the majority work in dispensaries in rural areas. Their long duration of employment as Health Attendants as well as their years of employment at their present health facility imply that they are not only knowledgeable about their community but they also have substantial health care experience and are relatively stable. Many Health Attendants expressed satisfaction with their work; others indicated that additional training, among other thing, would increase their job satisfaction.

B) FP/RH Training efforts are feasible and desirable

The MOH already offers a one-year formal training course for Health Attendants which is financed and managed at regional level. Forty percent of Health Attendants interviewed have attended this training course. This training infrastructure within the MOH could be further developed, at relatively little cost, to include FP/RH content in their course offerings. Health Attendants, both with and without previous training, expressed a desire to receive formal training in FP/RH.

C) Male and female Health Attendants can deliver FP services

Both women and men are represented in this cadre of health service providers and both are currently providing a wide range of FP/RH services. Neither the client nor the community groups indicated any gender preference for service providers. Formal FP/RH training would enable these Health Attendants to provide even a more comprehensive range of FP/RH services, and services of a better quality.

D) Health Attendants have MCH, FP/RH experience, and a knowledge and skills base

Although none of the Health Attendants have had any formal FP/RH training, some have had Health

Attendant training, and all of them do have on-the-job experience, and at least rudimentary knowledge and skills in these areas. They have demonstrated skills in health education, explaining FP, infection control and developing rapport in the community. Similarly, they have a base of knowledge about FP methods, the meaning of FP, and attitudes toward FP. A well designed FP/RH training course could build on these capacities and further develop them to better meet the needs of the communities in which the Health Attendants work.

E) Opportunity for integration of FP/RH with MCH Services

While over 80 percent of the Health Attendants interviewed reported that they provide MCH services, such as immunization and child growth monitoring, and some 70 percent give health education talks and perform deliveries, only about 60 percent provide some sort of FP services. Improving the Health Attendants' FP/RH knowledge and skills through formal training would serve both to improve the quality of those services and to better integrate them into MCH Services.

F) Health Attendants are valuable community motivators/educators

As female and male community members who are literate, with elementary school education and with years of health services experience, Health Attendants are potentially excellent community motivators and educators in the area of FP/RH. Most are in the reproductive age years themselves and over half have been contraceptive users at some time while about one-third are current FP users. As longtime, respected community members, FP users and FP providers, these Health Attendants have the potential to serve as important community motivators/educators.

G) Health Attendants are favorably recommended as FP providers

Health Attendants are regarded favorably as FP service providers by both the instructors of their one-year formal training course and by their MCH supervisors. Among other attributes, Health Attendants are described as being effective communicators and being easily accessible to their clients, two traits which are especially important for FP/RH providers in changing communities.

H) Existence of a local FP/RH infrastructure

The local health facility infrastructure for FP/RH services is already in place. In addition to the range of services being offered, most health facilities also have systems in place for maintaining some form of inventory or supply management records and a mechanism for storage of FP and other medical supplies.

Whatever the limits and shortcomings of this infrastructure, it is a functioning system which could be the foundation for further development.

2. Negative implications with regard to Health Attendants' potential for FP provision and expansion

A) Structural shortcomings related to space, supplies and water

All facilities report the lack of private rooms/space for FP client counseling and history taking, and almost all health facilities report an acute/perennial shortage of drugs and other essential commodities. A shortage of contraceptive supplies was observed in all the health clinics visited. The mean number of pill cycles available to FP clients in all 33 clinics on the day of the visit was 11, the corresponding means for condoms and foam tablets were 752 and 151 respectively, while Depo Provera was absent in all clinics. This finding contradicts reports from In-Charges of the health facilities, who indicated that they have no problems getting FP supplies. A reliable supply of water in the health facilities is also a serious problem for almost half of the clinics. The shortage of water has implications for the maintenance of asepsis, other infection control measures and sanitation.

B) Transportation limitation

Most of the health facility In-charges reported severe transportation problems, coupled with poor conditions of roads especially during the rainy season. These problems may hinder regular and timely supply of commodities and essential drugs and thus affect service expansion and access to these rural communities.

3. Findings related to factors affecting the formulation of a training strategy

A) The fact that all Health Attendants can read and write in Kiswahili has a bearing on the:

- medium of instruction;
- language of the training materials;
- processes to be used in developing the materials from the initial stages.

B) The relatively low educational background of Health Attendants implies :

- the use of training approaches and techniques that will be more suitable for trainees of low educational level (i.e., more practice, less theory ,use of training media and methodologies that are locally familiar for example , poems that are sung, -ngonjera, mashairi- drama story etc.);
- training should not necessarily be of long duration but perhaps phased, with specific skill areas to be attained at each phase;
- a training strategy should address a set of simple content areas at a time;
- training aids should be visual/audio and simple enough for easy interpretation;
- the possibility exists to use non-traditional learning approaches, which maximize adequately supervised on-the-job practice opportunities.

C) The FP curriculum developed for the training of Health Attendants should:

- be performance based;
- reinforce those aspects of client centered interpersonal and communication skills that currently exist and develop missing aspects;
- aim at enhancing quality of care and building strong client-provider professional relationships.

D) In designing the FP curriculum, client preferences and opinions should be solicited and taken in account to enhance Health Attendants' ability to reach clients.

E) The perspectives of the community, clients, providers, supervisors and instructors imply that the curriculum content for Health Attendants should address the following essential areas:

- client provider interaction and work ethics and client rights;
- counseling for FP and educating on FP and RH, pre-natal and other safe motherhood services;
- screening clients for high risk factors;
- FP services for all including special groups for example adolescents, males, post partum women etc.;

- infection prevention and control ;
- record keeping and reporting;
- supplies management in relation to quality of care;
- how to use visual aids and audio visual materials for client and community education/motivation.

F) Given that a large majority of Health Attendants work in dispensaries in rural areas, the training should take place in either their own or similar kinds of sites.

G) The training strategies developed for Health Attendants will need to include training in FP/RH training for both instructors and supervisors.

H) Shortages of contraceptives and other health care supplies in health clinics have negative implications on:

- performance of the trained service providers;
- access to quality services that encourage continuation of FP use ;
- provision of less effective, less appropriate, or less preferred methods of contraception.

In preparation of a new FP/RH training strategy to be formulated, there is a need to address the supplies problems identified above.

I) FP/RH trainers should be knowledgeable, and also good teachers and role models.

4. Discussion

Eight positive implications of Health Attendants potential were drawn from the findings of this needs assessment. These were:

a) Health Attendants provide a stable and dependable workforce;
b) Training efforts for Health Attendants are sustainable;
c) Male and female Health Attendants can deliver FP services;
d) Health Attendants have a knowledge and skill base;

e) There exists the opportunity for the integration of FP into other services using Health Attendants;
f) Health Attendants are potential community motivators/educators;
g) Health Attendants are accepted as FP service providers by their supervisors;
h) The existence of an FP/RH infrastructure in Health Attendants working environment to support the provision of FP services.

This study provides evidence from multiple sources to show that Health Attendants are a group which could ably fulfill an important role in the expansion of FP/RH services in Tanzania. There is supporting evidence that, if trained, Health Attendants will continue to serve both male and female clients not only in the same rural community but also in the same health facility. In addition, the fact that they already provide selected MCH/FP services offers the opportunity for the integration of FP/RH into the other MCH services. It is expected that the integration of FP into their responsibilities will not be a difficult process given that Health Attendants already demonstrate FP knowledge and possess a skill base.

Some deficiencies may be due not only to lack of training but also to shortcomings in the work environment, for example the shortage of running water and fuel to heat water in many health facilities. Identification of these work environment limitations is important in designing an appropriate training curriculum as well as in developing a list of needed changes in the work place.

One job that Health Attendants are certain to continue to perform well is establishing and maintaining rapport with clients. They are literate in Kiswahili (the lingua franca), are community residents and share many personal characteristics with the clients they serve. They are therefore in a good position to communicate appropriately with clients. In addition, a large proportion of the Health Attendants have used FP and therefore have potential to serve as community motivators/educators for the use of FP.

However, in order for the clients and the community to benefit fully from the FP/RH services to be offered by the trained Health Attendants, certain structural shortcomings must not be overlooked. Almost all health facilities reported an acute and perennial shortage of drugs and other essential commodities including contraceptive supplies and almost half reported the need for a regular water supply. No doubt that lack of contraceptive supplies may lead to poor performance of the trained service provider, poor access to quality services that encourage continuation of FP use; and the provision of less effective and less appropriate or less preferred methods of contraception. Similarly, identified

transportation limitations affect distribution of supplies to health facilities for use by Health Attendants, while public transportation limitations may hinder users from reaching the health facilities that offer FP services.

In the formulation of a training strategy, factors related to Health Attendants' personal characteristics; their perspectives with regards to suitable trainers, training sites, methodologies and approach (theory compared to practice); as well as clients' preferences are important considerations. Health Attendants' literacy in Kiswahili will have a bearing on the medium of instruction, the language of the training materials and the processes used in developing the materials. The fact that the majority of Health Attendants have only achieved primary level of education implies a relatively low capacity to absorb a lot of content during the theoretical part of the training. Training configurations that emphasize more practice and less theory and more visual and audio training media, will therefore be a more productive training option.

In conclusion, Health Attendants working in the MCH clinic setting offer a potentially useful cadre for the expansion of FP service delivery. They possess suitable personal characteristics which can be relied upon for reaching potential FP clients, especially in the rural areas. Given the existence of an established training system which is regionally based and managed, an investment in the training of this group can be sustained with minimal resources. However, in order to maintain and improve the quality of FP services provided by such trained personnel FP commodities, equipment and supplies should be made available and be properly cared for at all service delivery points.

5. Strengths of this study

A) A study which is jointly planned and implemented by a technical agency and host country representatives strengthens the collaborative efforts and ensures confidence in the results and findings of the study.

The greatest strength of this Needs Assessment was that planning and implementation were achieved by joint collaborative effort between the host country and INTRAH/PRIME. While technical leadership was provided by INTRAH/PRIME, overall coordination of the study was the responsibility of the Family Planning Unit of the Tanzanian Ministry of Health (FPU/MOH). In addition, a resource person was assigned on a permanent basis to represent Tanzania's context throughout the study. This resource

person participated actively in every stage related to planning, implementation of the study, analysis of the data and production of the report. In particular, the resource person contributed to developing and finalizing the project proposal, developing and translating the study instruments from English to Kiswahili, planning for and carrying out the data collection, analysis of the qualitative data, reviewing the draft report and dissemination of the findings to the Tanzania Ministry of Health and USAID mission in Tanzania.

Besides this input from the MOH central level, the study was designed to accommodate active involvement of the Regional and District Health Management teams (RHMT and DHMT). from the study area. These teams' contributed to the refinement of the project proposal by providing relevant regional and district based data, assisted in the selection of the appropriate data collectors, and ensured that the planning for and actual data collection proceeded smoothly within the study districts. The continuous support to the study given by the Regional Medical Officer was in itself a major strength of the study.

Without doubt, this joint and cohesive effort between MOH/FPU, the Regional and District Health Management teams and INTRAH /PRIME proved to be an advantage for the successful planning and implementation of the study. The successful implementation was aided by the use of health workers who were familiar with the health system, the cultural characteristics and the geographical profile of the area as the data collectors. Their background contributed to the achievement of nearly a 100 percent response rate.

B) The use of the local language for developing and administering of the instruments enhances the quality of the data collected.

A second advantage which this study had was the use of Kiswahili as the medium of communication for collecting the required data. The use of this lingua franca served to increase the level of accuracy of the information provided by respondents. The use of multiple instruments, which characterizes the DAPP approach, provided information from a variety of respondents involved with service providers and the use of a combination of quantitative and qualitative methods provided the opportunity to focus not only on the Health Attendants but also on the context within which they function in the health care system.

6. Considerations for future research

The development and refinement of nine instruments in English and Kiswahili consumed more time than

is usual for other Needs Assessment studies. Time must therefore be allotted for the translation from English to Kiswahili and the back-translation from Kiswahili to English before and after pretesting of the instruments. The use of the local language as the medium of collecting the data also has time implications during the analysis, particularly of the qualitative data. Notes recorded in Kiswahili had to be transcribed into English before summarizing the information under the themes of interest.

Researchers intending to use qualitative data collection methods during the application of the DAPP approach must be aware that the use of focus group discussion technique requires particular skills. Not all qualified data collectors necessarily possess the skills.

The nine instruments provided a wealth of data which have not been fully utilized in the report because priority was given to the immediate issue of analyzing those data necessary for the development of training materials (Part 2 of Phase 1). However, both qualitative and quantitative sources provided information that will be useful for other purposes and therefore additional detailed research may not be required. For example, information provided by clients and members of the community during the focus group discussion sessions can be used for the development of information, education and communication (IEC) materials for clients.

VI. Program Recommendations

1. General Program and Policy Recommendations

Based on findings of this needs assessment which identified many supportive elements for more fully incorporating Health Attendants into the provision of MCH/FP/RH services, the following recommendations are made:

A) In-Service Training (IST)

FPU and INTRAH/PRIME should :

i. Design and field test a training strategy for Health Attendants that takes into account the findings and implications of the DAPP and other field realities. (See training strategy).

ii. Revise the training strategy approaches, materials, implementation plan upon conclusion of the field test and train in Kigoma where the strategy can be applied, using the revised materials and training approach.

iii. Conduct training impact study by means of systematically monitoring changes in service delivery over time at the selected clinic sites with trained Health Attendants.

B) Health Attendant One Year Training Program (On-the-Job)

To standardize the RH/FP and child survival training for this cadre of primary service provider, the MOH training division and the Family Planning unit should assist the RHMTs to strengthen the existing one year program managed at regional level. The assistance should focus on improvement of content and instruction in the MCH/FP sections of the syllabus provided by the Nursing Council. The training materials developed tested and found to work should be provided to this group and trainers be assisted in their use.

C) Training support

i. Supervisors of Health Attendants

- The Rural Medical Aide (RMA), the worksite technical and administrative supervisors of the Health Attendant should receive two weeks Reproductive Health Update (RHU) and orientation to the Health Attendant training, so that they provide a conducive learning environment and support to Health Attendants .

- A one day team building and orientation activity should be organized for Health Attendants' supervisors based at the regional and district levels (RNO, RMCHCo, DMCHCo) who will serve as resource person to the training program. The purpose of the one day activity will be to orient them to the program and on their facultative role during the practical training.

ii. Trainers

Given that the medium of instruction in Kigoma will be Kiswahili supplemented by the local languages and that the training locus will be at the district and health facility level, the trainer team in each pilot district should include the following:

- One district or regional trainer (Nurse-Midwife or Public Health Nurse)
- Two technically competent Nurse Midwives trained in Comprehensive or Basic Clinical Skills.
- Due to the paucity of these cadre of personnel in the region, the Community Based Development (CBD) trainers may also be included in the team. However, at least one of the trainers must be a midwife.
- The trainer team should be involved in selected tasks during the training material development and also trained in the use of the materials and the curriculum.

D) Training materials

- Training materials should include print references and other problem oriented materials suitable for supporting self learning at worksite.
- Training print materials developed for Health Attendant should:
  i. be in large print to accommodate limitations of a low literacy and reading habits,
  ii. include visuals and have Tanzania specific messages where appropriate,

iii. present basic essential information on each topic at a time,
iv. contain information that is easily understood,
v. be in Kiswahili.

E) Training Approach

Training approaches and methodology should provide room for delivery of material through other media besides lecturette and demonstrations (e.g. songs, stories, drama , case studies etc.).
Given the training content areas of priority deduced from the results/findings, there exists ready-made materials in-country from which the content may be adapted. These include the CBD curriculum, CBD protocol manual, the FP comprehensive skills curriculum, the preceptorship curriculum and the Reproductive Health Update (RHU) curriculum for Medical Assistants and the Management Information Systems (MIS) manuals.

F) Service Delivery

i. Special Client Groups:

FPU should explore and/or test modalities for providing RH/FP services for special groups such as males and the youth.

ii. Supplies:

FPU should follow-up the issue of inadequate and irregular supply of contraceptives and essential drugs with a view to getting the Regional health management team review their current supplies management system and resolve inherent severe distribution problems.

iii. Information, Education and Communication (IEC)

The information obtained from the clients and community regarding the preferences on IEC materials should be shared with MOH IEC program supported by PCS for use in development for RH client materials.

G) Policy Guidelines

It is recommended that IUCD insertion be excluded from the expected functions of Health Attendants stipulated in the Policy guidelines because of the environment in which the Health Attendants work and the actual difficulties experienced/expected in maintaining the required standards for infection prevention and control.

2. Recommended Training Strategy

The training strategy recommended below reflects the following objectives:

- A program of training for updating facility in-charges and orientation of district and regional supervisors to support and promote learning.
- A program of training for strengthening existing trainers abilities to plan and conduct training and to provide on- the- job assistance to Health Attendants.
- A program of training for Health Attendants that combines traditional clinical training approach with self learning using training aides at worksite..

A) Training for Health Attendants supervisors and trainers

i. A program of training for HA supervisors

a) WHO: Rural Medical Aides (RMAs) or Medical Assistants /Clinical Officers in charge of facilities from which Health Attendants will be drawn

FOR HOW LONG: Two weeks

WHAT: Update on RH/FP content, practices and trends

- Orientation on Health Attendants training and their roles .
- Prepare them for their roles to support training of Health Attendants .
- Prepare them to receive referrals.
- Update on ordering/logistics management
- Staff allocation for sustaining skills and quality of care

b) WHO: Resource persons (RMCHCo, RNO, DMCHCo)

FOR HOW LONG: One Day (preferably tagged on to trainers training activity).

WHAT:

- Team building
- Orientation on Health Attendant training
- Prepare them on their expected facilitative role during the practical training.

ii. A program of training for trainers of Health Attendants.

WHO :Trainers: (Must include)

- One District or regional trainer with proven competency.

- Two technically competent Nurse Midwives from the district (trained in Comprehensive or Basic FP/RH clinical skills).

FOR HOW LONG: Two weeks

WHAT:

- Orientation to the training of Health Attendants and trainer's roles
- Update on client oriented interpersonal relationship.
- Update in client rights and human rights.
- Update in selected Contraceptive/ RH/areas.
- Training in effective team work.
- Orientation on proposed Health Attendant training approaches
- Training on how to use Health Attendant curriculum and materials.
- Orientation on how to conduct on- the- job supportive follow up
- Orientation on how to conduct simple skills assessment
- Update on record keeping, reporting and data use
- Role of trainers in assisting Health Attendants maintain quality of care
- How to use audio and visual materials
- How to use audio tapes and Health Attendant Handbook in both classroom and on-the-job.

B) Program for Training Health Attendants

i. Selection

Health Attendants working in MCH clinics with no MCH aides in the two pilot districts will be the group targeted for the pilot training.

ii. Recommended In Service training (IST) approach

The recommended training approach will be a combination of Distance Based Learning (DBL) and the traditional training approach. The approach will allow minimal disruption of services and the opportunity of Health Attendants to practice on their own at worksite.

iii. Organization

Training will be organized in a modular form consisting of four blocks, spread over a period of four to six months.

Block 1 - Two weeks theory and practice in a central location in the district.

Block 2- Six weeks application at worksite with DBL support materials and at least one day follow up support from a member of the training team, for every trainee and a minimum of two supportive visits from the district service supervisor.

Block 3- Two weeks theory and practice.

Block 4- Three weeks application at worksite with DBL support materials and at least one day follow up support from a member of the training team, for every trainee. The service supervisor will also visit the trainee at least once during this block.

iv. Practice

The practice at worksite will be supervised by the RMAs who are the Health Attendants' supervisors and by a member of the training team during the follow up visit. The DMCHCo will make at least one supervisory visit during his/her regular monthly visit to the clinic.

v. Evaluation

Baseline service data will be collected prior to the training, the data will be updated by the DMCHCo during each supervisory visit for the purpose of assessing the influence of the training on service delivery during the practice period.

vi. Suggested Curriculum Content

The broad areas of content proposed are as follows and are selected on the basis of the results and findings from various perspectives of the study, including community, clients, supervisors, providers, from observation and the policy guidelines.

Block 1: Theory, simulations and limited practice

- Client/provider communication
- Community perspective/quality of care
- Client centered relationship and interpersonal communication as they relate to day

to day work of Health Attendants.

- Client and provider interaction
- Client rights/human rights and work ethics
- Counseling skills
- Leading/conducting health education talks
- How to recruit clients from the community and from other services in the clinic
- Family Planning method provision
- Contraception services for special groups (adolescents, post partum, males, post abortion)
- Eligibility of FP methods
- Counseling on all FP method
- Explaining methods to clients including LAM, natural family planning methods
- Family Planning services(initiating pills, resupply of oral contraceptives, Depo Provera, condoms

Block 2: Practice in own worksite

Block 3: Safe motherhood initiatives,

- Child Health and STI/HIV/AIDS prevention
- Provision of prenatal care./ Assessment of ante natal clients
- High risk identification(steps for identifying risk groups, services to offer)
- Immunization of pregnant women
- Monitoring mothers in labor
- Assisting mothers with delivery
- Immediate care of the new born
- Initiation of breast feeding
- Growth monitoring
- Nutrition
- Referring MCH clients
- Immunization
- Planning/conducting education on FP/STDs/HIV/AIDs prevention
- Recognition and referral of clients with STI

Block 4 :Practice in own worksite

vii) The PST Approach: The one year training course

1. Training, PST tutors/instructors in comprehensive FP/RH skills.
2. Involvement of regional team members in the re-organization of training (e.g. RNO, DNO RMCHOs).

Examples of how to reorganize PST training:

- Review of the PST syllabus to incorporate/adapt the IST FP/RH components;
- Develop a systematic practicum plan and clinic objectives for both the FP/MCH/SMI components;
- Strengthen the hospital and urban health centre practicum sites;
- Include FP/RH MCH and SMI in the final exams;
- Use materials developed for the In-Service Program.

Appendix A

Tables

Table 1
Health Facilities*, MCH Aides, and
Health Attendants (HAs) by District

	Total Health Facilities				MCH Aides	HAs		
	Hospital	Health Center	Dispensary	Total	Total	One-Year Formal	On-the-Job	Total
Kasulu	3	5	46	54	30	86	109	195
Kibondo	1	4	64	69	41	58	95	153
Total	4	9	100	113	71	144	204	348

* All health facilities provide MCH services

Table 2
Subjects for Whom Data Collection Was Completed

Target group	Number expected	Number inter-viewed	% Completed
HAs in MCH clinics (I1, I2)	112	109	99
Health Attendant (HA) Instructors (I3)	3	3	100
MCH Supervisors (I4)	39	39	100
Health Facilities To Be Site Visited (I5)	30	33	110
In-Charges of Health Facilities Selected for Site Visit (I5)	33	33	100
HAs for Assessment of FP-Related Skills (I6)	36	36	100
Focus Groups for HAs (I7)	10	9	90
Focus Groups for Male Community Members (I8B)	8	8	100
Focus Groups for Female Community Members (I8A)	8	8	100
Focus Groups for MCH Clients (I8A)	10	10	100

Table 3a
Personal Characteristics of HAs by District

Personal Characteristics	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Comment
	No.	%	No.	%	No.	%	
Age Group							
20 - 29	17	30.9	7	13.0	24	22.0	About half of all HAs are between 30-39 years
30 - 39	28	50.9	32	59.3	60	55.0	
40 and over	10	18.2	15	27.8	25	22.9	
Sex							
Male	9	16.4	28	51.9	37	33.9	Females are in the majority
Female	46	83.6	26	48.1	72	66.1	
Educational Attainment							
Less than Standard 7	3	5.5	4	7.4	7	6.4	
Standard 7	42	89.1	48	88.9	97	89.0	89% completed Standard 7
Form 1-2	0	0.0	1	1.9	1	0.9	
Form 3-4	1	1.8	0	0.0	1	0.9	
Other	2	3.6	1	1.9	3	2.8	
Literacy							
Can read Kiswahili	55	100	54	100	109	100	All can read and write Kiswahili
Can write Kiswahili	55	100	54	100	109	100	
Marital Status							
Married	36	65.5	41	75.9	77	70.6	71% are in marital unions
Widowed	0	0.0	2	3.7	2	1.8	
Divorced	6	10.9	1	1.9	7	6.4	
Separated	1	1.8	0	0.0	1	0.9	
Cohabit	5	9.1	2	3.7	7	6.4	
Single	7	12.7	8	14.8	15	13.8	
Religion							
Roman Catholic	22	40.0	34	63.0	56	51.4	More Christians (89%) than Muslims (11%)
Protestant	25	45.5	16	29.6	41	37.6	
Muslim	8	14.5	3	5.6	11	10.1	
African Traditional	0	0.0	1	1.9	1	0.9	

Table 3b
Personal Characteristics of HAs by Sex

Personal Characteristics	Male N = 37		Female N = 72		Total N = 109		Comment
	No.	%	No.	%	No.	%	
Age Group							
20 - 29	1	2.7	23	31.9	24	22.0	77% of HAs are between 20-39 years
30 - 39	16	43.2	44	61.1	60	55.0	
40 and over	20	54.1	5	6.9	25	22.9	
Mean Age (Years)	40.1		31.2		35.5		Average age of males higher than females.
Educational Attainment							
Less than Standard 7	3	8.1	4	5.6	7	6.4	
Standard 7	32	86.5	65	90.3	97	89.0	87% of males and 90% of females have completed Standard 7
Form 1-2	0	0.0	1	1.4	1	0.9	
Form 3-4	0	0.0	1	1.4	1	0.9	
Other	2	5.4	1	1.4	3	2.8	
Marital Status							
Married	35	94.6	42	58.3	77	70.6	71% are in marital unions
Widowed	0	0.0	2	2.7	2	1.8	
Divorced	0	0.0	7	9.7	7	6.4	
Separated	0	0.0	1	1.3	1	0.9	
Cohabit	2	5.4	5	3.7	7	6.4	
Single	0	0.0	15	20.8	15	13.8	

Table 3c
Personal Characteristics of HAs by Training

Personal Characteristics	One-year Formal Training N = 44		On-the-Job Training N = 65		Total N = 109		Comment
	No.	%	No.	%	No.	%	
Age Group							
20 - 29	17	30.9	7	13.0	24	22.0	About half of all HAs are between 30-39 years
30 - 39	28	50.9	32	59.3	60	55.0	
40 and over	10	18.2	15	27.8	25	22.9	
Sex							
Male	16	36.4	21	32.3	37	33.9	No difference in training status by sex
Female	28	63.6	44	67.7	72	66.1	
Educational Attainment							
Less than Standard 7	0	0	7	10.8	7	6.4	Formally trained HAs have a higher education status. 91% completed Standard 7 and one completed Form 3.
Standard 7	40	90.9	57	87.7	97	89.0	
Form 1-2	0	0.0	1	1.5	1	0.9	
Form 3-4	1	2.3	0	0.0	1	0.9	
Other	3	6.7	0	0.0	3	2.8	
District							
Kasulu	23	52.2	32	49.2	55	50.5	Training status similar between districts
Kibondo	21	47.7	33	50.8	54	49.5	
Marital Status							
Married	29	65.9	48	73.8	77	70.6	No significant differences in the distribution of marital status by HA training
Widowed	2	4.5	0	0.0	2	1.8	
Divorced	4	9.1	3	4.6	7	6.4	
Separated	0	0.0	1	1.5	1	0.9	
Cohabit	2	4.5	5	7.7	7	6.4	
Single	7	15.9	8	12.3	15	13.8	

Table 4a
Training Status of HAs by District

Training Status	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Comment
	No.	%	No.	%	No.	%	
One year formal training	23	41.8	21	38.9	44	40.4	60% of HAs are trained on the job
Trained on the job	32	58.2	33	61.1	65	59.6	

Table 4b
Training Status of HAs by Sex

Training Status	Male N = 37		Female N = 72		Total N = 109		Comment
	No.	%	No.	%	No.	%	
One year formal training	16	43.2	28	38.9	44	40.4	No difference in training status by sex
Trained on the job	21	56.8	44	61.1	65	59.6	

Table 5
Work Experience of HAs by District

Work Experience	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Comment
	No.	%	No.	%	No.	%	
Recruitment Procedures							
Recruited by District Committee	42	76.4	38	70.4	80	73.4	73% have been recruited by the district committee
Recruited by Region Committee	5	9.1	14	25.9	19	17.4	
Recruited by Private Agency	8	14.5	2	3.7	10	9.2	
Mean Number of years working as HA	13.0 years		14.0 years		13.5 years		HAs have worked for an average of 13.5 years
Mean number of years employed in present health facility	7.8 years		7.7 years		7.8 years		HAs have worked at their present health facility for an average of 7.8 years.

Table 6
Work Environment of HAs by District

Work Environment	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Comment
	No.	%	No.	%	No.	%	
Type of Health Facility							
Hospital	6	10.9	3	5.6	9	8.3	72% of HAs work in a dispensary
Health Centre	18	32.7	4	7.4	22	20.2	
Dispensary	31	56.4	47	87.0	78	71.6	
Place of Residence							
Within the Clinic	10	18.2	11	20.4	21	19.3	All live in the community in which they work and 19% actually live within the clinic complex
Outside the Clinic	45	81.8	43	79.6	88	80.7	
# of Sites Reporting Provision of Health Services							
Curative care	55	100	54	100	109	100	Over 95% of HAs indicated that curative care, immunization, health education, child growth monitoring and antenatal care are provided in the health facility in which they work.
Immunization	55	100	54	100	109	100	
Child growth monitoring and development	55	100	54	100	109	100	
Antenatal care	54	98.2	54	100	108	99.1	
Deliveries	47	85.5	53	98.1	100	91.7	
Home visits	44	80.0	49	90.7	93	85.3	
Health education	55	100	54	100	109	100	
Family planning	53	96.4	54	100	108	98.2	

(continued on next page)

Table 6 (continued)
Work Environment of HAs by District

Work Environment	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Comment
	No.	%	No.	%	No.	%	
# of Sites Reporting Services Provided by HAs							
Curative care	52	94.5	52	96.3	104	95.4	HAs are utilized more often for the provision of curative care, immunizations, and child growth monitoring, but 66% also provide FP services
Immunizations	45	81.8	47	87.0	92	84.4	
Child growth monitoring and development	46	83.6	46	85.2	92	84.4	
Antenatal care	33	60.0	36	66.7	69	63.3	
Deliveries	40	72.7	37	68.5	77	70.6	
Home visits	29	52.7	28	51.9	57	52.6	
Health education	43	78.2	43	79.6	86	78.9	
Family planning	33	60.0	39	72.2	72	66.1	
Supervisor of HAs in Clinic							
Medical Assistant Rural Medical Aide	35	63.6	34	63.0	69	63.3	63% are supervised by Medical Assistants or Rural Medical Aides
MCH Aide	6	10.9	10	18.5	16	14.7	
Nurse/Nurse Midwife/ Public Health Nurse	28	50.9	3	5.6	31	28.4	
Another HA	5	9.1	3	5.6	8	7.3	
No Supervisor	0	0	0	0	0	0	
Does Work for HA in His/Her Absence							
MCH Aide	20	36.4	25	46.3	45	41.3	Other HAs and MCH Aides help do their work in their absence.
Another HA	33	60.0	20	37.0	53	48.6	
Nurse/Nurse Midwife/ Public Health Nurse	16	29.1	1	1.9	17	15.6	
None	0	0	0	0	0	0	

Table 7
HAs Perception of Work Load and the Job Satisfaction by Districts

Workload and Job Satisfaction Work Experience	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Comment
	No.	%	No.	%	No.	%	
Workload of HA							
Too many clients	20	36.4	25	46.3	45	41.3	Workload is perceived as either just right or too heavy
Just about right	35	63.6	29	53.7	64	58.7	
Job Satisfaction							
Very Satisfied	28	50.9	18	33.3	46	42.2	42% of HAs claim to be very satisfied with their job.
Fairly Satisfied	27	49.1	36	66.7	63	57.8	

Table 8
HAs Views on the Availability and Provision of FP Services by District

Availability and Provision of FP Services	Kasulu District N = 55		Kibondo District N = 54		Total N = 109		Significance
	No.	%	No.	%	No.	%	
Availability of FP Services in HAs Clinic							
Yes	54	98.2	54	100	108	99.1	Almost all HAs confirmed the provision of FP services in their clinics
No	1	1.8	0	0.0	1	0.9	
Mean Daily Duration of Availability of FP Services in Clinic	7.1 hours		7.8 hours		7.5 hours		According to HA: Services are available an average of 7.5 hours daily
FP Methods Available in Clinic							
Oral Contraceptive	51	94.4	53	98.1	104	96.3	The three most widely available FP methods were OC, condoms and Depo
Intrauterine Devices	11	20.4	8	14.8	19	17.6	
Injectables	37	68.5	46	85.2	83	76.9	
Condom	47	87.5	46	85.0	93	86.1	
Foam	15	27.8	18	33.3	33	30.6	
Diaphragm	8	14.8	8	14.8	16	14.8	
Natural Methods	13	24.1	16	29.6	29	26.9	
FP Services Provided by HA							
Counseling Clients	41	74.5	29	53.7	70	64.2	HAs mainly counsel clients for FP and give Health Education talks on the benefits of FP
Giving Health Education	35	63.6	29	53.7	64	58.7	
Providing Pills to First Acceptors	17	30.9	21	38.9	38	34.9	
Resupplying Pills	26	47.3	28	51.9	54	49.5	
Providing Barrier Methods	4	7.3	15	27.8	19	17.4	
Refer Clients for Other Methods	24	43.6	6	11.1	30	27.5	
Community Motivation	27	49.1	12	22.2	39	35.8	

Table 9
Mean Number of Children Ever Born (MNCEB) and Alive to HAs

Mean # of Children Ever Born and Mean # of Children Alive	Kasulu District	Kibondo District	Total	Comment
Mean # of Children Ever Born to All HAs	4.2	5.5	4.8	MNCEB TO HA is higher in Kibondo than in Kasulu district
Mean # of Children Alive	4.0	5.1	4.6	

Table 10
HAs Who Have Ever Used and Currently Using Contraceptive and Contraceptive Methods Ever Used and Currently Used by HAs

Fertility Regulation	Kasulu District		Kibondo District		Total		Comments
	No.	%	No.	%	No.	%	
Past Use of Contraceptives by HA							
Yes	37	67.3	23	42.6	60	55.0	55% of HAs have used contraceptives in the past
No	18	32.7	31	57.4	49	45.0	
Present Use of Contraceptive by HA	N=34		N=22		N=56		
Yes	22	64.7	15	68.2	37	66.1	66% of those who have ever used an FP method are presently using contraceptives
No	12	35.3	7	31.8	19	33.9	
FP Methods Ever Used by HA	N=36		N=23		N=59		
Pill	28	77.8	13	56.5	41	69.5	The pill was the most common contraceptive method used in the past by 70% of HA who have ever used contraceptive
IUD	2	5.6	1	4.3	3	5.1	
Depo	2	5.6	0	0.0	2	3.4	
Condom	2	5.6	8	34.8	10	16.9	
Natural	2	5.6	1	4.3	3	5.1	
FP Methods Currently Used by HA	N=22		N=15		N=37		
Pill	12	52.2	8	53.3	20	52.6	The pill, injectables and condoms are the three contraceptive types currently used by 34 of the 37 HAs
IUD	1	4.3	0	0.0	1	2.6	
Depo	5	21.7	1	6.7	6	15.8	
Condom	3	13.0	5	33.3	8	21.1	
Natural	1	4.3	1	6.7	2	5.3	
Sterilization	1	4.3	0	0.0	1	2.6	

Table 11a
Display of Visual Aids
(Observations Made at the Clinic Sites Visited)

Item Observed	Kasulu District		Kibondo District		Total		Comments
	No.	%	No.	%	No.	%	
Display of FP Visual Aids (posters)							
Yes	15	83.3	14	93.3	29	87.9	29 (88%) of the 33 Health facilities displayed Visual Aids
No	3	16.7	1	6.7	4	12.1	
Mean # of Visual Aids	5.4		12.7				
Where Visual Aids displayed (Yes Responses)							
– At waiting area	12	80	8	57.1	20	69.0	Visual Aids are more frequently displayed in the MCH/FP area
– At MCH/FP area	12	80	13	92.9	25	86.2	
– At the curative area	11	73	7	50.0	18	62.1	

Table 11b
Content and Source of Visual Aids
(Observations Made at the Clinic Sites Visited)

	Kasulu District		Kibondo District		Total		Comments
	No.	%	No.	%	No.	%	
Content of Visual Aids							
– Promotion of FP birth spacing	15	100	14	100	29	100	All clinics displayed visual Aids on promotion of FP Birth spacing
– Methods available	11	73.3	12	86	23	79	
Source of Visual Aids (Yes Responses)							
– Tanzania MOH	15	100	12	86	27	81.8	The MOH is the main source of Visual Aids on FP. Although more clinics in Kasulu displayed Visual Aides designed by international Organization
– International Organization	15	100	8	57	23	79.3	
– Locally Made	1	6.7	2	14.3	3	10.3	

Table 11c
Use of Visual Aids with Clients and Influence of Visual Aids
(Observations Made at the Clinic Sites Visited)

Item Observed	Kasulu District		Kibondo District		Total		Comments
	No.	%	No.	%	No.	%	
Use of Visual Aids with Clients							
Yes	15	100	14	100	29	100	Visual Aides were used with clients in all clinics visited
No	0		0		0		
Situation in which Visual Aids Used with Clients (Yes Responses)							
– Individual Clients in Counseling Session	13	86.7	7	50.0	20	69.0	Visual Aids were used with client during individual counseling sessions as well as in group sessions
– With Groups in Education Session	12	80.0	12	85.7	24	82.8	
Influence of Visual Aids (Yes Responses)							
– Support the overall sessions	15	100	14	100	29	100	Use of Visual Aids supports the overall counseling and group education sessions

Table 11d
Clients Materials
(Observations Made at the Clinic Sites Visited)

	Kasulu District		Kibondo District		Total		Comments
	No.	**%**	**No.**	**%**	**No.**	**%**	
Source of Client Materials (leaflets, pamphlets) Yes Responses							
– Tanzania MOH	10	66.7	14	100	24	82.8	Tanzania MOH is the main source of client FP materials
– International Organization	7	46.7	10	71.4	17	58.6	
– Locally Made	1	6.7	2	14.3	3	10.3	
Clients Taking FP Materials Home (leaflets and pamphlets)							
Yes	8	53.3	9	64.3	17	58.6	Clients were observed taking FP materials home in about half of the clinics visited.
No	7	46.7	5	35.7	12	41.4	

Table 11e
System of Client/Service Flow, and
Services Offered on the Day of the Visit
(Observations Made at the Clinic Sites Visited)

Items Observed	Kasulu District		Kibondo District		Total		Comments
	No.	%	No.	%	No.	%	
System of Client Flow at Facilities:							
– Clients Use Same Door for Entrance and Exit	16	53.3	13	86.7	29	87.8	The Majority of health facilities are designed so that clients use the same entrance
– Clients Use Separate Entrance and Exit	2	11.1	2	13.3	4	12.1	
Service Client Flow							
– First Come/First Served/Queue	12	66.7	8	53.3	20	60.6	Two thirds of waiting clients are served on a first come first served basis
– Is Given According to Type of Service	6	33.3	7	46.7	13	39.4	
Services Offered on the Day Visit (Yes Response)	N=18		N=15		N=33		
– Curative/First Aid	13	72.2	10	66.7	23	69.7	Health facilities were mostly observed providing MCH services Health Education and Curative care only 16 clinics provided FP on day of visit
– MCH	17	94.4	11	73.3	28	84.8	
– Family Planning	10	55.6	6	40.0	16	48.5	
– Health Education	10	55.6	11	73.3	21	66.7	
Number of Clients Waiting for FP Services During Visit						41	41 clients were waiting for FP services in 16 clinics

Table 12
Amount of Contraceptive by Type Available in the Clinics on the Day of the Visit (Observations Made at the Clinic Sites Visited)

Item Observed	Kasulu District	Kibondo District	Total	Comments
	No.	No.	No.	
Quantity of FP Methods in Clinic				Extreme variation in # of FP methods available and type. The mean # of OC cycles available for client use was 11 in both districts.
– Mean # of OC	8 Cycles	13 Cycles	11 Cycles	
– Mean # of IUDs	1	3	2	
– Mean # of Injectables	–	–	–	
– Mean # of Condoms	393	1112	452	
– Mean # of Foam Tablets	127	174	151	

Table 13
MCH/FP Registers
(Observation Made at 33 Clinic Sites Visited)

Item Observed	Kasulu District		Kibondo District		Total		Comments
	No.	%	No.	%	No.	%	
MCH Clinic Register in Health facility							
Yes	18	100	14	93.3	32	97	All health facilities with the exception of one had an MCH register.
No	0	0	1	6.7	1	3	
Staff observed filling in MCH clinic register (Yes Responses)							
– HAs	12	66.7	5	33.3	17	51.5	HAs an MCH Aides are the two cadres responsible for completing the MCH clinic register.
– MCH Aides	7	38.9	6	40.0	13	39.4	
– Nurses/Nurse Midwives and Nurses PH	1	5.7	4	26.7	5	15.2	
FP register in health facility							
Yes	15	83.3	15	100	30	90.9	Thirty out of the 33 clinics had a FP register
No	3	16.7	0	0	3	9.1	
Staff observed filling in FP register							
– HAs	9	50.0	2	13.3	11	36.7	Only in eleven clinics were HA observed completing the FP register at the time of the visit.
– MCH Aides	7	38.9	0	0.0	7	23.3	
Is the FP Register Up to date							
Yes	12	67.0	15	100	27	90.9	FP registers were up to date in 27 of 30 clinic.
No	3	16.7	0	0	3	10.0	

Table 14
Distribution of the In-Charges Interviews
in the Clinics Visited by Cadre
N = 32

Question/ Variable	Response		Totals	Comments
	Kasulu	Kibondo		
Cadre of person interviewed	N = 18	N = 14	N = 32	– It appears that most of the facilities (about 40%) have R.M.A. as the In-Charges
R.M.A.	5	8	13 (40.6%)	– In another 42% of the health facilities, Medical Assistants and HAs were found to be In-Charges.
MA	6	1	7 (21.9%)	
HA	5	2	7 (21.9%)	
MCHA	0	3	3 (9.4%)	
Doctor	2	0	2 (6.3%)	

Table 14a
Distribution of the health
workers in the clinics visited, by cadre

Type of Health Worker	Mean Number of Health Care Workers		
	Hospital n=2	Health Centre n=6	Dispensary n=25
Health Attendant	2.0	6.8	1.9
MCH Aide	2.0	1.5	0.8
Rural Medical Aide	0.5	0.8	0.1
Nurse Midwife	0.5	1.1	0.1
Public Health Nurse	0.5	1.0	0
Clinical Officer	2.5	1.7	0.2

Table 15a
Type of FP Services Currently Available or Recommended at the Clinics (Data Collected Through Interview with In-Charges of the Clinics Visited)

Variable/Question	Response	District		Totals	Comments
		Kasulu	Kibondo		
Which FP methods are currently available or recommended at the facility?					
– Oral Contraceptives	Yes	18	15	33 (100%)	Except for: Implants and Vasectomies, most facilities offer or recommend all methods of FP.
– IUDs	Yes No	15 3	13 2	28 (84.8%) 5 (15.5%)	
– Injectables	Yes No	16 2	12 3	28 (84.8%) 5 (15.5%)	
– Implants	Yes No	5 13	6 9	11 (33.3%) 22 (66.7%)	
– Tubal Ligation	Yes No	1 17	14 1	15 (45.6%) 18 (54.5%)	
– Vasectomy	Yes No	1 17	11 4	12 (36.4%) 21 (63.6%)	
– Condoms	Yes	18	15	33 (100%)	
– Diaphragm	Yes No	9 9	9 9	18 (54.5%) 15 (45.6%)	
– Foam	Yes No	14 4	12 3	26 (78.8%) 7 (21.2%)	
– LAM	Yes No	12 6	12 3	24 (72.7%) 9 (27.3%)	
– Other Natural Methods	No	17	15	32 (96.8%)	

Table 15b
(Data Collected Through Interview with In-Charges of the Clinics Visited)

Variable/Question	Response	District		Totals	Comments
		Kasulu	Kibondo		
Are FP services provided?	Yes No	18 0	15 0	33 (100%) 0	All facilities reported that they provided FP services.
How are the MCH and FP services provided?					
– FP offered at special time		4	5	9 (27.3%)	In majority of cases (54.5%) the MCH and FP services are provided by different providers at the same time.
- Both by provider at some time		4	2	6 (18.2%)	
– By different providers at the same time		10	8	18 (54.5%)	
– Other		0	0	0	
Who provides FP services?					
HA	Yes No	11 7	11 4	22 (66.7%) 11 (33.3%)	In most of the cases (over 66%), the FP services are offered either by MCHA and HAs. But in 50% of the clinics FP services are offered jointly by MCH and HA. Only 6 facilities 18% had a nurse midwife offering FP services.
MCHA	Yes No	9 9	14 1	23 (69.7%) 10 (30.3%)	
Nurse	No	18	15	33 (100%)	
Nurse Midwife	Yes No	4 14	2 12	6 (18.2%) 26 (78.8%)	
Public Health Nurse	No	18	15	33 (100%)	
	R.M.A. is another cadre that significantly offers FP services.				

Table 15c
Waiting Time, Privacy Offered to Clients Clinics
(Data Collected Through Interview
with In-Charges of the Clinics Visited)

Variables/Question	Response	District		Total	Comments
		Kasulu	Kibondo		
Maximum Waiting Time for FP Clients					
- Less than half an hour	Yes	7	11	18 (55%)	Waiting time in over 90% of health facilities visited is said to be less than one hour.
– Between half an hour to one hour	Yes	9	3	12 (36%)	
– More than one hour	Yes	2	1	3 (9%)	
Is there a separate room for clients privacy during the provision of each of the services?					
- Counseling	Yes No	3 15	0 15	3 (9.1%) 30 (90.9%)	Most health facilities do not offer clients privacy.
– History taking	Yes No	3 15	0 15	3 (9.1%) 30 (90.9%)	
– Physical Examination	Yes No	2 16	3 12	5 (16.2%) 28 (84.8%)	
Giving instructions/ method	Yes No	0 18	0 15	0 33 (100%)	

Table 15d
Problems Encountered in Getting FP Supplies
(Data Collected Through Interview with In-Charges of the Clinics Visited)

Variable/Question	Responses			Total	Comments
Some of the problems incharges hear	– Transportation problems, such as bad roads, lack of vehicles, use of bicycles to get supplies, slows the process – Lack of adequate number of staff			12 3	The major problem cited by most of health facility In-Charges of personnel is the lack of adequate means of transportation.
	Response	**District**		**Total**	
		Kasulu	**Kibondo**		
Do supplies arrive in poor condition?	Yes No	4 21	2 5	6 26	In most cases FP supplies get to the facility in good condition.
Description of some of the problems/bad conditions	– Sometimes (especially in the rainy season) transportation is mostly by bicycle and reports get wet. – Breakage of drug containers due to bad roads and poor transportation. – Sometimes drugs and supplies are expired by the time they reach the facility.			6 3 1	In most cases where supplies and reports reach the health facility in bad shape, this is usually due to the existing problem of poor transportation means and poor state of the roads.

Table 16a
Availability of Equipment and Supplies
(Data Collected Through Interview with In-Charges of the Clinics Visited)

Variable/Question	Response	District		Total	Comments
		Kasulu	Kibondo		
Examination Bed	Yes No	8 10	4 11	12 (36.4%) 21 (63.6%)	Over 50% of the facilities did not have: - an examination bed – a BP machine – a weighing machine – reliable kerosene supply
IUD Insertion	Yes No	17 1	12 3	29 (87.8%) 4 (12.1%)	
BP Machine	Yes No	5 13	11 4	16 (48.5%) 17 (51.5%)	
Weighing Machine	Yes No	5 13	2 13	7 (21.2%) 26 (78.8%)	
Reliable Water Supply	Yes No	11 7	8 7	19 (57.6%) 14 (42.4%)	A good proportion of the facilities (42.4%) have no reliable supply of water within facilities or between the districts.
Reliable Kerosene Supply	Yes No	1 16	1 14	2 (6%) 30 (94%)	
Adequate Sitting Facilities	Yes No	15 3	11 4	26 (78.8%) 7 (21.2%)	
Methods used for sterilizing equipment in the facility	Disinfection Boiling Autoclaving	4 14 0	4 7 0	12 (36.4%) 21 (63.6%) 0	Most of the facilities (63.6%) indicated that boiling was the major method of sterilization. No facility had autoclaving equipment.

Table 16b
Storage of Supplies N = 33
(Data Collected Through Interview with In-Charges of the Clinics Visited)

Variable/Question	Response	District		Total	Comments
		Kasulu	Kibondo		
Where are FP supplies stored?					
In a locked store room	Yes No	3 15	3 12	6 (18.2%) 27 (81.8%)	Most of the facilities (about 61% keep FP supplies in locked cupboard).
In an unlocked store room	No	18	15	33 (100%)	
In a locked cupboard	Yes No	11 7	9 6	20 (60.6%) 13 (39.5%)	
In an unlocked cupboard	Yes No	1 17	3 12	4 (12.1%) 29 (87.9%)	

Table 16c
Availability of Stationary for Recording FP Activities
(Data Collected Through Interview
with In-Charges of the Clinics Visited)

Variable/Question	Response	District		Total	Comments
		Kasulu	Kibondo		
Stock of the following:					
MOH FP Cards	Yes No	17 1	14 1	31 (94.0%) 2 (6.0%)	Most of the facilities indicated they had all the stationary needed for FP recording. There were no important differences between facilities or districts.
Antenatal Card	Yes No	18 0	15 0	33 (100%) 0	
Stock Notes	Yes No	9 9	12 0	21 (63.4%) 9 (27.3%)	
Inventory Books	Yes No	12 6	14 1	26 (84.8%) 7 (21.2%)	
Register Books	Yes No	18 0	15 0	33 (100%) 0	
Difficult getting FP supplies?	Yes No	6 11	0 15	6 (18.2%) 26 (78.8%)	Majority of the health facilities have no difficulties getting their FP supplies.
Whether FP supplies protected from:					
Rain	Yes No	18 0	15 0	33 (100%) 0	All the facilities reported that their FP supplies are protected from rain and sun.
Sun	Yes No	18 0	15 0	33 (100%) 0	

Table 16d
Availability of MCH and FP Registries in the Clinics
(Data Collected by Interview
with In-Charges of the Health Facilities Visited)

Variable/Question	Response	District		Totals
		Kasulu N = 18	Kibondo N = 15	
Does the health facility have a MCH clinic register?	Yes	16 (88.9%)	15 (100%)	31 (93.9%)
	No	2 (11.1%)	0	
Does the health facility have a FP register?	Yes	16 (88.9%)	15 (100%)	31 (93.9%)
	No	2 (11.1%)	0	2 (6.1%)

Table 16e
Types of FP Supply Records
(Data Collected Through Interview
with In-Charges of the Clinics Visited)

Variable/Question	Response	District		Total	Comments
		Kasulu	Kibondo		
What type of FP supply records are kept at the facility?					
Request Forms	Yes	2	1	3 (9.1%)	
	No	16	14	30 (90.9%)	
Delivery Notes	Yes	11	12	23 (69.7%)	There is no important difference between the districts.
	No	7	3	10 (30.3%)	
Stock Notes	Yes	9	12	21 (63.4%)	
	No	9	0	0	
Inventory Book	Yes	7	12	19 (57.6%)	
	No	11	3	14 (42.4%)	
How often are reports submitted to the districts?	Yes	18	15	33 (100%)	All facilities submitted monthly reports.

Table 17a
Background and Socio-demographic Characteristics of HA "Tutors"/Instructors
(N = 33)

Variables	Response	Tally
Location	Kigoma	3
Gender	Male Female	1 2
Age	45 Years 46 Years 48 Years	1 1 1
Religion	Catholic Protestant	1 2
Professional Status	Registered Nurse Registered Nurse/Midwife Registered Nurse/Midwife Public Health	1 1 1
Educational Attainment	Standard 4 (Primary) Completed Primary	1 2
Duration of time tutors have served in the present capacity	4 Months 2 Years 4 Months 16 Years 4 Months	1 1 1
Duration of time, tutors have served int the present site	1 Year 4 Months 8 Years 6 Months	2 1
Whether ever attended a course in family planning?	Yes, Weeks, Communication skills (Umati) No	1 2

Table 17b
Tutors Perspective on HAs Training

Variables	Response	Tally
Whether Family Planning is part of the Curriculum used for the training of HAs	Yes	3
Content for the Family Planning curriculum	– Breastfeeding	1
	– FP methods	2
	– Side effects of FP	2
	– Advantages and disadvantages of FP	2
	– Anatomy of male and female reproductive system	1
	– Objectives of FP	1
	– Anatomy of the reproductive system	2
	– FP counseling	2
	– All Family Planning methods	2
	– Physical examination	1
	– All Family Planning methods	1
	– Physical examination	1
	– Side effects on FP usage	
	– Indications and contraindications of FP	
Recommendation for FP to be included in the current one year course?	Yes	3
	Reasons	
	– HAs will increase FP knowledge to the community	2
	– FP trained HAs will help in expanding FP services	2
Recommendation of FP training as separate in-service course for HAs?	Yes	3
	Reasons	
	– HA will understand FP content better since there will be adequate time	2
	– The course will act as an incentive for HA so that they could work harder in order to be nominated	1
	– After attending the course, HA will be more confident while providing services	1

(continued on next page)

Table 17b (continued)
Tutors perspective on HA FP training recommended training duration and recommended ratio of theory to practice

Variables	Response	Tally
Training Duration recommended to adequately address the above subjects	4-6 weeks 6-8 weeks **Reasons** – Enough time is needed so that HA can grasp the contents, and trainer would have enough time to evaluate and monitor progress. – Enough time is required since HA have a low educational level	1 2
How should in-service in FP training for HAs be structured? (ratio of theory to practice)	– Equal amount of theory and practice – Less theory, more practice **Reasons** **Equal amount of theory and practice**: – theory and practice are inter-related thus equal time should be availed. **less theory and more practice**: – with more practice, HA becomes experienced faster due to the exposure provided.	2 1

Table 17c
Tutor Perspectives on Suitable Trainers for HAs and Training Facility, and Suitable Training Setting for Training of HAs

Question/Variable	Qualities	Reasons	Tally
What qualities do you consider suitable for trainers of HA for provision of FP services?	a. Experienced in FP/be FP trained.	– Easier to train others in FP.	3
	b. Female	– Easier to explain FP to other female trainers	1
	c. Have ability to teach and be well understood.	– Able to explain FP issues with confidence.	2
What qualities in your opinion are suitable as training setting for training of HAs in FP?	a. Classroom must be near to clinic.	– so as to be able to do practicals.	1
	b. The training location should have enough health facilities and patients.	– to facilitate practical sessions	2
	c. Location should be accessible to trainees.	– transportation is not a problem	2
	d. Training site should be at the regional headquarters.	– to allow access to communication facilities (e.g., telephone, fax, vehicles)	1
	e. Classroom and practicum sites should be well equipped.	– in order to facilitate enough practice.	2

Table 17d
Tutor Perspectives or Suitable Positive and Negative Qualities that HAs Have that Will Influence Provision of FP Services

Variables	Qualities	Reasons	Tally
What qualities do HAs have that are suitable for provision of FP service?	a. HAs understand their working environment.	– They are known to most families they will be providing FP services to.	2
	b. HAs are able to use good communication that is culturally acceptable.	– Will be easily understood by potential customers.	2
	c. Are experienced in provision of health services.	– They provide services daily.	1
	d. HAs are clean and well disciplined.	– Clients look up to them for advice.	2
	e. HAs are easily accessible to patients.	– Are able to satisfy clients needs.	2
What qualities in your opinion do HAs have that are not suitable for provision of FP services?	a. Some HAs have no desire/drive to work harder.	– Do not work well.	1
	b. Some do not care.	– Clients don't like this attitude and it may scare them away.	1
	c. Some HAs do not understand what they are doing.	– Therefore they become very defensive.	1
	d. Some HAs are rough by the way they present themselves.	– Portray a bad image to client.	1

Table 17e
Type of FP Services Tutors Would Like HA to Provide in Health Facilities and Their General Comments on FP Provision

Types of FP services tutors would like HAs to provide in a clinic.	– Providing group health talks on FP.	3
	– Providing FP community outreach.	3
	– Identifying at risk clients.	3
	– Explaining FP methods to clients.	3
	– Providing instructions on the use of condoms, Depo, IUDs, Pills, Foam, etc.	3
	– Counseling clients to select a method.	3
	– Recording daily activity register.	3
	– Keeping records of FP supplies.	3
	– Taking and recording client history.	3
General comments on FP provision.	– FP clinics should be provided with adequate equipment and supplies.	2
	– HA should be encouraged to carry out home visits to families in the community and give health talks about FP.	2
	– HA should be FP trained in order to expand FP services.	2
	– MOH should provide updated FP teaching materials (books, visual aids) to tutors.	2
	– Enough FP trainers should be trained so that they can meet the demand of training HA and other FP service providers.	1
	– All service providers at MCH clinics should be FP trained.	1
	– FP updates should be done annually.	1

Table 18a
Socio-demographic Characteristics of MCH Supervisors
N = 39

Variable	Response	District		Totals	Comments
		Kasulu	Kibondo		
Gender	Male Female	4 17	4 14	8 (20.5%) 31 (79.5%)	There were relatively more female FP supervisors (4 times the no. of male supervisors).
Mean Age (Years)	–	34	39	Difference is 5 years	Mean age for Kibondo supervisors higher than that for Kasulu.
Religion	Catholic Protestant Muslim	11 7 3	9 5 4	20 (51.3%) 12 (30.8%) 7 (17.9%)	Most of the supervisors were either Catholic or Protestant.
Professional Status	AMO/MO HA MCHA RDA RNM Wife RN RNMW/PH RMA			2 (5.1%) 3 (7.7%) 19 (48.7%) 1 (2.6%) 6 (15.4%) 1 (2.6%) 2 (5.1%) 5 (12.8%)	Majority of the supervisors interviewed were MCH Aides.
Position Held	DMCH CO DO DNO In-Charges			1 (2.6%) 3 (7.7%) 5 (12.8%) 30 (76.9%)	Majority of supervisors are incharges of the clinics.
Educational Attainment	Primary Secondary Other	18 3 0	11 4 3	29 (74.4%) 7 (19.9%) 3 (7.7%)	Majority of the supervisors had only attained primary level education.
Average length of time in present capacity (years)	Overall mean	9.62	9.74		There is no significant difference in mean age between the supervisors of the two districts.
Average length of time working at the present worksite (years)	Overall means	7.45	8.0	-	There is no significant differences between the supervisors in the two districts for mean length in time served at the facility.
Whether ever attended a course in FP	Yes No	3 18	7 11	10 (25.6%) 29 (74.4%)	The number of supervisors who have not attended an FP course is 3 times the number of those who have attended.

Table 18b
MCH Supervisors Perspective of Services Offered by HAs
N = 39

Variable	Response	District		Totals	Comments
		Kasulu	Kibondo		
What services are offered by HA in your facility?					
Curative care/First Aid	Yes No	20 1	16 2	36 (92.3%) 3 (7.7%)	
Immunization	Yes No	18 3	16 2	34 (87.2%) 5 (12.8%)	
Child growth monitoring	Yes No	19 2	18 0	37 (94.9%) 2 (5.1%)	
Antenatal care	Yes No	13 8	12 6	25 (64.1%) 14 (35.9%)	
Deliveries	Yes No	15 6	11 7	26 (66.7%) 13 (33.3%)	
Home visits	Yes No	11 10	8 10	19 (48.7%) 20 (51.3%)	
Health Education	Yes No	15 6	14 4	29 (74.4%) 10 (25.6%)	
Family Planning	Yes	21	18	39 (100%)	

Table 18c
MCH Supervisors Views on FP Training
for HAs if in One Year Course
N = 39

Question	Breakdown/ Variable	Response		Comments
		Yes	No	
Would you recommend FP training for HAs during the one year training course?				
	District: Kasulu Kibondo	 21 16	 0 2	All supervisors from Kasulu and almost all from Kibondo recommended FP training of HA during the 1 year course.
Reasons given: Those who said "YES": – So as to increase their skills and knowledge on FP which is necessary for proper provision and expansion of FP services – So as to decrease the workload of MCHA. HA could be involved in more comprehensive provision of FP services to community – So as to be able to deliver FP services even in absence of MCHA or nurse/nurse midwives.				Those who said "NO": – One year is not enough for the current course so if they add FP content, then the course will be very congested. – If FP is added to the one year course what happens to all those HAs who underwent the one year course when there was no comprehensive FP content? – The number of HAs attending the one year course is low, so many of the other FP will not know about FP.

Table 18d
MCH Supervisors Views on Type of FP Activities that HAs Should Provide
N = 39

Variable	Response	District		Totals	Comments
		Kasulu	Kibondo		
Giving group health talks	Yes No	21 0	18 0	39 (100%)	
Giving FP messages outside the health unit	Yes No	21 0	18 0	39 (100%) 0	
Identifying at risk clients who come for other services	Yes No	21 0	18 0	39 (100%) 0	
Explaining FP methods to individual clients	Yes No	21 0	18 0	39 (100%) 0	
Giving instructions on:					
– Condoms, foam tablets, Depo, Pill	Yes No	21 0	18 0	39 (100%) 0	
– IUD	Yes No	20 1	18 0	38 (97.4%) 1 (2.6%)	
Helping clients select a suitable method	Yes No	21 0	18 0	39 (100%) 0	
Using the checklist for selecting pills	Yes No	21 0	18 0	39 (100%) 0	
Referring clients for other FP methods	Yes No	21 0	18 0	39 (100%) 0	
Taking and recording client's history on card	Yes No	21 0	18 0	39 (100%) 0	
Recording the daily activity FP register	Yes No	21 0	18 0	39 (100%) 0	
Sterilizing used FP equipment	Yes No	21 0	18 0	39 (100%) 0	
Keeping FP supplies in stock	Yes No	21 0	18 0	39 (100%) 0	
Keeping records on FP supplies	Yes No	21 0	18 0	39 (100%) 0	

Table 18e
MCH Supervisors Perspectives on Supervision and Communication in Health Facility
N = 39

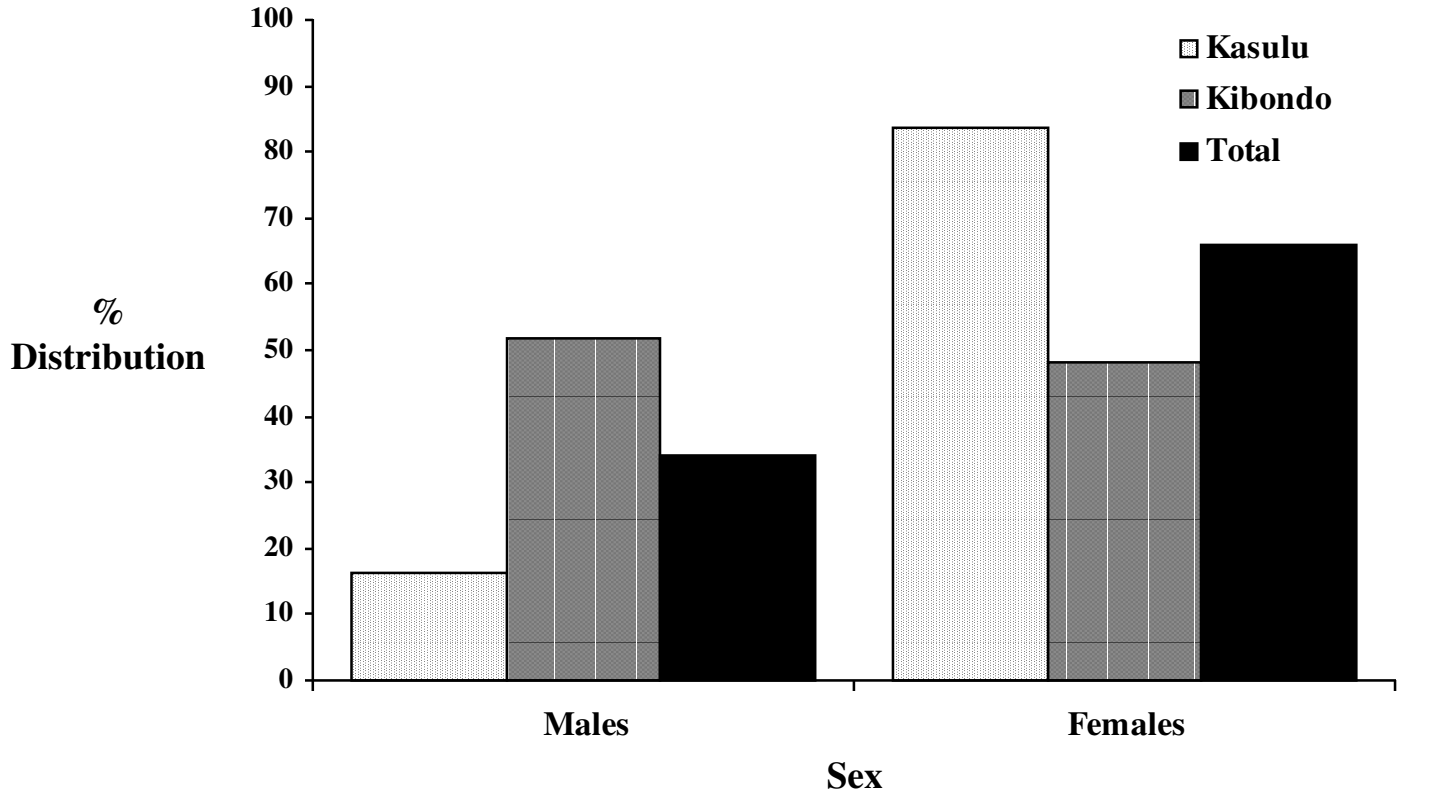
Variable/Question	Response	District		Totals	Comments
		Kasulu	Kibondo		
How often do you currently supervise HAs per month?					
	Daily	10	14	24 (61.5%)	
	Once	2	1	3 (7.8%)	
	Twice	0	1	1 (2.6%)	
	Three Times	3	1	4 (10.3%)	
	More than 3 times	0	1	1 (2.6%)	
	Longer than a month	0	1	1 (2.6%)	
	None	6	0	6 (16.4%)	
If family planning services were added to the present responsibilities of HA do you think they could cope?					
	Yes No	20 1	18 1	38 (97.4%) 1 (2.6%)	
	All the supervisors except the matron indicated that the HAs would cope if family planning services were added to their present responsibilities. **Reasons** – Majority of them are familiar and experienced with FP since it is offered in most of the settings in which they work. – There is enough time to perform all the duties since there will be good division of work especially with the MCHA and nurse-midwife. – Since they are currently performing less tasks relative to their ability to work. – Some of the HAs already offer FP services anyway. So if trained they would offer these services even more. – For the matron, she contend that HAs could not cope since they would be overloaded and thus could not concentrate on FP clients.				

Appendix B

Figures

Figure 1: Health Attendants (HAs) Needs Assessment

% Distribution of HAs by Sex and District



Kasulu N = 55 **Kibondo N = 54** **Total N = 109**

Figure 2: HAs Needs Assessment
% Distribution of HAs Age Group

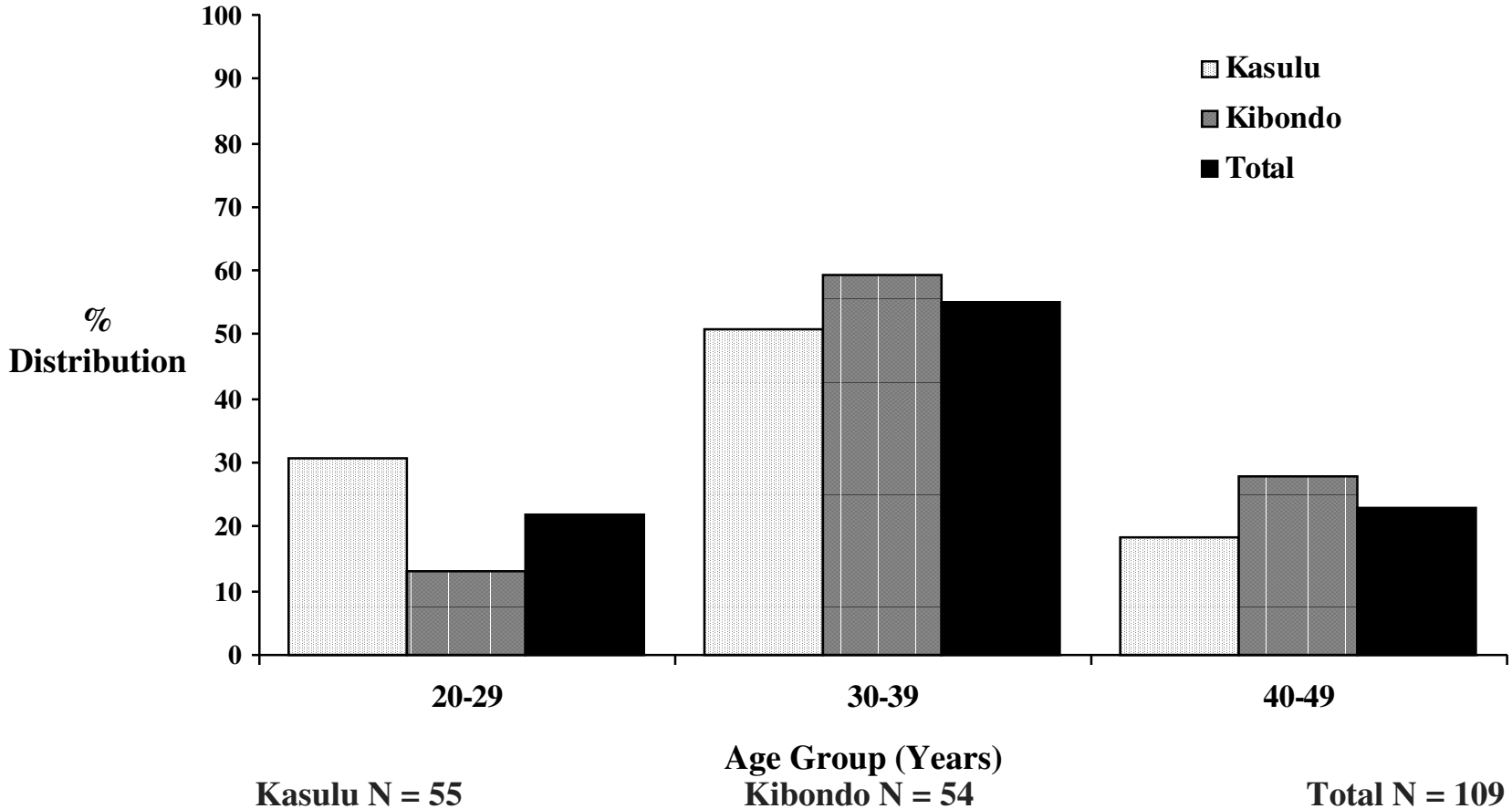


Figure 3: HAs Needs Assessment
Distribution of HAs by Training and District

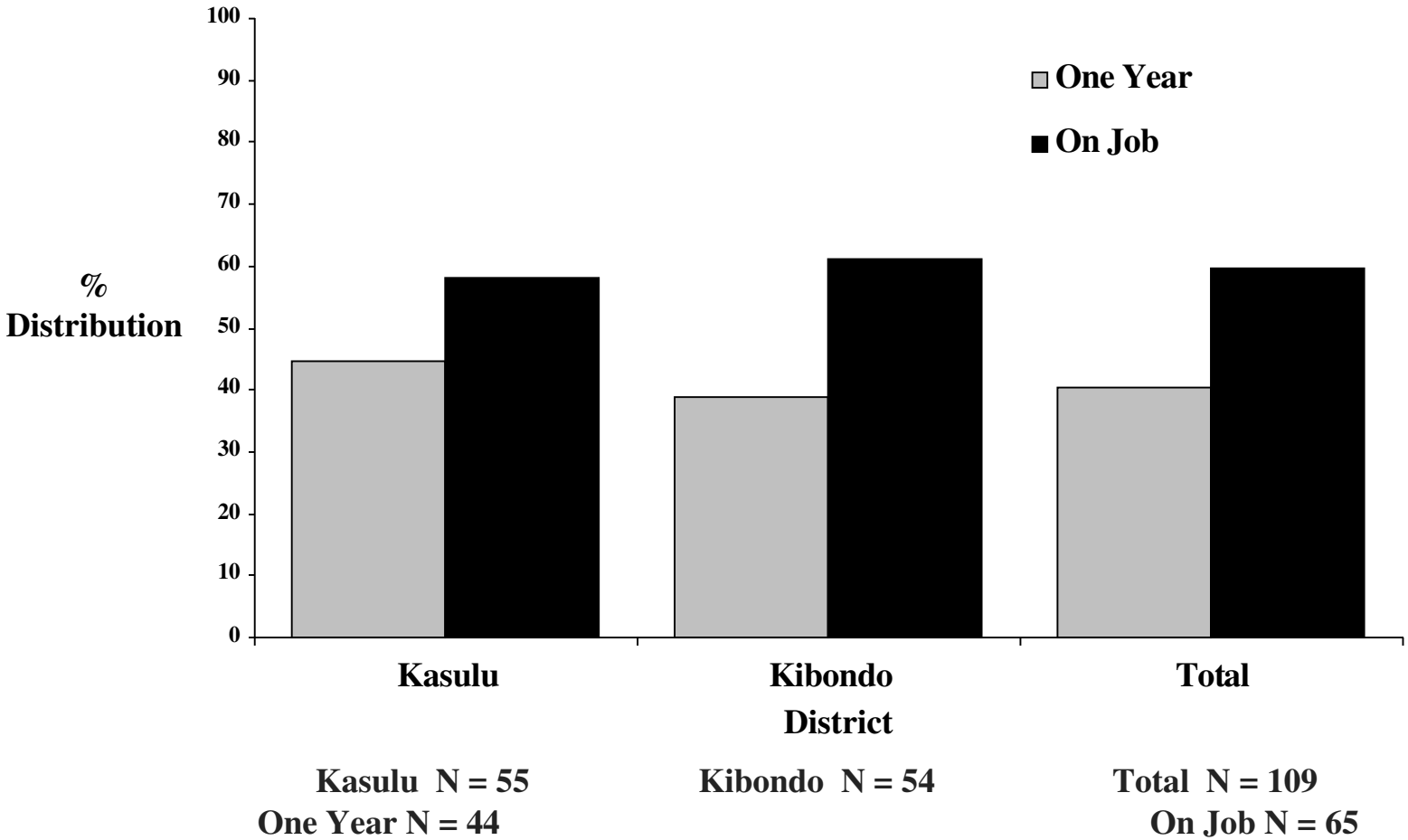


Figure 4: HAs Needs Assessment
% Distribution of HAs by Work Experience

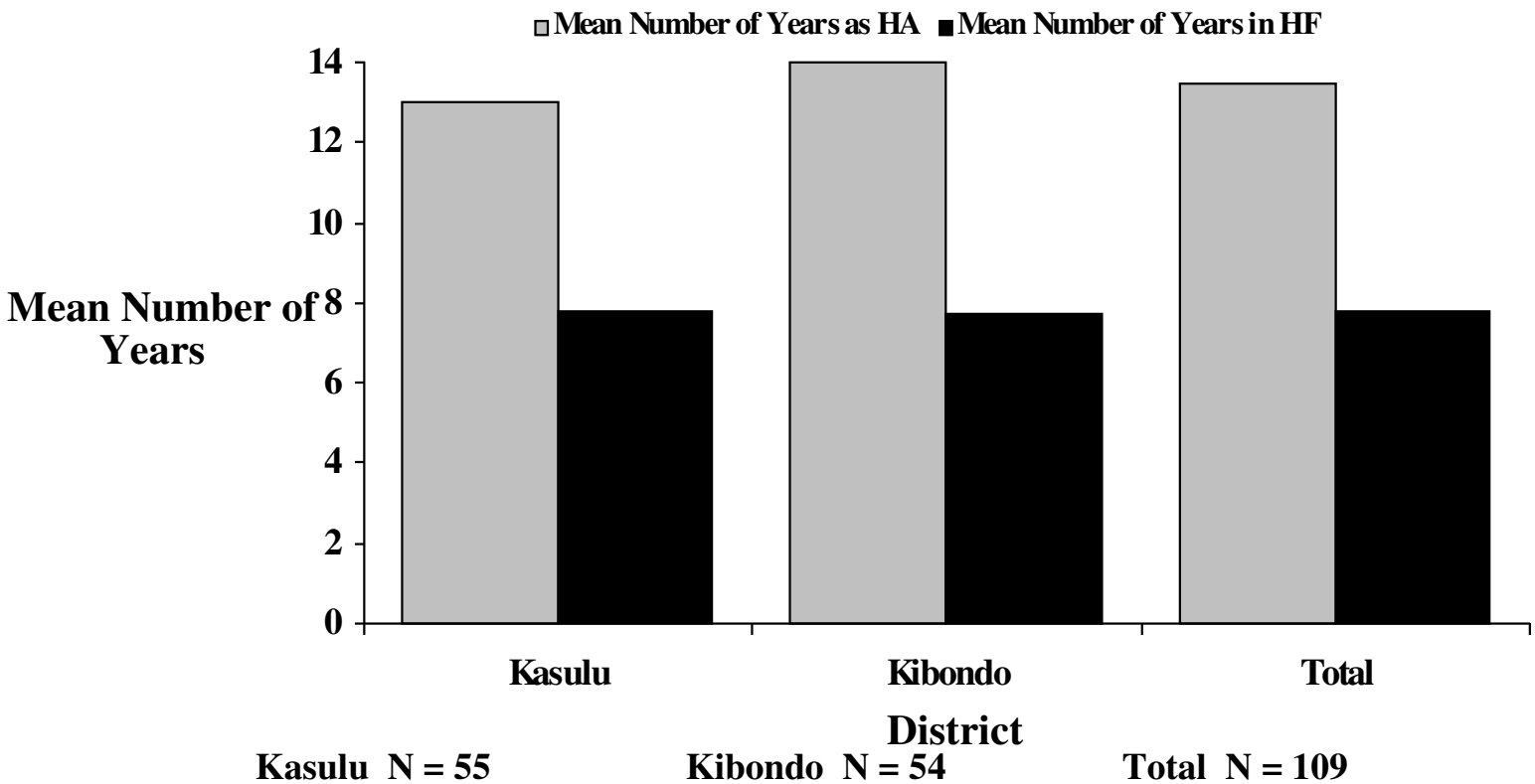


Figure 5: HAs Needs Assessment

% Distibution of Services Offered at Health Facility and by HAs

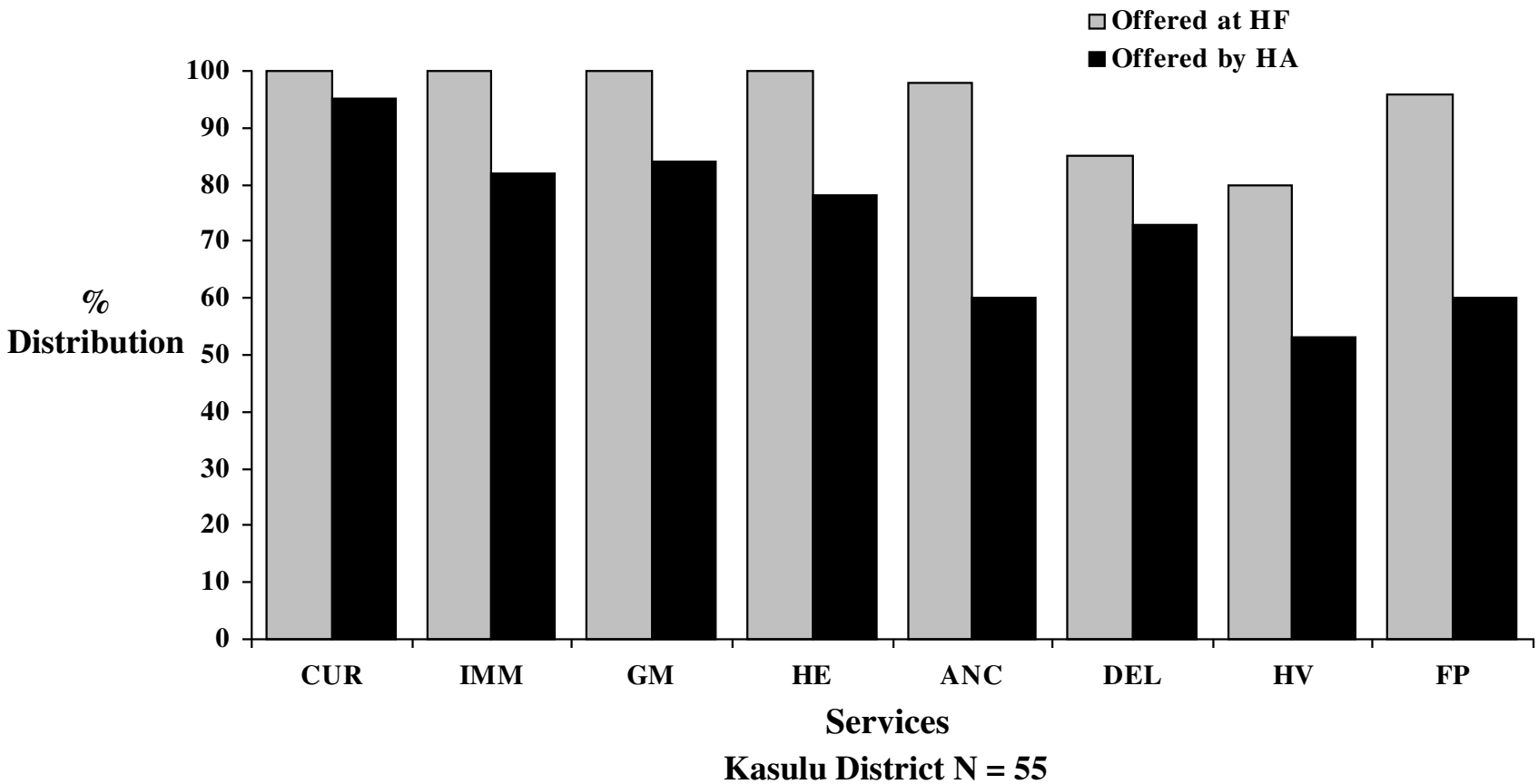


Figure 6: HAs Needs Assessment

% Distribution of Services Offered at Facility and by HAs

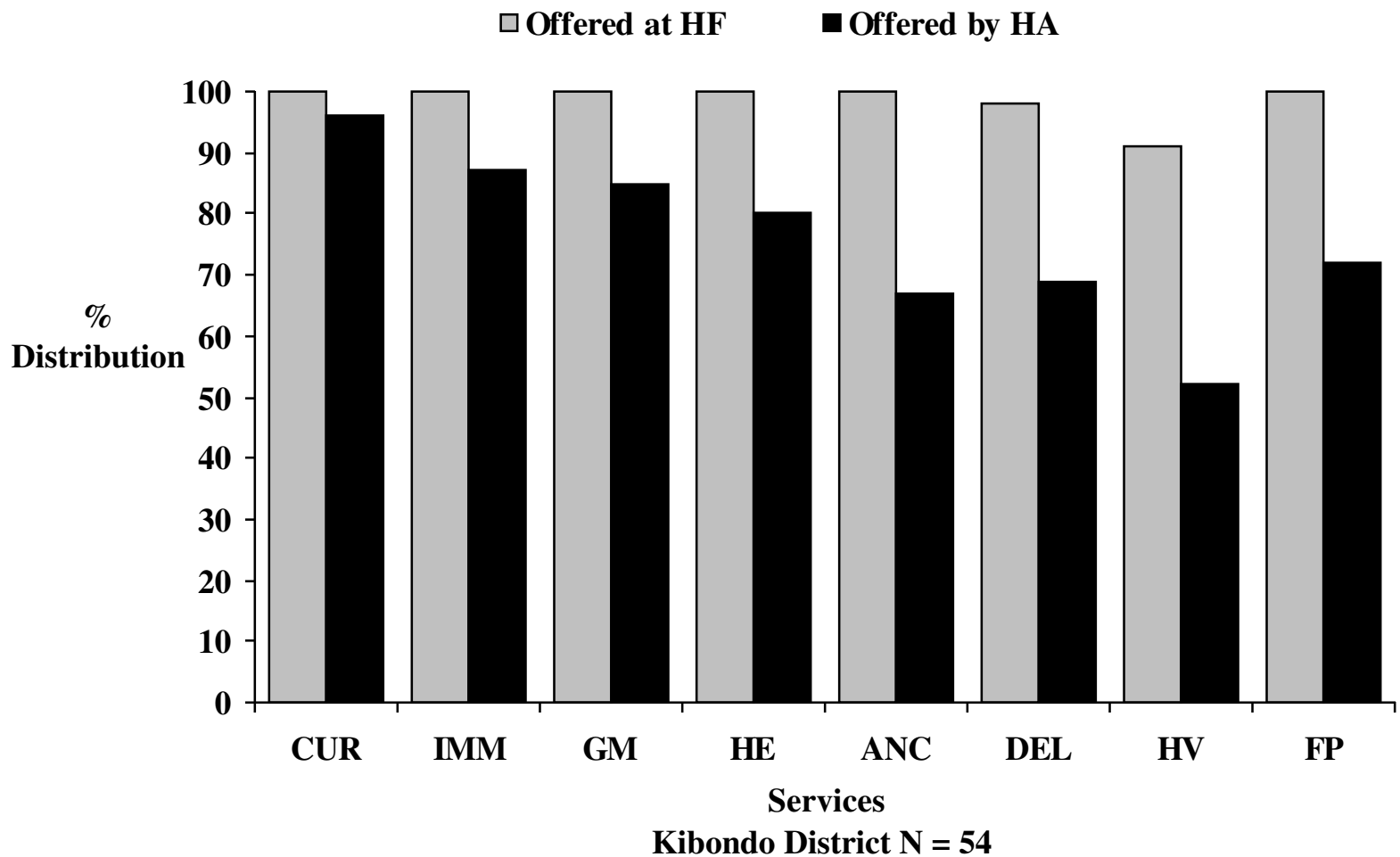


Figure 7: HAs Needs Assessment

Types of FP Methods Available in Health Facilities Using HAs Responses

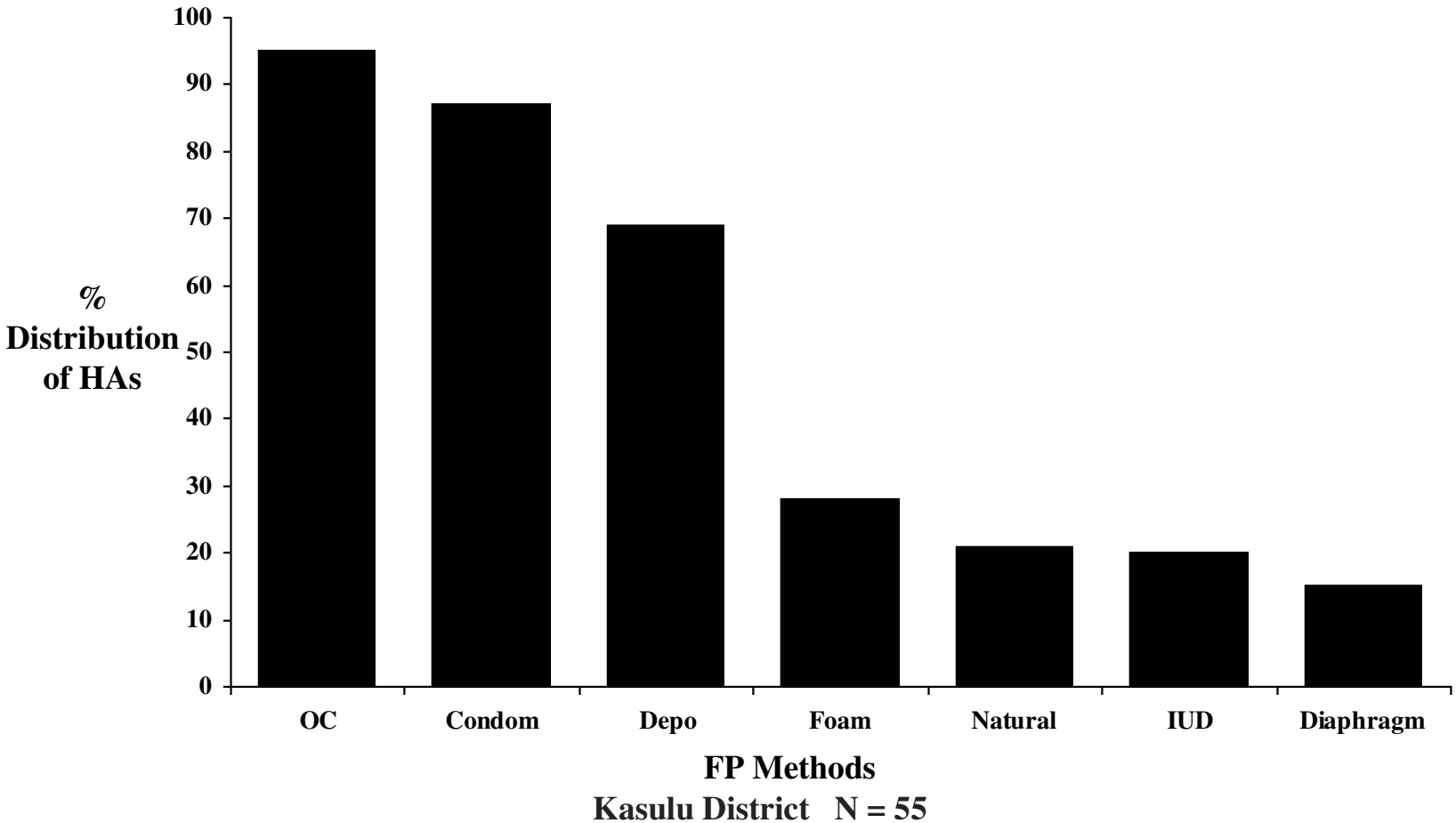
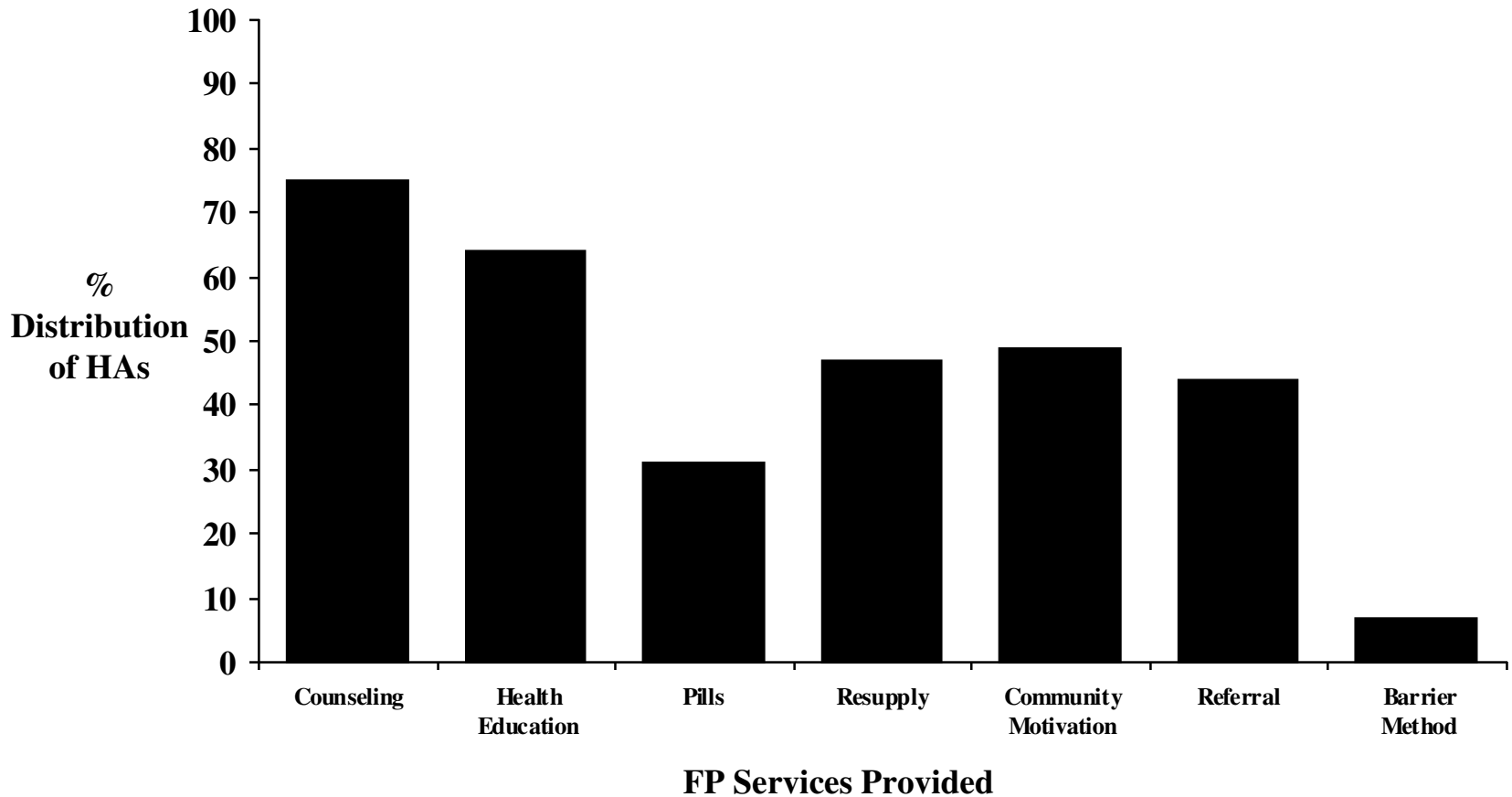


Figure 8: HAs Needs Assessment

FP Services Provided by HAs Using HAs Own Responses



Kasulu District N = 55

Figure 9: HAs Needs Assessment

FP Methods Available in Health Facility According to HAs Responses

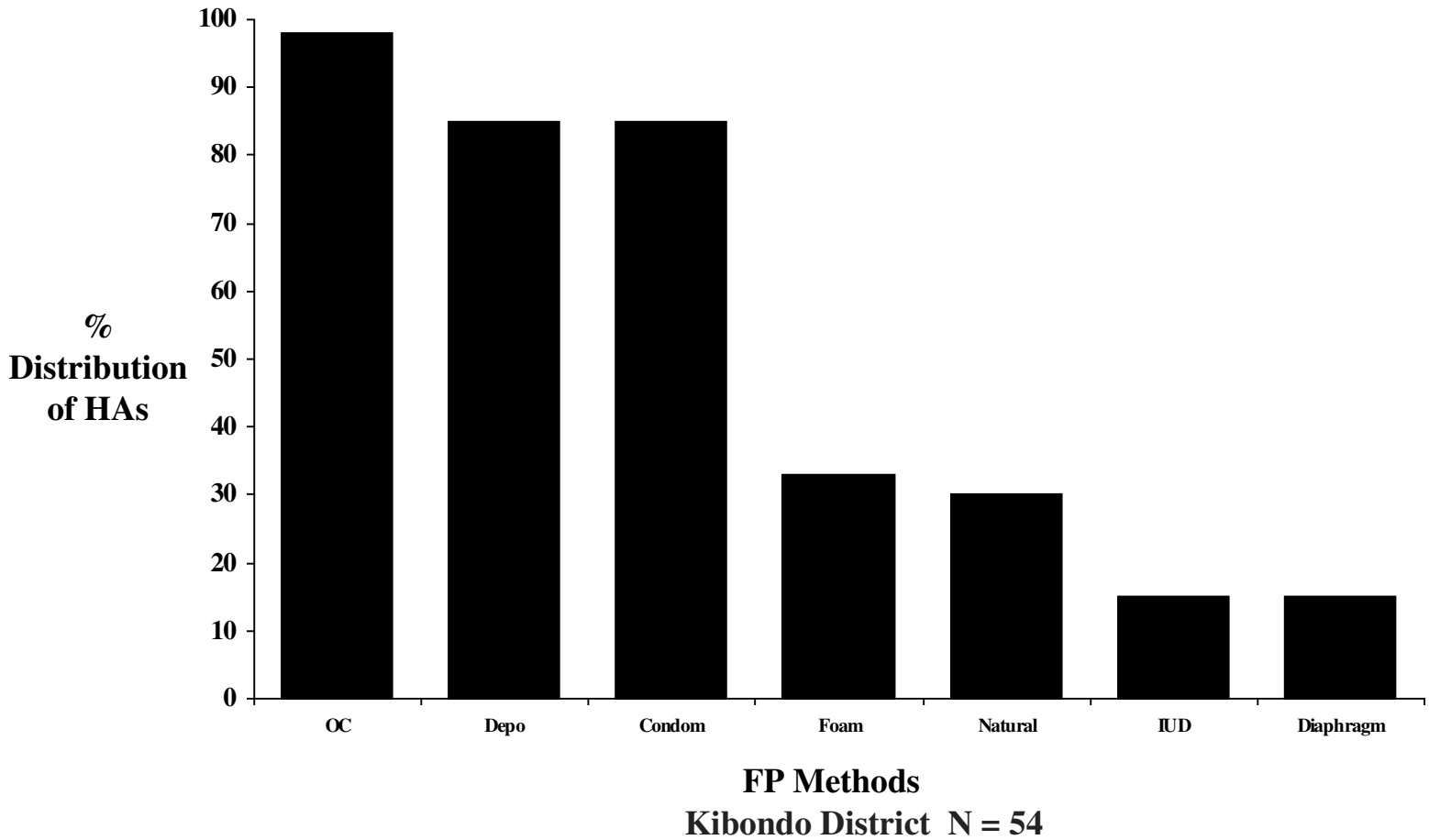


Figure 10: HAs Needs Assessment

FP Services Provided by HAs According to HAs Responses

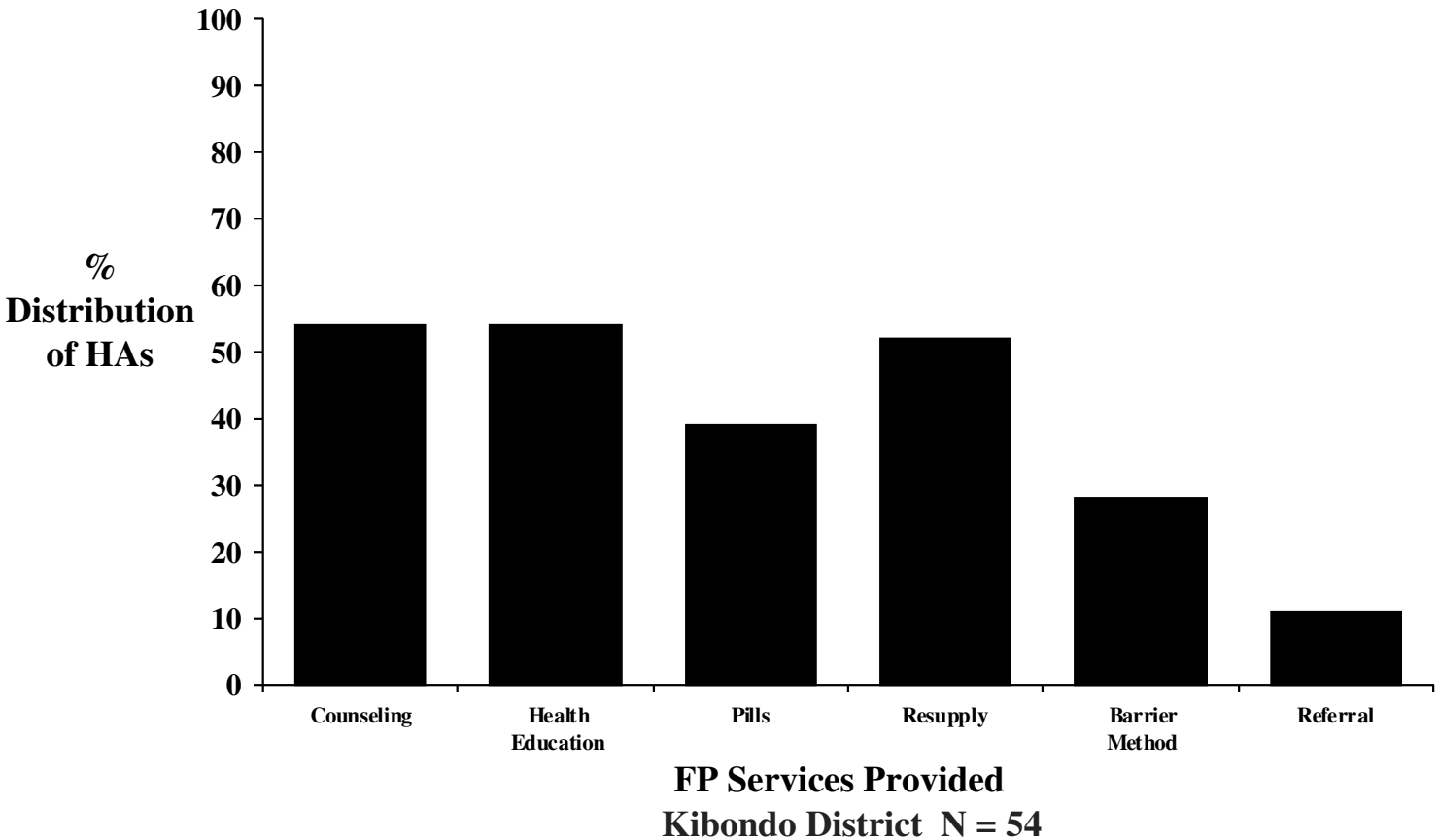
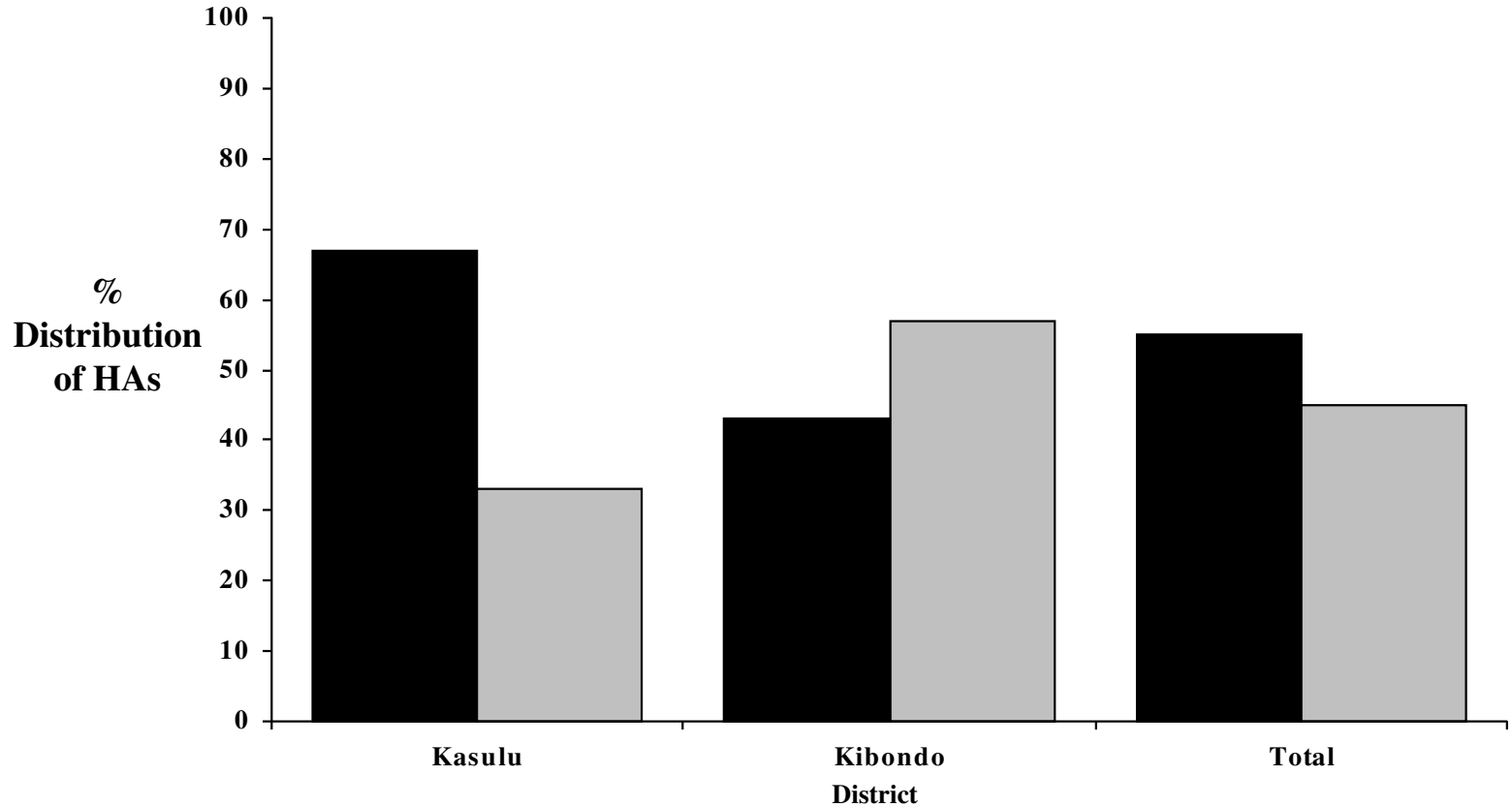
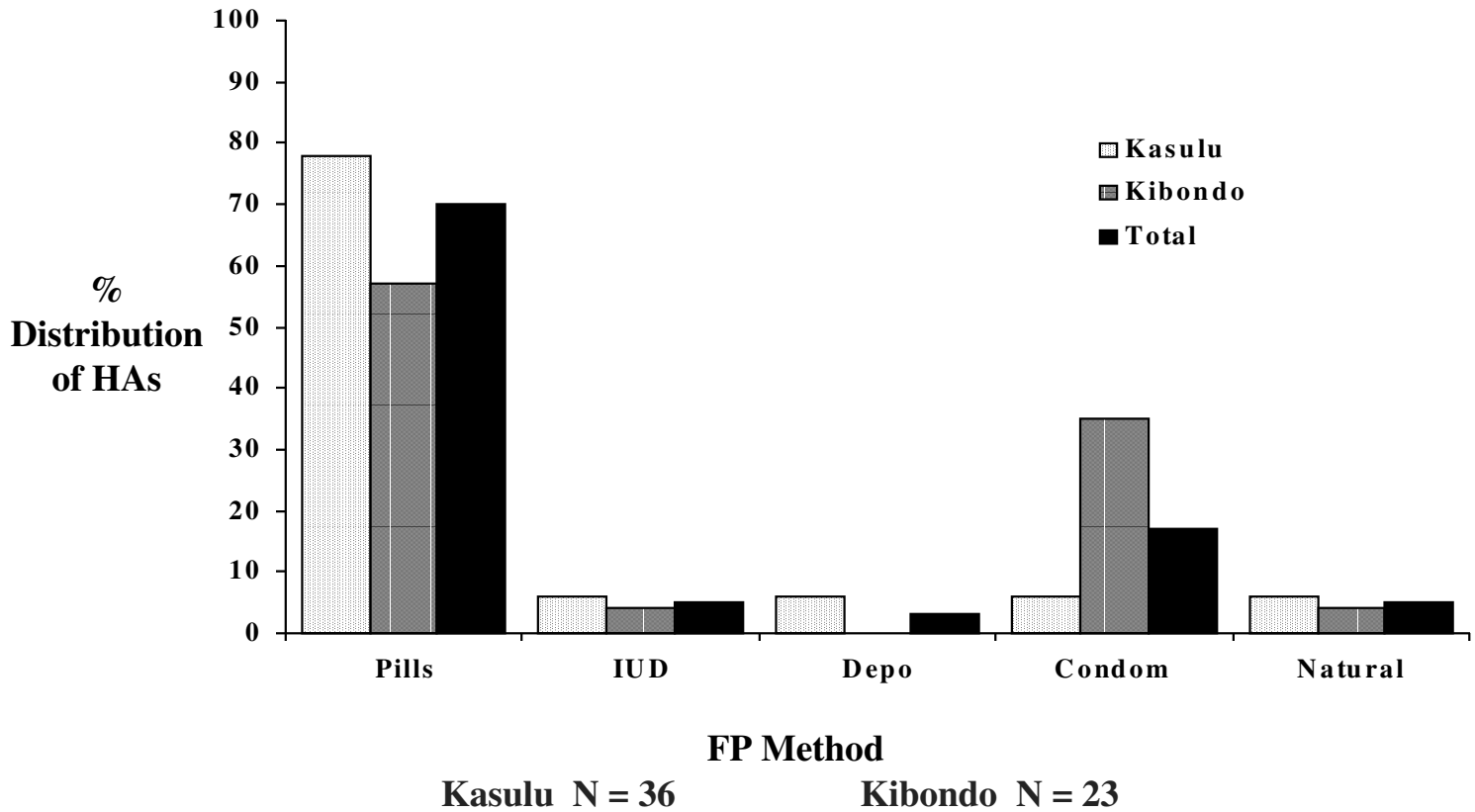


Figure 11: HAs Needs Assessment
Contraceptive Use by HAs by District



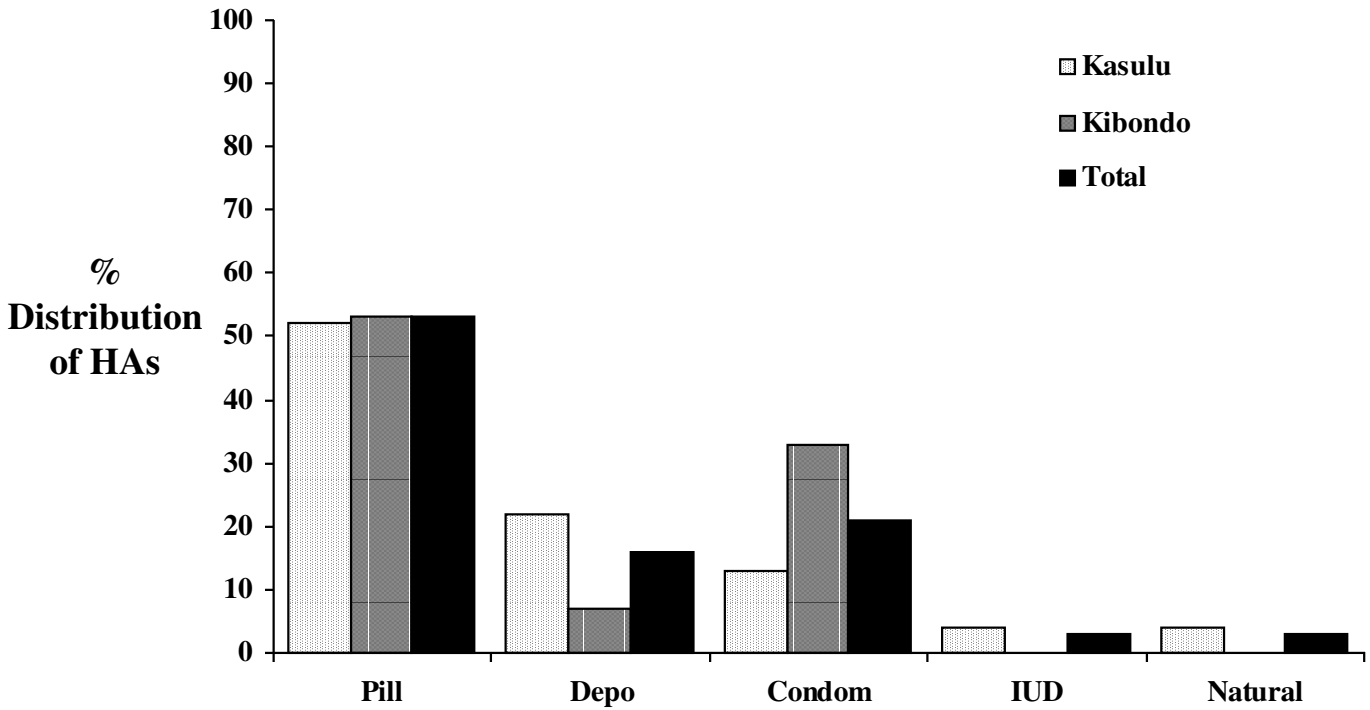
Kasulu N = 55 **Kibondo N = 54** **Total N = 109**

Figure 12: HAs Needs Assessment
% Distribution of Types of FP Methods Ever Used by HAs



Kasulu N = 36 **Kibondo N = 23**

Figure 13: HAs Needs Assessment
% Distribution of FP Method Currently Used by HAs



Kasulu N = 23 Kibondo N = 15 Total N = 38

Figure 14: HAs Needs Assessment
Mean % Knowledge Score by District

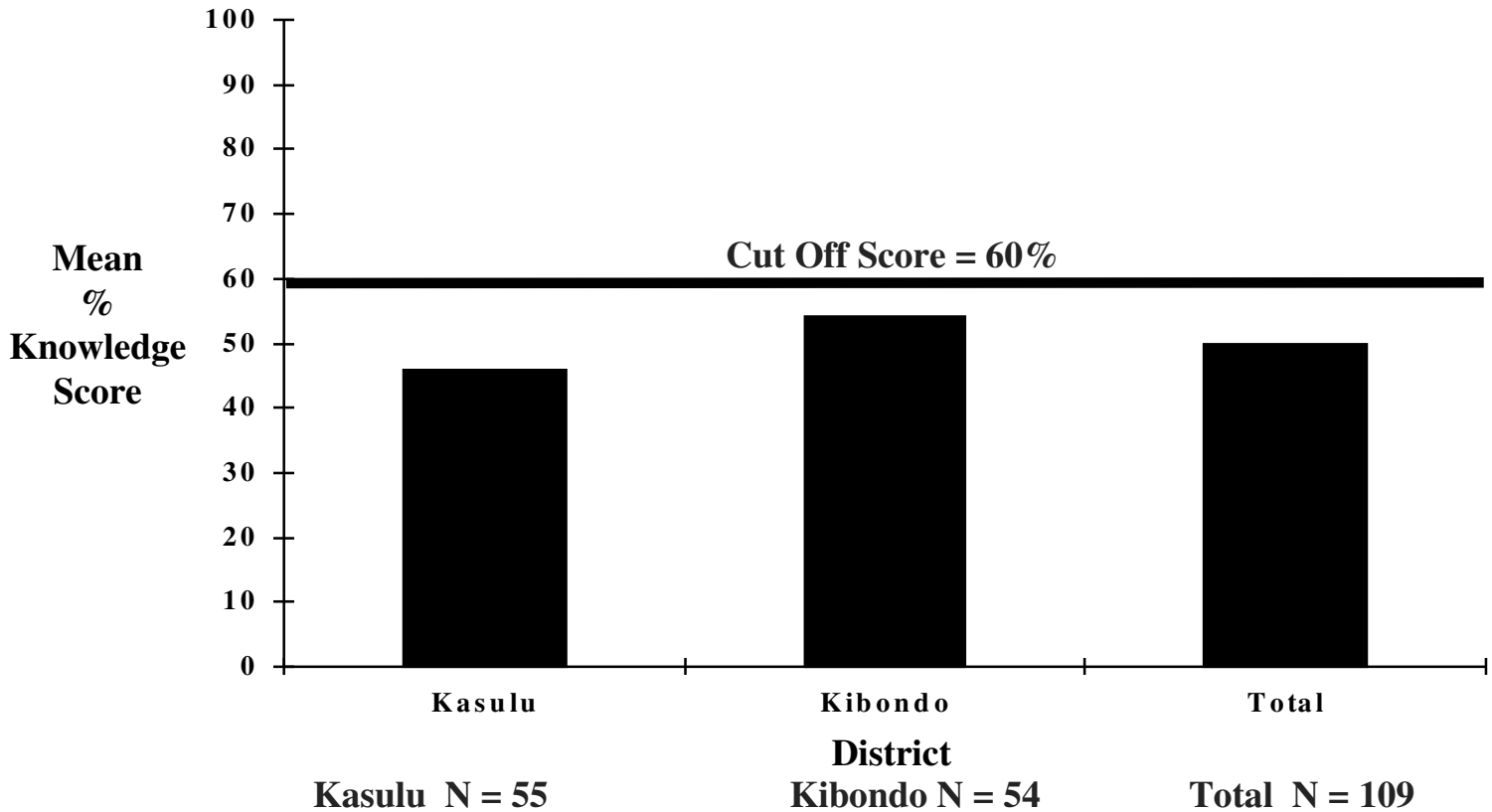
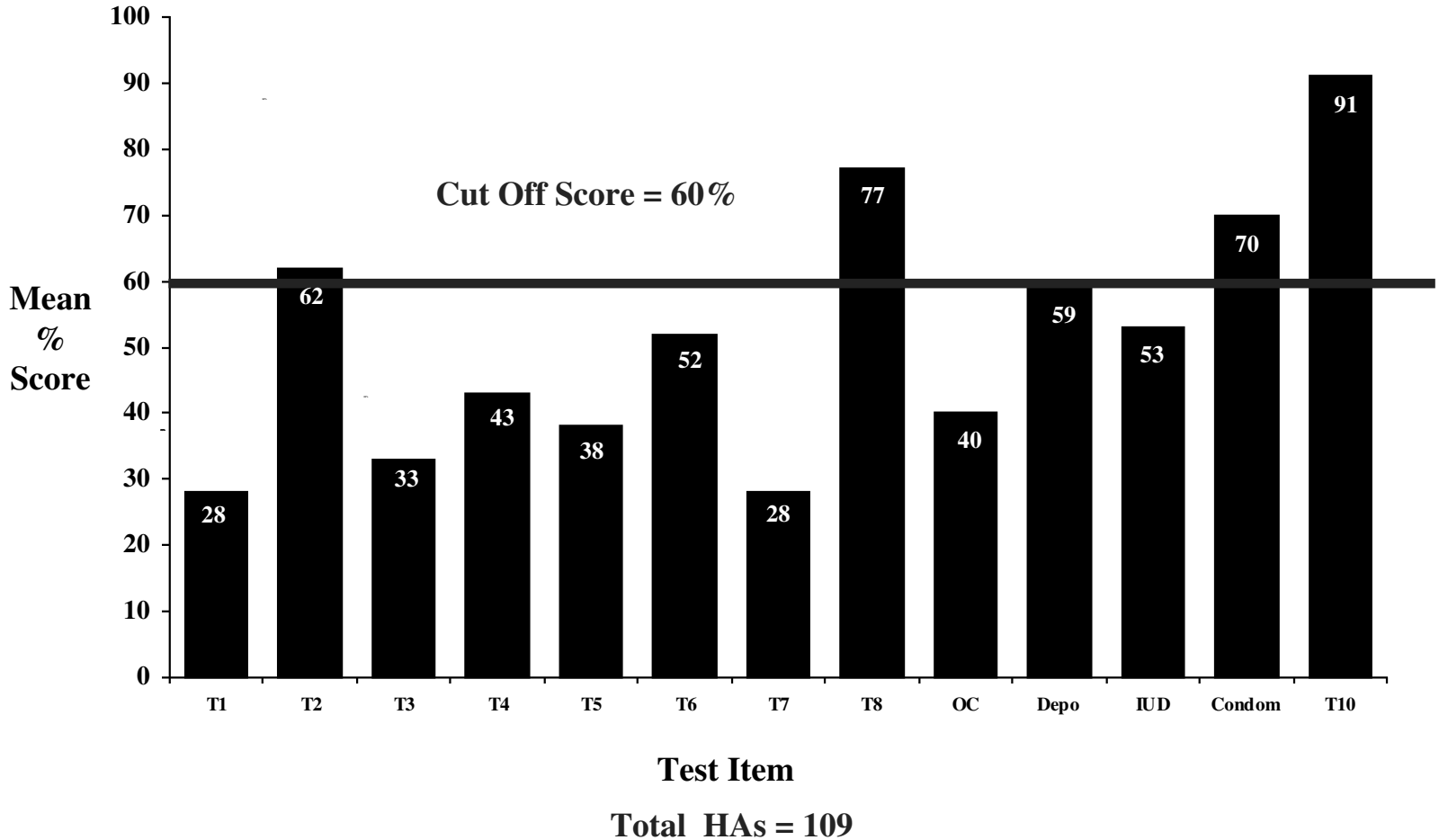


Figure 15: HAs Needs Assessment

Mean % Knowledge Score for Each Test Item



Total HAs = 109

Figure 16: HAs Needs Assessment
Mean % Knowledge Score by Sex

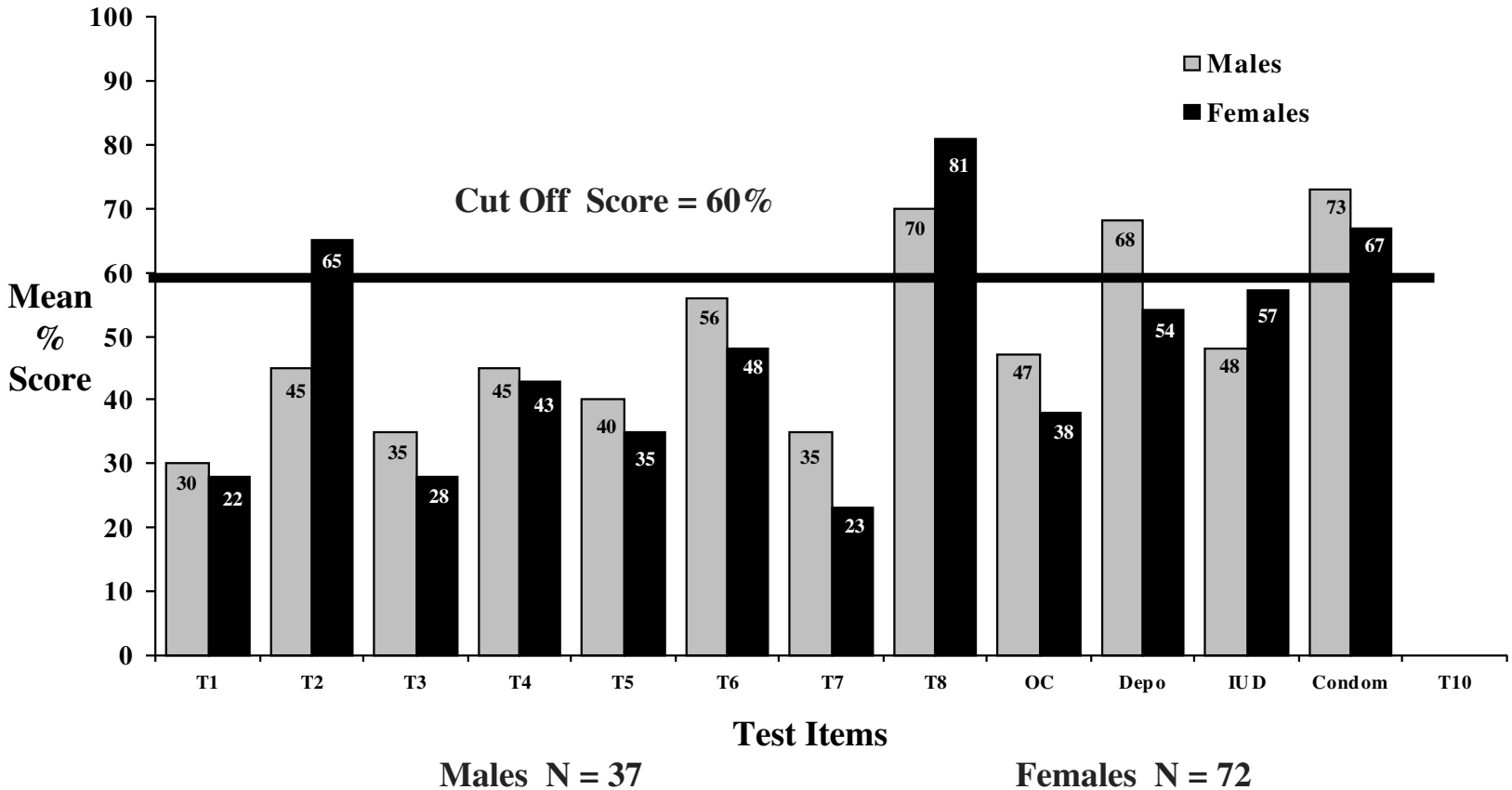
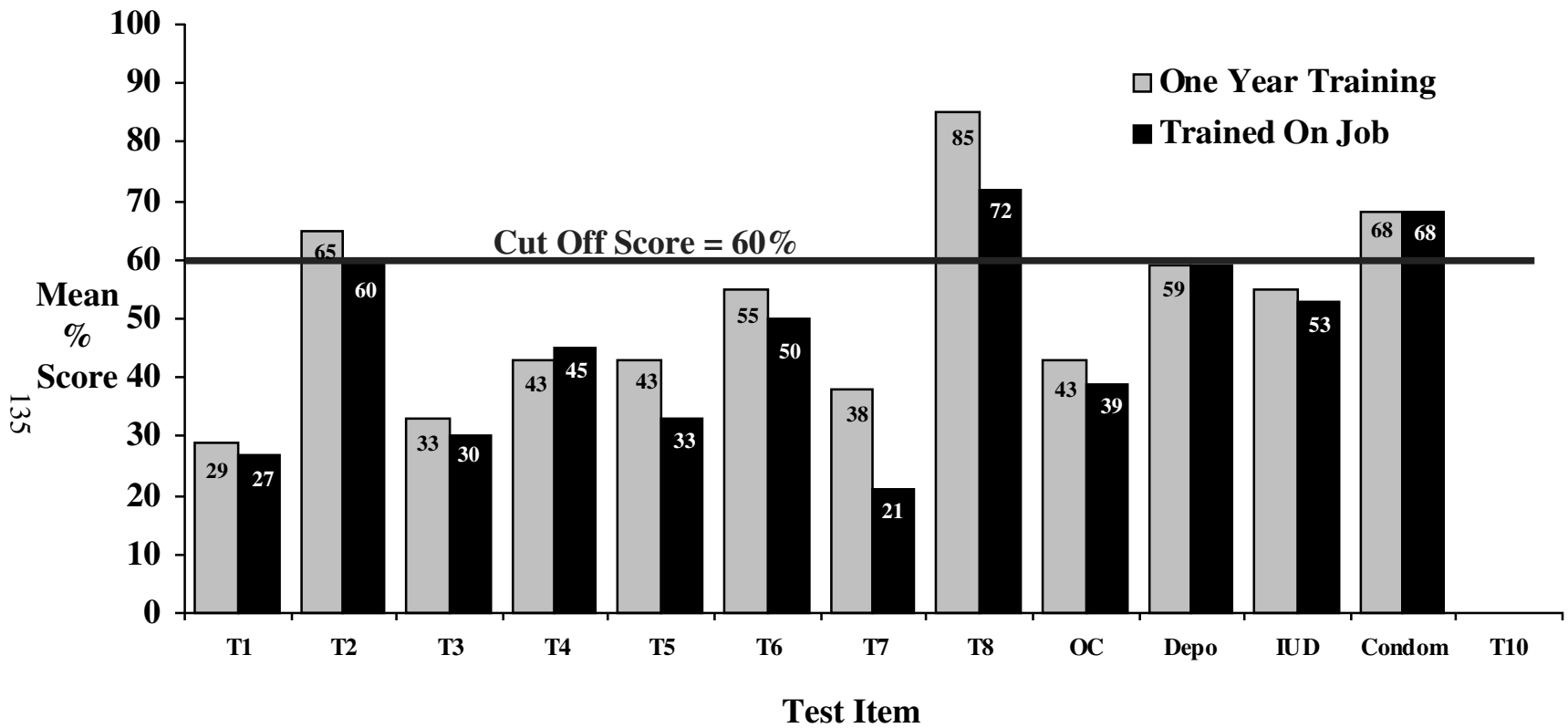


Figure 17: HAs Needs Assessment

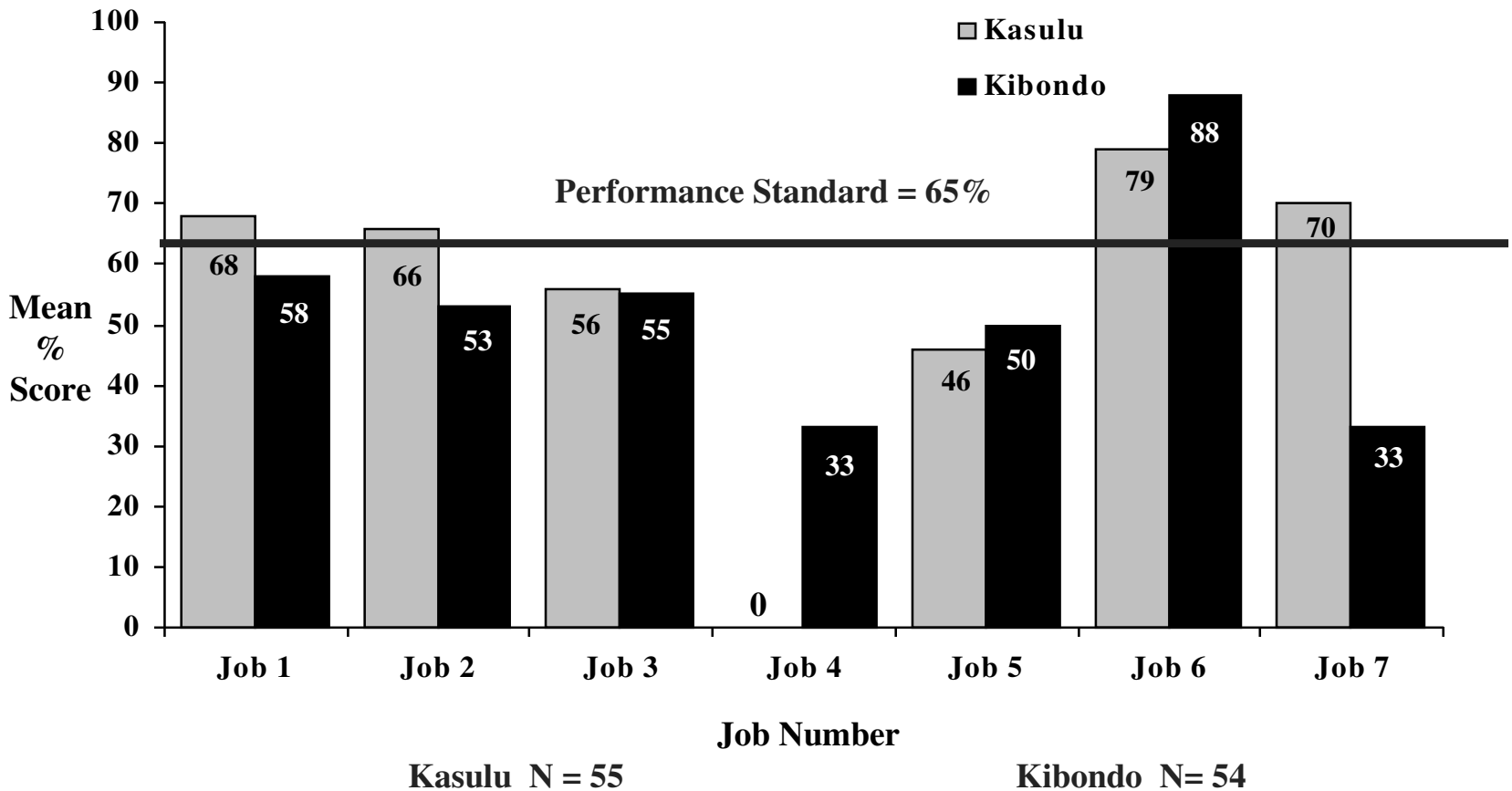
Mean % Knowledge Score for Each Test Item by Training Status



One Year Training N = 44 Trained On Job N = 65

Figure 18: HAs Needs Assessment

Average Performance Score of HAs for 7 MCH/FP Jobs by District



Appendix C

References

Bureau of Statistics, Tanzania. 1993. *Tanzania Demographic and Health Survey, 1991/1992*, Bureau of Statistics, Planning Commission, Dar es Salaam,Tanzania and Macro International, Columbia Maryland

Appendix D

List of Attendants in Kasulu

List of Health Attendants in Kasulu

#	NAMES	SEX	HEALTH FACILITY	TRAINING	STATUS	DATE
1	IDA ERNEST	F	BIHARU HC	OJT	**	16-6
2	LENA NASHON	F	BIHARU HC	*	*	
3	DISMAS MALILA-	M	MUNZEZE DISP	1 YR		
4	JOYCE GWIHA	F	KASANGEZI DISP	*	**	26-6
5	GERTRUDE BWILIZA	F	KIGANAMO HC	*	*	
6	SAKINA JUMA	F	*	OJT	*	
7	RAHEL JACKSON	F	RUSESA HC	1YR	**	26-6
8	SOPHIA KIYOYUA	F	RUHITA DISP	OJT		
9	REHEMA BAKIRA	F	MWEMBUYE DISP	OJT	**	27-6
10	ACHEL CHARLES	F	KIBWIGWA DISP	OJT	**	27-6
11	LEVINIA NUGUYE	F	MWEMBUYE DISP	OJT	**	16-6
12	STELLA YORAM	F	MUYAMA HC	1 YR	**	
13	FELICIA FIDELIS	F	NYAKITONTO	OJT	*	
14	ADELLA TAVATWAIKE	F	“	1 YR	*	
15	MANASSE BUHORANYI	M	ZEZE DISPENSARY	OJT		
16	DOTTO NDEE	F	KIGANAMO HC	1 YR		
17	BELLA BOAZ	F	SHUNGA HOSP	OJT		
18	REHEMA MASUD	F	KIGANAMO HC	1 YR		
19	METHOD NGARAMA	M	MWAYAYA DISP	1 YR		
20	EMANUEL MPERA	M	MUYAMA	1 YR	*	
21	LEOKADIA BAKANA	F	MVUGWE DISP	OJT	**	23-6
22	KITONDO KARAMBA	F	KWAGA DISP	OJT		
23	ABELLA BILALA	F	KIGANAMO HC	1 YR	**	12-6
24	BUJUJU BALIBUJA	M	MWANGA DISP	*	*	
25	MARY SAMWEL	F	KIBWIGWA DISP	OJT	**	27-6
26	RHODA BILOMO	F	KIGANAMO HC	1 YR	*	
27	GLASSIA MPOLENKILE	F	MWANGA DISP	OJT	**	
28	N. BILISHANGA	F	RUNGWE MPYA DISP	OJT	*	
29	NATALIS MNAZI	F	MAKERE DISP	OJT	*	
30	SPERANCIA MATABA	F	MUYAMA DISP	OJT		
31	JUDITH MGEMA	F	“	1YR		
32	CHUKI SHABAAN	F	KIGANAMO HC	OJT		
33	ZEERA NYICHA	F	MAKEERE DIS	1YR		
34	A. BARANDAJE	M	KAHAGA DISP	1YR		
35	JUSTINA BENEDICTO	F	HERI MISSION HOSP	1YR		
36	RHODA KILAMBONA	F	BUHORO DISP	OJT	*	
37	JANE HOSE	F	RUHITA	“		
38	JANET MWILIMA	F	BUGAGA DISP	1YR	**	20-6

39	FITIN RASHID	F	MURUFUTI DISP	OJT	**	10-6
40	ELINA WINSTONE	F	HERI MISSION HOSP	1YR		
41	MAGDALENA MPANGLIJE	F	BAGAGA DISP	OJT	**	20-6
42	CLEMENT LAMU	M	BUHORO DISP	OJT	*	
43	JESSICA LUGANJA	F	NYAMABUYE DISP	OJT		
44	SOPHIA THOMAS	F	BUHORO DISP	1YR	**	22-6
45	PHILBERT BALICHAKO	M	MVINZA DISP	1YR		
46	EVA RUSAMBI	F	NYAKITONTO HC	1YR	*	
47	MRAGARET FRANCIS	F	“	OJT	*	
48	ADELLA KAYANDA	F	RUSESA HC	OJT	*	
49	LUCY MCHIKA	F	“	OJT		
50	FATUMA YAHAYA	F	MUZYE DISP	OJT	**	
51	MARY BARAGOVYA	F	RUNGWE MPYA DISP	“	*	
52	MASENDEKA DAUDI	M	“	1YR		
53	JUMA MTORO	M	MUZYE DISP	OJT	*	20-6
54	REGINA JOEL	F	KABANGA MISSION	“	*	
55	AURELIA ANDRIANO	F	:	“	*	
56	CHAUSIKA SUKARI	F	KIBANDE DISP	OJT	**	27-6

* HA FOLLOWED TO SITE
* HA FOLLOWED AND OBSERVED

Appendix E

List of Attendants in Kibondo

List of Health Attendants in Kibondo

	NAMES	SEX	HEALTH FACILITY	TRAINING	STATUS	DATE
1	JENESTA KANYESI	F	KINOKO DISP	OJT	**	19-6
2	HELENA BIZAZAMBA	F	KIBUYE DISP	OJT		
3	FATUMA HAMISI	F	KIGAGA DISP	OJT	**	26-6
4	DEAGRATIUS MUTONDO	M	KASONGATI DISP	OJT		
5	ANNA JESSE	F	KINONKO DISP	1 YEAR	**	19-6
6	JORAM MBOGOYE	M	KIFURA HC	1 YEAR	**	20-6
7	BEATRICE MIYEGO	F	KABINGO DISP	1 YEAR		
8	BUSTINA KITONDE	F	BUSUNZU DISP	1 YEAR		
9	MATHEW NYENGO	M	RUGUNGA DISP	1 YEAR	**	28-6
10	LUCAS BUTONO	M	NYAKANYENZI DSP	1 YEAR		
11	JULIUS MADALALA	M	MAGUNZU DISP	OJT		
12	PHILLIPO WILLIAM	M	NYARUGUNGA D.	OJT		
13	KAHUBIRO TOYT	M	ITABA DISP	OJT	**	28-6
14	MICHAEL KAHITIRA	M	MUKABUYE DISP	1 YEAR		
15	DNAIEL KAHITIRA	M	KABINGO DISP	1 YEAR	**	20-6
16	HAMISI YERONIMO	M	MINYINYA DISP	1 YEAR	*	16-6
17	STEPHANO MIHAMO	M	GWANUMPU DISP	1 YEAR		
18	RAPHAEL KAPORI	M	MAKUNBUYE DISP	1 YEAR		
19	JOAKIM BARTHOLOMEW	M	NYAMBITAKA DSP	1 YEAR	**	21-6
20	KAGWAYA JACOB	M	KIGA DISP	1 YEAR		
21	LIBERATA NCHANA	F	RUGUNGA DISP	1 YEAR	**	28-6
22	CONSOLATA BASILA	F	NABUHIMA DISP	OJT	**	15-6
23	REGINA VINCENT	F	NENGO DISP	OJT		
24	TAUSI KAGINA	F	KIGOGO DISP	OJT	**	27-6
25	COROTRIDA MANGANGA	F	MAGUNZU DISP	OJT		
26	ZUHURU HAMISI	F	KIBONDO HOSP.	OJT	*	15-6
27	STAMILI MUHINI	F	KIBONDO HOSP.	OJT	**	15-6
28	STELLA MEDADI	F	KIBONDO HOSP.	1 YEAR		
29	MINANI NGARAMA	M	KIFURA H/C	OJT		
30	WILBARD MADALALA	M	MUKARAZI DISP	1 YEAR	*	23-6
31	FREDERICK MKONDO	M	NYARUGUSU DISP	OJT		
32	PAULO NGARULA	M	KATANGA DISP	OJT	*	30-6
33	PENINA MAYE	F	MABAMBA H/C	1 YEAR	**	22-6

34	PELO HAKILI	F	MABAMBA H/C	1 YEAR	**	22-6
35	DALOLOSA NOEL	F	KASONGATI DISP	OJT		
36	AUGOSTINO MPHAYOKULELA	M	KASUGA DISP	OJT		
37	EUTACH RAMADHAN	M	BUKIRRO DISP	OJT		
38	PHILBERT NDAGIGE	M	KIGOGO DISP	1 YEAR	**	27-6
39	ROCKY NTEBAGARA	M	KIGAGA DISP	1 YEAR	*	26-6
40	ERNEST BAGAYIMVO	M	RUMASHI DISP	OJT		
41	HTRHOTY KSYOYO	M	KATANGA DISP	OJT	*	30-6
42	KAGOROBA NTAMAGALA	M	KIBINDO DISP	OJT		
43	ELIAS KIHIWILI	M	NYARUYOMBA D.	OJT		
44	CHARLES SHINGWA	M	KUMHASHA DISP	OJT	*	3-7
45	MODSTA ADAM	F	KABARE DISP	1 YEAR		
46	CHAUSIKU ULEDE	F	MINYINYA DISP	1 YEAR	**	16-6
47	CAROLINA PAULO	F	KASUGA DISP	OJT		
48	LOSA HOSEA	F	KEZA DISP	1 YEAR	**	26-6
49	STELLA SABUHORO	F	KUMHASHA DISP	OJT	**	3-7
50	NDIKE BANTUMA	F	MUHANGA DISP	OJT		
51	RAHEL KABUTERANYA	F	NYAMIBUYE DISP	1 YEAR		
52	FORTUNATA MLILIWYE	F	KUMSENGA DISP	OJT		
53	STUMAINI BALAHENYA	M	KUMSENGA DISP	OJT		

** HA FOLLOWED

* HA FOLLOWED AND ASSESSED

Appendix F

List of Health Facilities in Kasulu

List of Facilities Site-visited in Kasulu

No:	Name of facility or site visited	Number. of HA's Present	Number of HA's Assessed for Skills
1.	Biharu HC	2	1
2.	Bugaga Dispensary	2	2
3.	Buhoro Disp.	3	2
4.	Kabanga Mission Hq.	2	0 *
5.	Kasangezi Disp.	1	1
6.	Kibande Disp.	1	1
7.	Kibwiga Disp.	2	2
8.	Kiganamo HC	7	1
9.	Makeere Disp.	2	0 *
10.	Murufiti	2	1
11.	Muyama HC	3	0 *
12.	Muzye Disp.	2	2
13.	Mvugwe Disp.	1	0 *
14.	Mwanga Disp.	2	1
15.	Mwembuye Disp.	2	2
16.	Nyakitonto HC	4	0 *
17.	Rungwe Mpya Disp.	2	0 *
18.	Rusesa HC	3	1
	Total	43	* 17

* Skills were not observed in the facility site-visited.

a) Skills not observed in 6 out of the 18 facilities site-visited

b) Skills observed for17 out of 42 Health Attendants site-followed:

- Some of the HA followed were either scheduled for PM or night shifts, or were on official leave of one form or another.

- In some of the health facilities, there were no drugs available and hence not much by the way of normal treatment activities was going on.

Appendix G

List of Health Facilities in Kibondo

List of Facilities Site-visited in Kibondo

No.	Name of Health Facility	Number. of HA's Present	No. of HA's Assessed for Skills	No. of HA's not Assessed for Skills
1.	Kibondo dist. Hosp.	2	1	1
2.	Mabamba HC	2	2	-
3.	Nabuhima Disp.	1	1	-
4.	Kigaga Disp.	2	1	1
5.	Kigogo Disp.	2	2	-
6.	Kumasha Disp.	2	1	1
7.	Minyinya Disp.	2	1	-
8.	Kabingo Disp.	2	2	-
9.	Itaba Disp.	1	1	1
10.	Rugunga Disp.	2	2	-
11.	Katanga Disp.	2	1	1
12.	Mukarazi Disp.	1	0	1
13.	Kinonko Disp.	2	2	-
14.	Keza Disp.	1	1	-
15.	Nyabitaka Disp.	1	1	-
	Total	25	19	6

Notes:
a) Skills were not observed in 6 out the 25 HA followed.
b) Skills only observed in 19 out of the 25 HA followed.
c) Skills were not observed in some of the HA followed because either they were not at the facility at the time, or there was no procedure that demanded to be performed by them.
d) Those HA whose skills were not observed, 5 out of 6 were males who are actually not working at the MCH clinic.