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MASTER OF SCIENCE IN COMMUNITY ECONOMIC DEVELOPMENT
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PROJECT PROPOSAL FOR CONSTRUCTING A HEALTH CENTRE FOR THE MBURAHATI COMMUNITY AT MBURAHATI WARD IN KINONDONI MUNICIPALITY

ROCKNESS ROBERT TEMBA

CERTIFICATION

This project has been submitted as partial fulfillment of the requirements for the award of the degree of Master of Science in Community Economic Development from the Southern New Hampshire University at the Open University of Tanzania, Dar Es Salaam.

Supervisor's Name: Clark R. Arrington

Date .....

Supervisor's Signature .....

CORPYRIGHT STATEMENT

DEDICATION

The work and effort to produce this study are dedicated to my beloved husband Dr Raymond K. Mwanga; my lovely daughter Vanessa and my lovely sons Leo and Kevin; without forgetting my dear parents Mzee Robert Temba and Mama Rovinessia Mamchau.

DECLARATION

I, Temba Rockness .R. declare that this project is my own work, and that to the best of my knowledge, no such project has been presented in any other Institution of higher learning for the similar award.

Date 9/9/2005

Signature .....

ACKNOWLEDGEMENT

I take this opportunity to acknowledge the help of friends and colleagues. I am indebted to my supervisor Mr. Clark R. Arrington for his helpful suggestions/challenges and encouragement which proved to be invaluable in the preparation of this work. I would like to thank my lecturer Mr. Michel Adjibodou for providing a wealth of project design and management skills, materials and his tireless devotion. I am also indebted to all lecturers in this program. I also thank the leadership and the people of Mburahati Barafu Community (MBADECO) for their acceptance and cooperation.

I am grateful to my lovely husband Dr. Raymond Mwanga for his financial support and encouragement, to my lovely daughter Vanessa, and my lovely sons Leo and Kevin for their patience. But without forgetting my house maid Veneranda who assisted me with house hold activities during my studies.

ABSTRACT

Mburahati Barafu Community Development designed a project of constructing a health centre with the purpose of providing and accessing health services within their locality. Tanzania, like many countries of the developing world, is faced with the challenge of providing adequate health services to all her people. However, available national resources, especially finance, are insufficient to implement this mammoth task. Consequently, under the Health Sector Reforms, the government is working together with a number of other agencies to help realise this goal.

Within the Mburahati Ward there is a large population of 21,608 people that at present time do not have access to health services in their locality. Only one government clinic is located near this area but it does not address all the needs for health services which are the rights of Mburahati Barafu community. In order to access these services the community people have to travel more than 10 km. The roads in this area are not well passable thus during the night it is difficult to find transport to access mother and child health services, as a result many expecting women deliver at home or on the way without being attended by health personnel.

The Project Objectives are as follows:

i. To construct one health centre for the population of Mburahati Barafu Community in Mburahati Ward by 2008.ii. To reduce the barrier of accessing health services by 85% in 2008.

ii. To provide improved health services to Mburahati Barafu Community by 85% in 2008.

iii. To provide voluntary counseling and test services in the community by 85% in 2008

iv. To improve the quality of life in Mburahati Barafu Community. How measured see logframe in appendix 3

Expected Results:

Health centre constructed and in operation within the Mburahati Barafu Community.

Barriers to the access to health services are reduced

Improved health services provided to the Mburahati Barafu Community

Voluntary counseling and test services provided in the community

Improved quality of life in Mburahati Barafu Community. How measured see logframe in appendix IV. Mburahati Barafu Development Community will implement the project in collaboration with Kinondoni Municipality.

The total cost is Tshs. **291,345,966** which is equivalent to (USD 267,290).

The contribution from the community is Tshs.20%- 58,269,193, (USD 53,458)

Kinondoni municipal 10% which is Tshs. 43,701,895, (USD 40,093) special events 5% - 14,567,298.(USD 13,365) Thus the requested amount from donor organization is Tshs. 174,807,580 (USD 160,374). The largest part of the budget will be used for constructing the health centre. The Government through the Ministry of Health and the Kinondoni Municipality will provide necessary equipments and incur operational costs.

LIST OF ABBREVIATIONS

CBO	**Community Based Organization**
CBIO	**Census-Based Impact Oriented**
CHWs	**Community Health Workers**
DED	**District Executive Director**
MBADECO	**Mburahati Barafu Development Community**
HIV/AIDS	**Human Immune Virus/Acquired Immune Deficiency Syndrome**
MCH	**Mother Children Health care**
NSGRP	**National Strategy for Growth and Reduction of Poverty**
PRA	**Participatory Rural Appraisal**
PHC	**Primary Health Care**
PHAST	**Participatory Hygiene and Sanitation Transformation**
TEHIP	**Tanzania Essential Health Interventions Project**
WHO	**World Health Organization**

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CHAPTER ONE

BACKGROUND OF THE STUDY

1:0 Introduction

This chapter outlines the historical background to the study area and the organizational profile.

1:1 Background Information

Mburahati Barafu Development Community (MBADECO) is a community-based organization, which is located in Mburahati Ward in Kinondoni Municipal in Dar Es Salaam. It is a registered organization under the societies ordinance, 1954 and received the certificate of registration number 9906 issued 16th June 1999 under the Ministry of Home Affairs. It was established with the aim of improving living standards of Mburahati Barafu Community through provision of better social services and support community initiatives towards poverty reduction.

Community profile

The total population

Women ----------5,295

Men ----------5,378

Children

Girls ----------2,775

Boys ---------- 2,258

Primary schools ----------3

Secondary schools ---------- nil

Health center ---------- nil

Dispensary ---------- 1

Other organizations and NGO's ---------- nil

According to 2002 population census, this ward has 21,608 people. The area consists both of planned and unplanned settlements. The majority of the population is self employed in the informal sector whereby their earnings are not sufficient to meet their basic needs. Generally most of the people in this area fall under the group of urban poor.

1:1:1 Vision and Mission statement

MBADECO's vision is to improve the living standard of the Mburahati Barafu community. The vision of the community acts as a guiding star, which cannot be reached but continues to provide hope and desire to move forward and carry on with the assignment.

The mission is to improve the living standards of the Mburahati Barafu Community through the provision of better social services and support community initiatives towards poverty reduction

Objectives

- To involve the community on how to identify and solve problems in education, health and income generating activities.

- To protect and conserve the environment.
- To provide clean and safe water.
- To collaborate with international and national organizations in achieving and implementing its community goals.
- To advocate human rights.

1:1:2 MBADECO Institutional Framework

The Community has the following office bearers:-

I. Chairman

II. Vice Chairman

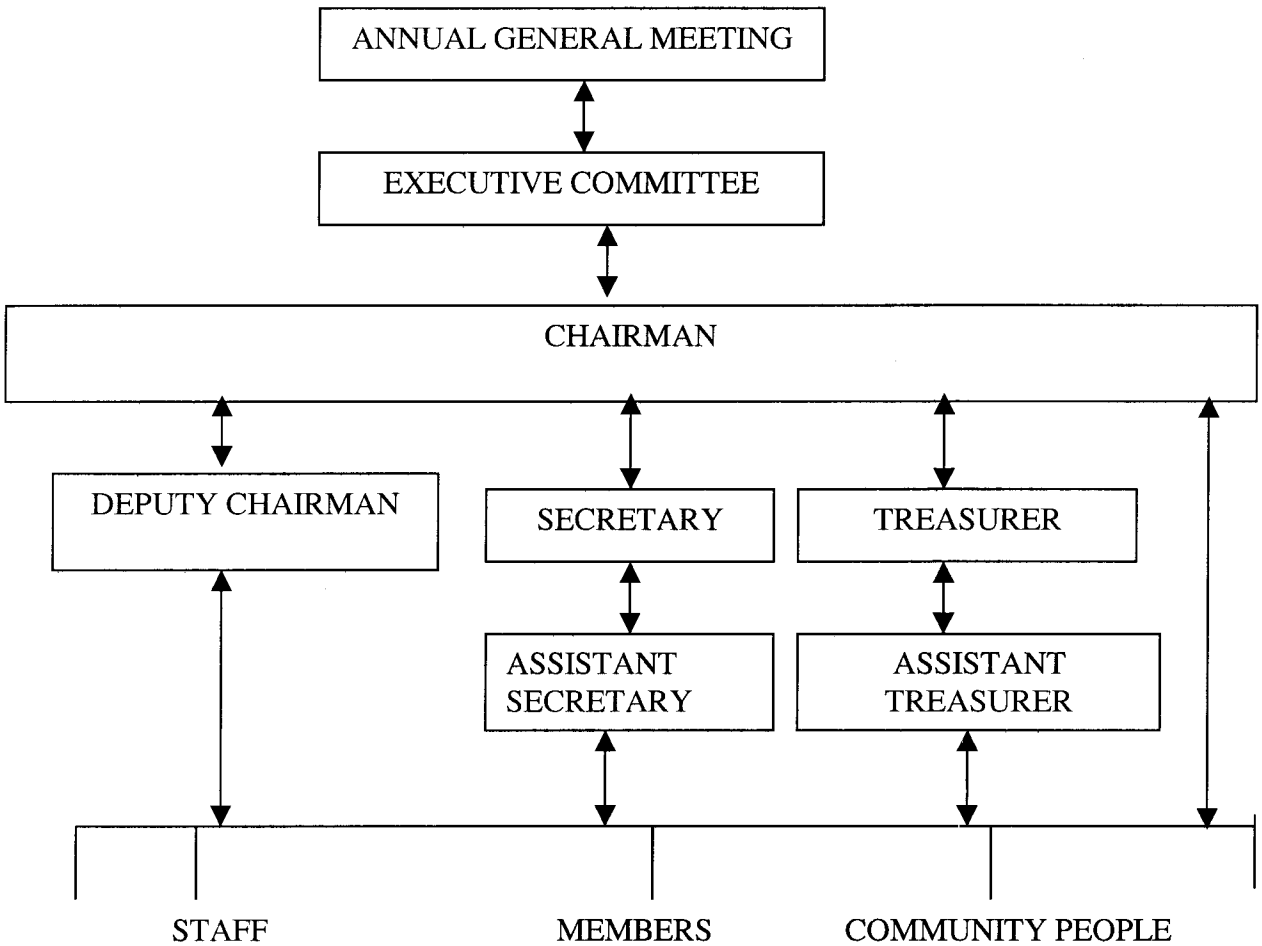
III. Secretary

IV. Assistant secretary

V. Treasurer

VI. Assistant treasurer

MBADECO Organizational Chart



MBADECO has two principle organs:-

I.The Annual General Meeting

II.The Executive Committee meeting

The annual general meeting is conducted once a year.

The office bearers hold the office for three years.

The annual general meeting is the supreme decision making body on all matters regarding the discharge of rights and duties of the members and an organ of the community on all issues pertaining to the Constitution, rules and their implementation. The management of the affairs and conduct of business of the community is vested in the Executive Committee which is elected by the annual general meeting and discharge its functions according to the constitution, rules, regulations and resolutions of the community in general meetings.

MBADECO has a treasurer who is responsible for receiving and keeping all monies in safe custody, maintaining and keeping proper books of accounts in respect to all monies collected and paid daily.

MBADECO has a bank account at the Magomeni National Micro Finance Bank

1:1:3 Programmes and Activities of MBADECO

Health Program

Activities:

Collection of solid waste, construction and maintenance of storm water, drainage system construction of school toilets, provision of information education and communication on awareness of HIV/AIDS and water borne diseases, cholera through peer education, PHAST team

Education Program

Activities:

Construction of classrooms, toilets provision of tables, chairs, desks

provision of life skills i.e. entrepreneurship skills, awareness creation on issues affecting the day to day lives of the community

Environmental Program

Activities:

Planting trees and collection of solid waste

Communication Program

Activities:

With support of Concern International, footbridges were constructed to enhance communication.

1:1:4 Social and Economic Achievements of MBADECO

Since the establishment of MBADECO, the organization has managed to score some achievements in the area. The achievements include: -

Education

MBADECO in collaboration with the support of Concern an international NGO, managed to construct two classrooms and a toilet at Muungano primary school. They have also furnished the classrooms with desks, tables, and chairs.

Health

With support of Concern, MBADECO has trained PHAST team, HIV/AIDS Peer educators and community health facilitators. They have also trained teachers on how to make the best use of the new types of ecological pit latrines at the school

Water and sanitation

Drainage water systems were constructed to reduce a problem of flood during rain season. They also managed to drill and develop a borehole and currently the community has clean and safe water, which is also a source of income to the organization.

Communication

Constructed a foot bridge which link Mburahati and Magomeni. This has facilitated communication from Mburahati to other parts of the city.

1:2 Project Area

The projected area is situated in Mburahati Ward in Kinondoni municipal in Dar es Salaam. The area consists both of planned and unplanned settlements.

1:2:1 Problem statement

Tanzania, like many countries of the developing world, is faced with the challenge of providing adequate health services to all her people. However, available national resources, especially finance, are insufficient to implement this mammoth task. Consequently, under the Health Sector Reforms, the government is working together with a number of other agencies to help realize this goal.

Within the Mburahati Ward there is a large population of 21,6o8 people that at present do not have access to health services in their locality. There is only one government clinic located near this area but it does not address all the health needs services. In order to access these services the community people have to travel more than 10 km. The roads in this area are not well passable thus during the night it is difficult to find transport to access mother and child health services. As a result many expecting women

deliver at home or on the way without being attended by health personnel. This causes a high incidence of maternal/child mortality.

1:3 GOAL

The overall objective is to provide and access health services within their locality

1:3:1 Specific objectives

i. To construct one health centre for the population of Mburahati Barafu Community in Mburahati Ward by 2008
ii. To reduce the barrier of accessing health services by 85% by 2008
iii. To provide improved health services to Mburahati Barafu Community by 2008
iv. To provide voluntary counseling and test services in the Mburahati Barafu Community by 2008
v. To improve the quality of life in Mburahati Barafu Community

1:4 Assignment

I conducted needs assessment through the survey to establish the needs of a health centre. Community people identified and prioritized the need of a health centre and therefore requested the researcher to prepare a Project Proposal for Constructing a Health centre.

CHAPTER TWO

THEORETICAL LITERATURE REVIEW

2:0: Introduction

The chapter surveys available literature on what has been said and documented by various scholars in the area of health and community participation in order to lay consistent foundation on the subject within an acceptable research framework.

2:1 What is Health

World Health Organization constitution of 1948 defined health as state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health has been considered less as an abstract state and more as a means to an end which can be expressed in functional terms as a resource which permits people to lead an individually, socially and economically productive life. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities. Tanzania as a member of WHO has adopted this definition and is the one which has been used in the country. The definition is appropriate one because it is known that health is encompassing all issues surrounding the life of human being and not merely absence of diseases only.

2:1:1 Health as a fundamental human right

The Ottawa Charter (1986) in keeping with the concept of health as a fundamental human right emphasises certain pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. Today the spiritual dimension of health is increasingly recognized.

Health is regarded by WHO as a fundamental human right, and correspondingly, all people should have access to basic resources for health. A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being to increase control over the determinants of health and thereby improve their health.This is applicable in Tanzania, because the government understands the importance of health to its citizen and hence undertook different strategies in order to make sure every Tanzanian is able to access health services though due to resource constraint the process is somehow slow.

2:1:2 Health for All

Glossary of Terms Used in WHO 1984 defined health for all as the attainment by all the people of the world of a level of health that will permit them to lead a socially and economically productive life. Health for All has served as an important focal point for health strategy for WHO and it's Member States for almost twenty years. Although it has been interpreted differently by each country in the light of its social and economic characteristics, the health status and morbidity patterns of its population, and the state of development of its health system, it has provided an aspiration goal, based on the concept of equity in health. Tanzania has understood this and she is working on it though constrained by resources but she has willingness to do so.

2:1:3 Vicious Cycle of Health and Poverty

It is recognized that there is a strong relationship between health and poverty which works in both ways: income poverty leads to poor health outcomes and adverse health outcomes contribute to income poverty.

A number of factors typically associated with income poverty are also determinants of ill health. These include high level of female illiteracy, lack of access to clean water, unsanitary conditions, food insecurity, poor household caring practices, heavy work demand, lack of fertility control, as well as low access to preventive and basic curative care. Opposite, unfavourable health outcomes which contribute to income poverty include ill-health in general, HIV/AIDS, malnutrition and high fertility. These reasons

cause poverty through diminishing productivity, reduced household income, and increased health expenditures.

2:1:4 Participation is essential to sustain health promotion action.

The Ottawa Charter (1986) identifies three basic strategies for health promotion. These are advocacy for health to create the essential conditions for health indicated above; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health. These strategies are supported by five priority action areas as outlined in the Ottawa Charter. Participation is essential to sustain efforts. People have to be at the centre of health promotion action and decision-making processes for them to be effective; health literacy/ health learning foster participation. Access to education and information is essential to achieving effective participation and the empowerment of people and communities.

2:1:5 Enhancing Community Participation

Walt, G: (1998), Said there is overwhelming evidence that participation of local community groups in the design and implementation of health sector activities and the kinds of intersectoral interventions have a significant impact on success and sustainability. Moreover, community involvement in the management of health facilities is emerging as an important aspect of district- based health systems in many African countries. Giving appropriate legal status to community management structures within African health care systems can facilitate their operation. Placing greater decision-making in the hands of community representatives tends to be associated with more

rapid and comprehensive identification of health needs and expectations; more reliable identification of the poorest households in the community; easier adaptation to cultural and religious preferences; unbureaucractic employment of local or community staff; and greater flexibility in executing activities outside normal work hours (for example, nights, weekends); use of nonconventional and creative methods to promote education and information (for example, theater, animation, dances and film production); and practical development of technologies that can be adapted to local conditions.

Community management committees can improve the performance of health systems for four reasons. First, they can play a major role in holding health care providers accountable to their clients. Indeed, accountability and transparency, based on continuous dialogue and interaction between service providers and communities. Second, involvement of community management committees helps to contribute good governance at the sub district level in the sense that diverse kin, ethnic, social, and cultural groups have an opportunity to present their grievances and collaborate in overcoming them. Third, participatory decision-making develops a sense of ownership, when community management committees participate in adopting a particular approach to solving local-level problems, such as nutritional monitoring, they are more likely to become engaged in the activities involved, assessing results, and monitoring progress. And finally, when communities are involved in managing district health facilities, relationships of empathy and trust are more likely to evolve between health care providers and clients.

Building on community strengths is not only a matter of inviting communities to participate in management. Part of the challenges is to attune health care providers and health professions to the advantage of involving community representatives. When health centres use cost-sharing or drug revolving funds with community resources, transparency is vital for establishing accountability and trust between health providers and communities. Tanzania knows this and currently is planning and implementing its health activities together with community people, though not yet spread all over the country but the willingness is there and with time community people will realize their rights.

Participation approaches are now widely used and accepted in the community development process as the appropriate way of empowering people. In Tanzania participatory approaches have been used for identifying needs, planning, implementing and evaluating different programs.

2:1:6 Community based health services and initiatives

Rene Loewenson: (2000) Participation of communities, of both organised and unorganised public groups, is widely argued to be an important factor in improving health outcomes and the performance of health systems. Despite this, and the common inclusion of 'participation' as both means and ends in health policy, participation is poorly operationalised, both in governance and accountability in health and in technical health interventions, so that there is little systematic analysis of its specific contribution to health and health systems outcomes. The term 'participation' has been loaded with

many meanings and aspirations. To some it implies a mechanism for increasing the efficiency or reducing the costs of programme implementation, improving sustainability of programmes and building local skills and experience useful for future interventions.

This form of participation is a means to other development 'ends', a way in which goals and objectives may be better achieved. Participation is however also conceived of as an end in itself, building networks of solidarity and confidence in social groups, building institutional capacity, empowering people to understand and influence the decisions which affect their lives, legitimising policy and practice, ensuring that they relate more closely to perceived public need and strengthening the incorporation of local knowledge.

The term 'community', as a social grouping with common characteristics, interests or identity equally needs to be unbundled to identify the interests or features that create that collective identity, and to recognise the conflicts or divisions that exist within groups. The manner in which participation is expressed is an important dimension of how a society conceives and practices democracy. It reflects the extent to which democracy extends to and beyond representative democracy, or the delegation of power through the election of representatives, to the systems of 'participatory democracy' that society uses to direct or control the exercise of power, establish accountability, communicate views and interests and contribute towards development between elections.

2:2 EMPIRICAL LITERATURE REVIEW

Tanzania Essential Health Intervention Project (TEHIP) was a donor-supported multi-faceted project with the aim of strengthening district health planning and management, with community participation as a central theme throughout many key activities. The project was implemented alongside government decentralization (both general as well as health sector) and other reforms in the health sector, including donor coordination. Simple but constructive tools were developed by the TEHIP research team that could be used by communities, through the district and health facility health management teams and Boards, for such activities as evidence-based planning, drug management, and health service evaluation.

Participatory Action Research (PAR) with involvement of TEHIP research staff, health workers and local populations' representatives in the collection of morbidity and mortality data to supplement the health facility-based one, have been adopted, and feedback is usually provided to local communities through scheduled official meetings organised by TEHIP in liaison with the local government and health authorities. Health workers became more accountable to the local community, and they were assisted in planning methods. The financial resources as well as technical input from the donor side were crucial factors in the success of this project. To translate the national political ideology of self-reliance into practice, TEHIP has collaborated with the office of the district council's executive directors (DED) of Rufiji and Morogoro Rural districts to initiate community-based health facility buildings.

In this regard, communities have been sensitized to, and actually participated in, cost sharing programmes, including their contribution of labour time and efforts in the construction of health facility buildings. This has reduced construction costs by 40-60%. Also, by promoting ownership of health facilities by local communities, TEHIP has used facility rehabilitation as an entry point to engage the 'community voice' in the whole process of planning and implementation in the district (de Savigny et al 2002; TEHIP News 2000-2002).

The Tanzania Essential Health Interventions Project shows how health systems benefit when local communities and officials contribute to key decisions and participate in efforts to improve health services. Whether it is making bricks to rebuild dispensaries or speaking up at village meetings, people are assuming responsibility for their futures.

Community participation has power in planning and implementing community activities. What is needed is capacity strengthening so that these community people can participate actively. In the case study above, tools such as "community voice" was used to help people identify local health needs and set priorities. Community people contributed their labour, material and backed up with districts. It is important to establish the sense of ownership.

Though the case study based mainly on establishing dispensaries, but the same strategies and tools can be used to establish a health centre. And by looking at the approaches used, is not different from what the Mburahati community has done so far i.e. they have identified and prioritized their needs, and they are willing to contribute.

Participation of community in health promotion in Cuba.

Cuba (Greene 2003) reports the experiences of implementing community participation schemes at national level. This initiative received support from highest levels, with strong ties to communist principles of community self-reliance, solidarity, fraternity and equality. While the level of community participation was claimed to be high, the communist principles are likely to have influenced this, as well as the approaches to implementation and the monitoring of the programme.

The country's priority on health promotion is disease prevention, and there is a widely acceptable policy throughout the country that allows community participation initiatives, and the devotion of the president himself to such health initiatives including his appearances at various public and media presentations especially in case of HIV/AIDS is a demonstration of the presence of a strong political will of the federal government that is a stimulus to other political leaders and the general public to participate in public health issues. Community participation basically consisted of information giving and education in health promotion and a situation analysis of the health of the local population. To ensure that community participation is effective, the federal government though its health ministry has adopted various methods including the use of local opinion leaders, formation of health committees, women's associations, training programmes of professionals and the general public and targeting neglected groups.

There has been a strategy for motivating those performing well by actively engaging themselves in health promotion campaigns and infant day care or in adult education teaching programs, by awarding certificates. A number of youth centres were

established, and youths participated in singing and dancing which was not only envisioned to maintain their youthful outlook on life but also as a source of income generation for their centre. Community participation is also high in the case of health care administration and the community themselves recognize their pivotal opportunities given to them as stakeholders in their own health care system while the government remains a leader in providing framework for regulatory purpose of weaker areas. This has also created a sense of ownership of the system rather than everyone thinking that health promotion is a responsibility of the state.

Census-Based Impact-Oriented (CBIO) approach to PHC in Bolivia

Community and NGO (Andean Rural Health Care and its sister organizations) input was seen as essential to the delivery of a more comprehensive (as opposed to selective) model of PHC, and have been in operation in some parts in Bolivia since early 1980s. Through a CBIO approach recently adopted in Bolivia (and whose model is tried in other countries of south and north America (including the U.S.A), a great deal of responsibilities were given to paid community health workers, such as who were selected instead of being elected.

One of the reasons for the success of this approach is that, at least some of the program staff are long-time members of the same communities they serve and the program has been built on principle of trust based on open and open communication between program staff and local communities. The new approach was stated to be much more responsive

to local needs, and through the regular discussions between the CHWs and the community, community health knowledge increased. High service coverage of about 75,000 people in three district ecological-cultural regions in the country has been facilitated by involving CHWs in the disease-epidemiologic surveillance system and services provided through home delivery (through routine systematic home visitation), when needed, and based on local health priorities, and with community members being strong partners in the planning, implementation and evaluation of the program activities. Identification of new services to provide to populations in need or the identification of the need for improving the existing types of services including the actual allocation of resources are based on information collected from community-oriented demographic and epidemiologic surveillance.

As a ground for ensuring that program activities are performed successfully, various activities have been designed, including among others, the employment and training of field staff, establishing working relationship with local communities, designing, piloting and refining methods for obtaining opinions from community members on their health priorities through open individual or group dialogues and methods for better delivery of health services to prioritised health needs. Due to its relevance and viability, the CBIO model has attracted attention from other countries, in the academic, NGO and government programme departments who are interested in undergoing community participation strategies in health (Perry et al 1999).

Participation of community in Hygiene and Sanitation Transformation (PHAST) in South Africa, Uganda, and Zimbabwe.

The PHAST initiative has been implanted widely, with community participation a central feature, offering an approach 'learner-centered awareness creation', under which local communities were let to the attention of the need for environment sanitation, hygiene and conservation as an important factor for better health and sustainable development. Under support from government ministries of health, agriculture, natural resources and work, communities in beneficiary countries as mentioned have obtained an opportunity for appraising environmental health projects in areas such as water and reforestation, including their involvement in planning, management, evaluation and cost sharing programs in the projects agreed commonly to be initiated. All these initiatives could be possible given the supportive policy framework that emphasizes on devolution of decision-making power from central level to local populations through their local government authorities. For example, in all the countries where the PHAST Project was implemented, consultations were made by the project management staff with the local populations to see what could be done, e.g. where to dig wells and their willingness to share the costs of running the projects, including provision of volunteer labour power or payment out of pockets. Through health committees, local populations were made aware of their ownership of - and their responsibility towards making the projects initiatives succeed. This is evident by their actual participation in the cost sharing and voluntary labour initiatives, and owing to this, PHAST has demonstrated increasing coverage of

water and sanitation facilities (Breslin, 1998; Mukungu, 1998; Musabayane 1998- all in I.C. et al., (edit). 2000).

Policy review

2:3 Tanzania Health Policy

Tanzania Health Policy of 1990 aimed at improving the health status of all people wherever they are in urban and rural areas, by reducing mobility and mortality and raising life expectancy, Good health, i.e. physical, mental and social well being is the major resources and economic development. This health policy emanates from the history of health services in this country since independence. Before independence health services were established in urban areas and were mainly curative. After independence health services plans were considered an integral part of the overall national development plans as follows: the First Five Year Development Plan 1964-1969 which had a section on health. One of the goals of this plan was to establish a regional hospital to provide specialist and surgical medical care in all regions.

The Government planned to establish 300 rural health centres each to serve about 50,000 people and to supervise 5 satellite dispensaries. Each health centre was to have 8 maternity beds and 6 general beds for short term hospitalization. The Government aimed to increase the number of students enrolled in medical training institutions and also introduce new courses to satisfy the demand for health care workers. In the second five year development plan 1969-1974, the major step was the direction of health services towards preventive services to curb the spread of communicable diseases. The

Government planned to construct 80 new health centre and 100 dispensaries, the target was one the health centre for every 50,000 people and one dispensary for every 10,000 people by the year 1985. Training personnel was to go hand in hand with expansion of health services.

In the third five year development plan, the Government gave priority to ; environmental sanitation and good nutrition. The Government initiated various health campaigns like "(chakula ni uhai (food is life)" and "mtu ni afya(A person is health)", construction of rural health centres and dispensaries, expansion and strengthening of preventive services , provision of primary education to all children attaining the age of going to school and provision of adult education and distribution of health education materials. This was the beginning of integration of other sectors in the implementation of Primary health care.

2:3:1 Health policy objectives

The overall objective of the health policy is to improve the health and well being of all Tanzanians, with focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people.

2:3:2 The specific objectives of the policy are as following:

- Reduce infant and maternal morbidity and mortality and increase life expectancy through the provision of adequate and equitable maternal and child health services, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions.

- Ensure that health services are available and accessible to all people wherever they are in the country, whether in urban or rural areas.
- Move towards self sufficiency in manpower by training all the cadres required at all levels from village to national levels.
- Sensitize the community on common preventable health problems and improve the capabilities at all levels of the society to asses and analyze problems and to design appropriate action through genuine community involvement.
- To promote awareness in government and the community at large that the health problems can only be adequate solved through multisectoral cooperation, involving such sectors as education, agriculture, water and sanitation, community development, women organizations, the party and non governmental organizations.
- Create awareness through family health promotion that the responsibility for ones health rests squarely with the able-bodied individual as an integral part of the family.

The policy states that objectives must be achieved through Primary Health Care (PHC); community involvement in health is an essential prerequisite for implementation of Primary Health Care. Involvement and participation should be voluntary and the community should have a full say about their health. They should be involved in identification of the problem areas, planning implementation and evaluation of all health programs from villages to national levels. Efforts should be made to enlighten the people

and various sectors about their roles and responsibilities to enable them to participate full in attainment of better health. The community should be motivated to participate in construction and maintenance of health facilities.

2:3:3 Health Services financing

Central Government Funds

The central government finances the health services in two ways:

i. The ministry of health provides funds to the referral hospitals and the various medical schools. It also provides funds to its parastatals such as Muhimbili Medical Centre, the Tanzania food and Nutrition Centre and the National Institute for Medical Research. The ministry gives Subventions to KCMC hospital, Bugando hospital and other designed hospitals belonging to the religion organizations.

ii. The Prime minister office provides funds for the running of regional and district hospitals including salaries for their employees. At the same time the Prime minister office gives Subventions to the local councils for the salaries of running health centres and dispensaries.

Local government Funds

The local government is responsible for running of dispensaries and health centres in rural areas. They have to provide funds for: purchase of medicines and equipments, salaries and training and development of employees; construction and maintenance of the dispensaries and health centres. Local governments get their fund from government subventions and local taxes.

The National Health Policy (1990) states that health care will be provided "FREE" However it recognized the burden of the government in providing health care free and stated that the government is looking into ways of how people can contribute in paying for some of the health services so as to minimize the burden.

Conclusion and Recommendations

The health policy has recognized the importance of involving community in achieving its objectives however lacked implementation strategies/capacity to enhance effective participation. As a result awareness of community participation in health issues is ineffective and that is why many Tanzanian do not know their right to health services. The health policy (1990) is the one which is currently used to implementing health services, this is pity as so many changes are happening and yet not reflected in the health policy. It is time to formulate new policy which will include all necessary changes and new strategies in order to achieve its objectives.

2:4 Health Sector Reform

It has been the policy of the government to offer free medical services in all hospitals and health centres however recently, Tanzania has been experiencing a series of changes which have affected the health care system. The on going political, economic and social reforms had contributed the need for a review of a health care delivery system. The government financial capabilities to finance all health services has decreased and made her not possible to meet the ever increasing costs. Recent studies on the performance of the health sector are full of examples of ineffective policy implementation initiatives such as dependence on donor funding for basic programmes, poor distribution of staff, inadequate supplies (particularly drugs), poor management, lack of supervision and motivation, and the growing gap between community and public health providers. These problems have been witnessed both in rural (Gilson et al 1993) and urban areas (Kanji et al 1992). Due to these shortcomings the government had to take corrective measures /reforms to rectify the shortcomings.

The reforms are in the following dimensions: managerial reforms or decentralization of health services; financial reforms, such as enhancement of user-charges in government hospitals, introduction of health insurance and community health funds and public/private mix reforms such as encouragement of private sector to complement public health services. They also include organizational reforms such as integration of vertical health programmes into the general health services; health research reforms such as establishment of a health research users fund and propagation of demand oriented researches in the health sector.

The Health Sector Reforms Programme has the following objectives:

i. Improve access, quality and efficiency of primary health (district level) services. Strengthen and reorient secondary and tertiary service delivery in support of primary health care.

ii. Improve capacity for policy development and analysis, development of guidelines for national implementation, performance monitoring and evaluation, and legislation and regulation of service delivery and health professionals.

iii. Implement human resource development programme to ensure adequate supply of qualified health staff for management of primary, secondary, and tertiary services.

iv. Strengthen the national support systems for personnel management, drugs and supplies, medical equipment and physical infrastructure management, transport management and communication.

v. Increase the financial sources and improve financial management.

vi. Promote private sector involvement in the delivery of health services.

vii. Within the sector-wide approach, develop and implement a system for donor involvement, coordination, monitoring and evaluation.

Their inter-linked strategies are:

The provision of accessible, quality, well-supported cost-effective district health services with clear priorities and essential clinical and public health packages which are organized at the decentralized level.

Provision of back-up secondary and tertiary level referral hospital services to support

primary health care.

Redefinition of the role of the central Ministry of Health as facilitator of health services, providing policy leadership and a normative and standard-setting role.

Addressing of the challenges of human resource development to ensure well-trained and motivated staff deployed at the appropriate health service level.

Ensuring of the required central support systems such as personnel, accounting and auditing, supplies, equipment, physical infrastructure, transportation and communication.

Ensuring a sustainable health care financing which involves both public and private funds as well as donor resources, and exploring a broader mix of options such as health insurance, community-cost-sharing as well as user fees.

Addressing the appropriate mix of public and private health care services.

Restructuring the relationship between Ministry of Health and the donors.

Conclusion

It is true that the government is overburden but the decision on introducing the cost sharing to a country whereby most of its population is poor, is also dangerous because these poor groups might find not to be able to access health services and this will contradict with the aim of the national health policy.

2:5 Recent Health Systems Situation

The national health policy pursued and strategies implemented until recently have not been able to meet the growing demand for health. According to health policy, every

50,000 people are supposed to have a health centre, thus according to the total population of Dar Es Salaam which is 2,497,940 the health centres were supposed to be 50 in Dar Es Salaam. But this is a far way dream, as it can be seen in the table below the total number of health centres in Tanzania in 2002 were 479, but the truth, according to the second five year development plan 1969-1974, the target was one health centre for every 50,000 people and one dispensary for every 10,000 people by the year 1985. But up 2004 the target is not yet achieved.

HEALTH FACILITIES IN TANZANIA, 2000:

Facility	Agency				
	Govt.	Parastatal	Vol/Rel	Private	Others
Consultancy/Specialized Hospitals	4	2	2	0	-
Regional Hospitals	17	0	0	0	-
District Hospitals	55	0	13	0	-
Other Hospitals	2	6	56	20	2
Health Centres	409	6	48	16	-
Dispensaries	2450	202	612	663	28
Specialized Clinics	75	0	4	22	-
Nursing Homes	0	0	0	6	-
Private Laboratories	18	3	9	184	-
Private X-Ray Units	5	3	2	16	1

Source: Tanzania Ministry of Health, 2000

Health facilities in Kinondoni Municipal

Facility	Ownership			
	Government	Voluntary	Parastatal	Private
Hospital	1	1	1	8
Health centre	2	0	1	3
Dispensaries	24	1	7	161

Source: Kinondoni Municipal Medical Services.

According to the preliminary report of the 2002 population and housing census, Kinondoni Municipal has 1,088,867 population. Relying on this number, Kinondoni alone is supposed to have 22 health centres. But if you compare it with the actual figure i.e. 6 health centres in the whole municipality, one can see exactly how big the problem is. Thus it is the right of Mburahati Barafu people to have a health centre facility in their locality because as it can be seen, this facility is still in need in Kinondoni Municipal in order to offer its people access to health care. It can be concluded that Tanzania has a long way to go in order to satisfy the needs of health services to its population. The national health policy is appropriate but finance constraints also are a big problem.

2:6 NSGRP AND HEALTH SERVICES

Introduction

The National Strategy for Growth and Reduction of Poverty (NSGRP) is a second national organizing framework for putting the focus on poverty reduction high on the country's development agenda. The NSGRP keeps in focus the aspirations of Tanzania

Development Vision 2025 for high and shared growth, high quality livelihood, peace, stability and unity, good governance, good education and international competitiveness. It seeks to widen the space for country ownership, effective participation of civil society, facilitate private sector development and build fruitful local and external partnerships. The NSGRP recognizes the constructive roles of all sector and other major policy processes and counts on inter-sector collaboration. It maintains commitment to the regional and international initiatives for social and economic development.
The NSGRP builds on the Poverty Reduction Strategy Paper (PRS(P)) (2000/01 -02/03) and the one-year of PRS Review that revisited the recent experience in poverty reduction as well as the three -year Medium Term Plan for Growth and Poverty Reduction. The strategy is expected to last 5 years, i.e. from 2005/06 to 2009/10

According to NSGRP, Trends in health service outputs during the 1990s show a mixed picture. The proportion of births that were attended by trained personnel and those that took place in health facilities both declined and urban-rural disparities increased. This has implications on both infant and maternal mortality: both have not changed and so the poverty reduction targets and MDGs are far from being achieved. Contraceptive prevalence increased and child vaccination rates show a small net increase. There have been steady improvements in vaccination rates since 2000, with an impressive coverage of 90 percent by 2002, thus surpassing PRS targets. Improvements in TB treatment completion rates are also encouraging. Rural areas and the poor remain disadvantaged both in terms of outcomes and service uptake.

It is thus important to ensure that health services are accessible to the poor population and the quality of services is improved. Also important is the need to strengthen the routine data system to generate indicators for measuring health service delivery.

Key obstacles include health care charges, long distances to health facilities, inadequate and unaffordable transport systems, poor quality of care, weak exemption and waiver system to the sick who unable to access health care by a fee, shortage of skilled providers and poor governance and accountability mechanisms. The availability of drugs has increased, but some continuing deficiencies and particularly the cost of drugs still makes them unavailable to some people at the time of illness.

Immunization levels have increased but there are still large disparities, which require a more targeted approach in the delivery of preventive and curative health services. The strategy aims at reducing infant mortality, child mortality, malaria related mortality and maternal mortality.

NSGRP recognized the problem of many Tanzanian unable of accessing health facility and thus among its strategies is to ensure that health services are accessible to the poor population and quality of services are improved. As the obstacles shown above, I think the only intervention to remove some of them is to establish health facilities where they are not available, Mburahati Barafu inclusive.

Conclusion

From the above analysis of literature and Tanzania national health policy, it can be correlated that Mburahati Barafu community; through community involvement/participation and with a support from government and donors can construct a health centre. It is indicated that community participation is the central in achieving the national health policy objectives. What is needed is to find strategies to sensitize/capacity strengthening to community people so that they can participate fully. Since the provision of health services requires close cooperation among various sectors, NGOs, donors and government can be approached in order to offer assistance because these community people need back-up.

If a health centre is built in the Mburahati Barafu area, the barrier of traveling more than 10 km in order to access health services will end up. All services such as primary health care, mother and child health, reproductive health will be obtained nearby and this allows many to access them. Again due to gender inequalities in most of Tanzanian societies, many women and children will now be able to access heath services near to their locality in which will reduce the burden of women to travel long distances with their children looking for these services. The time used to search for these services will now be used for more productive issues at home as we all know women are less mobile and at the same time are home managers.

CHAPTER THREE

RESEARCH METHODOLOGY

3:0 Research design

In order to conduct needs assessment the Researcher conducted a survey in Mburahati Barafu community in order to identify key problems facing this people. In May 2004 data was collected through distribution of structured questionnaires, observation and face to face interview to the leaders and sampled respondents in Mburahati Barafu. The information was to complement the information the Researcher had already collected from available literature and other sources within MBADECO and government offices in the project area.

Through reviewing MBADECO documents, the profile of Mburahati Barafu was established and small sample size of 120 respondents was randomly selected from the population of 10,673 to represent the entire community. Out of 120 respondents, 56 i.e. 51.9% were women and 52 i.e. 48.1% were men. Data analysis was through descriptive statistics: Data was edited, coded, tabulated and analyzed using SPSS program, frequencies were done to determine variables mostly identified as the main problem in the community.

3:1 Research Approach and strategy.

From May 2004 a research/survey through structured questionnaires, face to face interview and observations was conducted. Structured questionnaires were dropped in Mburahati Barafu in order to obtain some important information that will lead the assessment of the community needs and prioritization and hence coming up with appropriate interventions to address their problem. The research team consisted of 7 persons including 4 leaders and the author who was a principle researcher.

3:1:1 Sampling Techniques

Probability sampling also known as random sampling was used, whereby every item of the universe has an equal chance of inclusion in the sample. Thus 120 people were selected randomly in the community population of 10,673 adult women and men. 120 people as a sample size was chosen due to resource constraint i.e. finance constraint, otherwise the big sample size could have been chosen.

3:1:2 Data Collection Methods

This research was recognized as a social study, which employs social science approach/ strategy to get access to useful data and information. The approach which was used in data collection was that which is usually used in social survey, histories or archives. Qualitative and quantitative methods of data collection were employed to get useful data for this study from both Primary and Secondary data sources;

(i) Primary data were obtained from Mburahati Barafu Community through survey by using a structured questionnaire, interviews and observations.

(ii) Secondary data. Under this source, information relevant to the research was mainly gathered from MBADECO records (offices) and outside the research area such as from Tanzania Beaural of statistics, Kinondoni Municipal Medical Services and Tanzania Ministry of Health.

The four main methods were employed, namely; documentary sources, interviews, questionnaires and observation

Documentary

The following documents and data were used to obtain secondary data;

i. Library through readings books, documentary reports, and records.
ii. MBADECO Memorandum, Records of accounts (financial statements, books of accounts), Meeting minutes, and so on.
iii. Various MBADECO reports.

Interviews

Interviews were conducted to the leaders of MBADECO.These were supplemented by discussions and on site observations.

Questionnaires

I conducted pilot study for pre- testing the questionnaires in order to rehearsal the whole process of main survey. Then structured questionnaire forms were distributed to the community people.

Questionnaires were administered to 120 Mburahati Barafu community people; both open and close questionnaires were used. The interviews and questionnaires were used concurrently in order to improve the accuracy of information from respondents. A sample of the questionnaire is attached appendix III

3:2 Methods employed in data analysis included;

Descriptive statistics: Data was edited, coded, tabulated and analysed using SPSS program, frequencies were done to determine variables mostly identified as the main problem in the community.

CHAPTER FOUR

4:0 FINDINGS AND CONCLUSIONS

I conducted a survey in order to establish the needs of establishing a health centre in Mburahati Barafu.

On 25 of May 2004, I sent structured questionnaires to the community people in order to verify their needs and prioritize them and to affirm whether are the same as those of the leaders or not. The research process was designed for achieving valid information useful in decision-making and building a common vision and consensus across the community. Needs assessment research requires a "triangulation" of findings across various levels and groups. As a consequence, it is important to ascertain whether the responses from the various groups and levels corroborate or conflict with each other.

There are several reasons why citizen groups, public officials, and local government staff should secure accurate information about the needs of a community. All communities are in a continual state of change - through births and deaths of citizens, through people moving out and new people moving in, and through the natural growth and development of the community over time. As a consequence, what once may have been an appropriate policy or program can eventually become inappropriate. The character or attitude of a community can shift as a result of the interplay of social, cultural, and economic changes.

The needs of different groups of people in a community are difficult to identify and frequently interrelated. In many instances, people do not express their attitudes and feelings openly; sometimes community needs and opinions are not revealed until a crisis occurs. This makes priority setting and long range planning essential; however, planning and action cannot be carried out effectively without accurate and up-to-date information about citizen needs and desires.

A community needs assessment process is an excellent means of involving the public in problem solving and developing local goals. There is a tendency for people to resist change, frequently because they have inadequate information, or because they have not been involved in making decisions. A needs assessment can be viewed as a process of citizen involvement to allow people not only to learn more about the current situation, but most importantly, to feel that they have had a voice in the outcome. (Lorma Butler and Robert Howell, 1980)

4:1 Data Analysis

Data was edited, coded, tabulated and analysed using SPSS program, frequencies were done to determine variables mostly identified as the main problem in the community.

Method used: descriptive statistics

The sample size of 120 community people were chosen randomly and given questionnaire forms. Due to resource constraint i.e. finance, only 120 sample sizes were chosen.

Table 4.2 Gender Distribution

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	female	56	51.9	51.9	51.9
	male	52	48.1	48.1	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

Out of 120 people, 108 people returned the forms as follows:

56 female community people which is 51.9% were included in the research and 52 male community people were also included.

Table 4.2.1 Age distribution

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	15-20	16	14.8	14.8	14.8
	21-40	44	40.7	40.7	92.6
	41-60	40	37.0	37.0	51.9
	over 60	8	7.4	7.4	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

From the above analysis, the highest percentage was falling within the age range of 21-40 years- 40.7%. This implies that this was the reproductive group mostly affected by lack of health facilities in the community.

Table 4.2.2: Problems in the community

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	health centre	64	59.3	59.3	59.3
	water	12	11.1	11.1	70.4
	water, health centre & road	32	29.6	29.6	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

Out of 108 community people who retuned back the filled questionnaire forms, 64 indicated that lack of health center in Mburahati Barafu area as the main problem. These 64 people are 59.3% of total number of community people who were approached to identify their problem. This implies that lack of health services is main problem in this community.

3 people indicated water as the main problem in the area, this is 11.1%. And 8 people indicated that lack of health centre, water, and road are main problems in the area. Thus according to the results, lack of health centre is identified as the main problem in this area.

Table 4.2.3: Needs Prioritization

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	health centre	108	100.0	100.0	100.0

Source: Survey data by Author, 2004

108 community people prioritized health center, this was 100% of the total number of community people who filled and returned the questionnaire forms. This implied that lack of health facility in this community was the big problem.

Table 4.2.4: Difficulties in accessing health services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	96	88.9	88.9	88.9
	no	12	11.1	11.1	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

96 community people which is 88.9% showed that there is a problem in obtaining health services in their community. And 12 community people which is 11.1% showed no difficulties in obtaining health services. High percentage indicated that there is a problem in accessing health services.

Table 4.2.5: Distance from your locality to health centre

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	10 km	96	88.9	92.3	92.3
	over10km	8	7.4	7.7	100.0
	Total	104	96.3	100.0	
Missing	System	4	3.7		
Total		108	100.0		

Source: Survey data by Author, 2004

Table 4:2:6 showed that 96 i.e. 88,9% of the community people, indicated that they had to travel 10 km in order to access health services hence time and transport cost must be incurred, and this people fall under urban poor group implies that most likely these people would not be able to access health services.

Table 4.2.6: Are you ready to participate/contribute to social development activities in your locality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	104	96.3	96.3	96.3
	no	4	3.7	3.7	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

104 community people which are 96.3% are ready to participate in community activities 4 people which are 3.7% are not ready. This analysis indicated that the community people were willing to participate in community activities in order to achieve changes they would like in their community, this was a good indicator.

Table 4.2.7: What economic activities do you do to earn your living?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		4	3.7	3.7	3.7
	self employed	84	77.8	77.8	81.5
	employed	4	3.7	3.7	85.2
	unemployed	12	11.1	11.1	96.3
	student	4	3.7	3.7	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

The analysis data surveyed showed that, 84 respondents in this community were self employed -77.8% in informal sector whereby their earnings are very small.

Table 4.2.8: What is your contribution in social development activities in your locality?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid		4	3.7	3.7	3.7
	finance	12	11.1	11.1	14.8
	labour	88	81.5	81.5	96.3
	working material	4	3.7	3.7	100.0
	Total	108	100.0	100.0	

Source: Survey data by Author, 2004

Tables 4:2.9: showed that majority of correspondents, 88 people i.e.81%, were ready to contribute their labour in any of the development activities to be carried in their locality. Only 12 people i.e. 11% would be able to contribute in terms of finance and 4 people – 3.7% would be able to contribute working material. Contributions in labour or working material can be converted into money.

Conclusion and recommendation

Through needs assessment, the problem i.e. lack of health centre was identified and prioritized by the community people themselves. The solution was also obtained i.e. building of health centre in Mburahati Barafu Community. Thus according to the results, lack of health centre is the main problem in this community also the results showed that

96.3% community people are ready to contribute in kind, labour and finance which is a good sign.

Recommendation

Since health is a right for all, it is recommended that a health centre be constructed at Mburahati Barafu area through community participation but with the assistance of the Kinondoni municipal, NGO's and charitable organizations.

The findings also indicated Malaria as the main problem in this area; I suggest that a community-based malaria control program be anchored on grass-root participation as a community health initiative, with the support of personnel from the National Malaria Control Program.

Such a malaria control program will increase activities in malaria control, sensitize the local populations on the mosquito bite prevention and avoidance of potential mosquito breeding sites, early detection of symptoms and signs, standard dosage of SP for malaria episodes or as a prophylaxis in pregnant women.

CHAPTER FIVE

IMPLEMENTATION OF ASSIGNMENT

5:0 Design of the Project Proposal

5:1 Introduction

This chapter outlines the detailed description of a series of activities aimed at solving the problem of accessing health services. These included project justification and rational, activities and implementation time line, methodology, and human, material and financial resources required.

5:1:1 Executive Summary

Project Title: Project Proposal for Constructing a Health Centre for the Mburahati ward

Name of CBO: Mburahati Barafu Development Community (MBADECO)

Contact Person: Mr. John Kasongo, P.O.Box 78455, DSM, and Mobile no.: 744377264

Location: Mburahati Ward Kinondoni Municipal

Proposal submitted by: MBADECO

Problem statement

Tanzania, like many countries of the developing world, is faced with the challenge of providing adequate health services to all her people. However, available national resources, especially finance, are insufficient to implement this mammoth task. Consequently, under the Health Sector Reforms, the Government is working together with a number of other agencies to help realise this goal.

Within the Mburahati Ward there is a large population of 21,6o8 people that at present time do not have access to health services in their locality. Only one government clinic located near this area but it does not address all the needs for health services which are the rights of Mburahati Barafu community. In order to access these services the community people have to travel more than 10 km. The roads in this area are not well passable thus during the night it is difficult to find transport to access mother and child health services. As a result many expecting women deliver at home without been attended by health personnel. This causes a high incidence of maternal/child mortality, malaria, diarrhea, cholera and HIV/AIDS which are the common diseases hampering development in this community.

Project Vision

To have a modern health centre which will provide the best health services in Mburahati Ward.

Project Mission

To provide and access health services to Mburahati Barafu community through community participation by constructing a health centre in their locality.

Goal

The overall objective is to provide and access health services within their locality

Specific objectives

- To construct one health centre for the population of Mburahati Barafu Community in Mburahati Ward by 2008

- To reduce the barrier of accessing health services by 85% by 2008
- To provide improved health services to Mburahati Barafu Community by 2008
- To provide voluntary counseling and test services in the Mburahati Barafu Community by 2008
- To improve the quality of life in Mburahati Barafu Community

Target Group

Total population of 21,608 from Mburahati ward , of which 10,882 are males and 10,726 are females, and 53,794 people from the neighbourhood ward Makurumla, of which 27,493 are males and 26,301, are females, (this was once one ward only) will be the beneficiaries of the health centre project. The populations in these wards are of low income or no income at all, whereby majority of people fall under urban poverty group.

Activities

- Contact informal and formal leaders of the community people
- Organize and conduct a meeting of community leaders to identify problems.
- Conduct needs assessment to verify the need of health centre
- Meet Government officials of Kinondoni municipality for clarifying issues of land, provision of equipments, staff of the health centre and its contribution in terms of money in the first phase of construction
- Mobilize and sensitize community people for fund raising
- Approach donors to solicit fund for construction.
- Construct health centre in Mburahati Barafu
- Sensitize community people to use health facilities

Project Expected Results

a. Health centre constructed and in operation in Mburahati Barafu Community.

b. Barriers to access health services are reduced

c. Different health services provided to Mburahati Barafu Community

d. Provided voluntary counseling and test services in the Community

e. Improved the quality of life in Mburahati Barafu Community

Requested for funding: Tshs.174, 807,580 (USD 160,374)

Contributions are as follows:

Kinondoni municipal -10% of the total cost- Tshs 43,701,895 (USD 40,093)

Contribution from Mburahati and Makurumla ward (20%) Tshs. 58,269,193 (USD 53,458)

Special events 5% 14,567,298 (USD 13,365)

Budget required: Tshs. 291,345,966 (USD 267,290).

5:2 Project summary

The health centre project will comprise of one major component which will address the current main problem which is facing Mburahati Barafu Community People. According to needs assessment, through the survey, health centre is the major social problem facing Mburahati Barafu people. Thus in order to remove this barrier the Mburahati Barafu Community people came up with the plan of building Community

health centre which will provide health services to these community people as per national guideline standards for health facilities.

5:3 Detailed Project description

The project involves the construction of health centre which will remove the barrier to access health services in Mburahati Barafu Community and hence the reduced high incidence of child/maternal mortality, malaria, cholera, diarrhea, HIV/AIDS, and malnutrition. Health centre will provide health services which will improve the health and development of the community people, most importantly, women and children which are the most vulnerable group to access health services. Provision of medical care during pregnancy, at delivery and under 5 five year children is essential for the survival of both the mother and their infants/children. The health centre will focus on the aspect of Primary Health Care will involve the following programs:

5:3:1 Health education about common health problems and what can be done to prevent and control them.

Education concerning prevailing health problems and methods of preventing and controlling them will be promoted. Health education is an integral part of community involvement in Primary Health Care. The health of an individual, family and the community at a large is dependent on such factors as environment, social cultural traditions and life style. The individual and community are in a position to change the environment and his/her behavour to the betterment of the health status of the community. Health education will be provided by the variety of methods including mass

media, and the continuous development and dissemination of health education materials and through dialogues with community.

5:3:2 Maternal and child health care, including family planning and normal deliveries

Women of child bearing age are the prime targets for the health care delivery. Maternal health will be given a top priority in this project. Through mothers children are reached and consequently their health situation will also be improved. Maternal health care is a key element in health delivery; it is an integrated curative, promotion and prevention services which reduces deaths, diseases and disabilities among children and women of child bearing age. This project will provide comprehensive health education for mothers. It will provide opportunities for family planning to men and women, will provide care for women before, during and after delivery.

5:3:3 Promotion of proper nutrition

Adequate intake of nutritious food is essential for the promotion and maintenance of physical and mental health. A good nutritional state will enable individuals and families to lead social and economical productive health. This program will launch activities which promote and support household food security. The availability of adequate food in quality and quantity among vulnerable groups; children, pregnant women and breast feeding mothers will be promoted. Proper feeding practice (breast feeding and weaning

habits) in infants and young children will be encouraged. Nutritional diseases should be prevented or detected and treated early.

5:3:4 Provision of Immunization against major infectious diseases

Through immunization services, majority of children will be protected against measles, whooping cough, polio, TB, diphtheria and tetanus. This program will sensitize mothers, community the importance of childhood immunizations and solicit their active support.

5:3:5 Prevention and control of locally endemic diseases; and appropriate treatment for common diseases and injuries

Communicable diseases are the most common disease in Mburahati barafu community, thus major efforts must be directed towards prevention and adequate treatment of these diseases. Special program will be formulated to control against such diseases as malaria, diarrhea, TB, STI and HIV/AIDS. This will reduce mortality and disability caused by these diseases.

5:4 Project Implementations

Activity Plan

Activities/Tasks Implementation Time

Result: Health centre constructed and operational	Start	End	Responsibility
Activity 1.Contact informal and formal leaders of the community people	19/9/2003	19/9/2003	Consultant student
1.1. Organize and conduct a meeting of community leaders to identify problems.			
1.2. Conduct needs assessment to verify the need of health centre	6/10/2003	6/10/2003	CBO leaders, Consultant
1.3. Meet Government officials of Kinondoni municipality for clarifying issues of land, provision of equipments, staff of the health centre and its contribution in terms of money in the first phase of construction	25/5/2004	6/6/2004	student Community people, consultant student
1.4. Mobilize and sensitize community people for fund raising	5/6/2004	5/6/2004	CBO Leaders,
1.5. Approach donors to solicit fund for construction.			consultant student

	27/7/2004 8/10/2004	27/7/2004 8/10/2004	CBO leaders, consultant student CBO leaders, consultant student
Result: Barrier to access health services reduced Activity: 2. Construct health centre in Mburahati Barafu	January 2004	December 2008	Community people
Result: Health status improved Activity: 3. Sensitize community people to use health facilities 3.1. start health awareness program	January 2007 January 2007	January 2008	Management of health centre, CBO Management

5:4:1 Resource Plan for Activity

Activity	Resource needed	Cost in Tshs.
Construction of Health centre	1.1. building materials, electrical, +drainage and labour	264,859,969
Sub Total		**264,859,969**
Add 10% contingencies		**26,485,997**
Grand Total		**291,345,966**

5:4:2 Fundraising strategies

Kinondoni municipal -10% of the total cost- Tshs.	43,701,895
Contribution from Mburahati and Makurumla ward (20%)	58,269,193
Special events 5%	14,567,298
Donors	174,807,580
Total in Tshs.	**291,345,966**

Kinondoni municipal was contacted and agreed that it received the Participatory development plan from Mburahati ward, which among other things a health center was identified and prioritized as the main problem in Mburahati ward. According to the local government regulations, all the needs and priority must originate from the people at their wards/streets and forwarded to the councils.

However due to financial constraint the Kinondoni municipal could not react immediately to this problem, but accepted that (verbal talks with the health secretary of Kinondoni municipal) this area needs a health center and this will also reduce the overcrowding at Magomeni health center. And encouraged to continue with this plan and that Kinondoni municipal will contribute 10% of the total cost, will supply all necessary health personnel and all equipments necessary for a health center and will provide any support as deemed. Community people from Mburahati and Makurumla ward were sensitized to contribute and that 20% of the total cost will be collected from community people, the two wards have 5,000 households and each household will contribute Tshs.12, 000 which will be contributed on monthly basis i.e.Tshs.1, 000 each month commencing from June 2005 to June 2006.

In each ward fundraising committees of six people were formed to make a follow- up. A special account will be opened and community people may deposit their contributions directly to the account or to any member of a fundraising committee and given a receipt. Personal visits to individuals and local businesses will be conducted. Key businessmen were identified and contacted in order to contribute and participate in fundraising activities. Both councilors and a member of parliament for Ubungo constituency were contacted and informed of conducting the fundraising special event (to be carried in July 2005). Fundraising committee was empowered and advised to follow different donors for a piecemeal funding whereby the donors will get credit by given the space on the funded activity to write the name of his/her organization. Different donors like Plan

International, Care International, and JICA were identified. Tanzania Social Action Fund (TASAF) also will be contacted.

5:5:0: Project Management

This project will be managed by different stakeholders i.e. project committee from MBADECO, (Municipal Medical Officer of health, council Health Management which are responsible for coordinating and supervising all health services in the Kinondoni municipality) and Ministry of Health which will provide manpower to run this health centre as follows:

CLINICAL CADRE	NURSING CADRE	PHARMACY	PARAMEDICAL
Assistant Medical officer- 1 Clinical officers - 4	Registered Nurse Midwife- 2 Public Health Nurse B- 2 MCH Aides -2	Pharmaceutical Assistant 1	Trained Laboratory- 1 Medical attendant -2

5:5:1 Monitoring and Evaluation Plan

5:5:2 Monitoring plan

Monitoring will be carried out on a continues basis to check if the project implementation is going as per plan, this will help the management to check if there is any deviation, in order to take corrective measures as soon as possible.

This will be done in a participatory approach where by all stakeholder will be involved. There will be monthly meeting whereby a project management committee will present a monthly progress report to MBADECO Executive Committee.

5:5:3 Evaluation plan

Evaluation will be carried out to assess the degree to which the intended objectives have been achieved. Evaluation will be carried out as a continuous activity with the participation of all stakeholders of the project, most important beneficiaries.

The evaluation will be carried out by the project management committee from the CBO, which will represent the community people as beneficiaries and some officials from the health centre. They will assess whether the project objectives have been achieved

Six months after the commencement of health centre services, the project management committee from CBO will collect information from the analysis of health centre register books in order to:

- Gather records of number of men, females, children attended to the health centre to receive health services.
- Know different health services the centre is providing e.g. MCH, Health awareness programs, immunization etc.

Information will be obtained from the officials from a health centre and community people, also from project monitoring report

This will be done through reviewing of health centre registers records, conducting interviews with health staffs and community people.

5:5:4 Dissemination Plan

Different strategies will be used to disseminate information to different stakeholders. Both project management committee from CBO and the management of health centre will be liable to disseminate information to all stakeholders. This can be done through meetings, reports, brochures, news letter, by using electronic facilities, and mass media.

5:5:5 Sustainability

According to the nature and initiatives of this project, health centre will be owned jointly with the community people and the Government, the later is the main source of finances to run the health centre. The community people are ready to pay small fee for the services received in order to have a sense of ownership and commitment, and again this is must due to health sector reform of 1994. Also there is Community Health Fund initiated in 1995, whereby the Households in the CHF communities have the option of paying fee for services or an annual membership fee. The collections of membership are matched by Central Government. The community then determines how the total fund will be utilized- this is intended to expand Community participation and empowerment as well as mobilize local resources for health.

5:5:6 Budget plan

According to bills of quantity the total cost of construction is detailed as per attached bill of quantity, Appendix 4. With an addition of:

Tshs. 26,485,997 as contingencies,

Thus the grand total is Tshs.**291,345,966** (USD 267,290).

Kinondoni municipal will supply all equipments and health personnel necessary for a health center, commitment letter from Kinondoni Municipal to follow.

Concluding remarks

Health is the right for all, and the National Health Policy recognizes this and is emphasizing that, but due to resource constraints, the Government fails to provide health facilities to all. Thus through community participation needs assessment, these people identified the problem that is facing their community and find that the solution is to build health centre. Good health is the key of development because there is a vicious cycle between health and poverty. With ill health people cannot participate in production fully, and will cause income poverty which again will lead to poor health. Thus if this health centre is built in Mburahati Barafu Community the barrier to accessing health services will be reduced.

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