

CHCD/MEA

**Village Health Worker  
Network  
Tanzania**

**Annual Report 2007**



**Community Health Care Direct Trust  
working with Medicine Education Africa**

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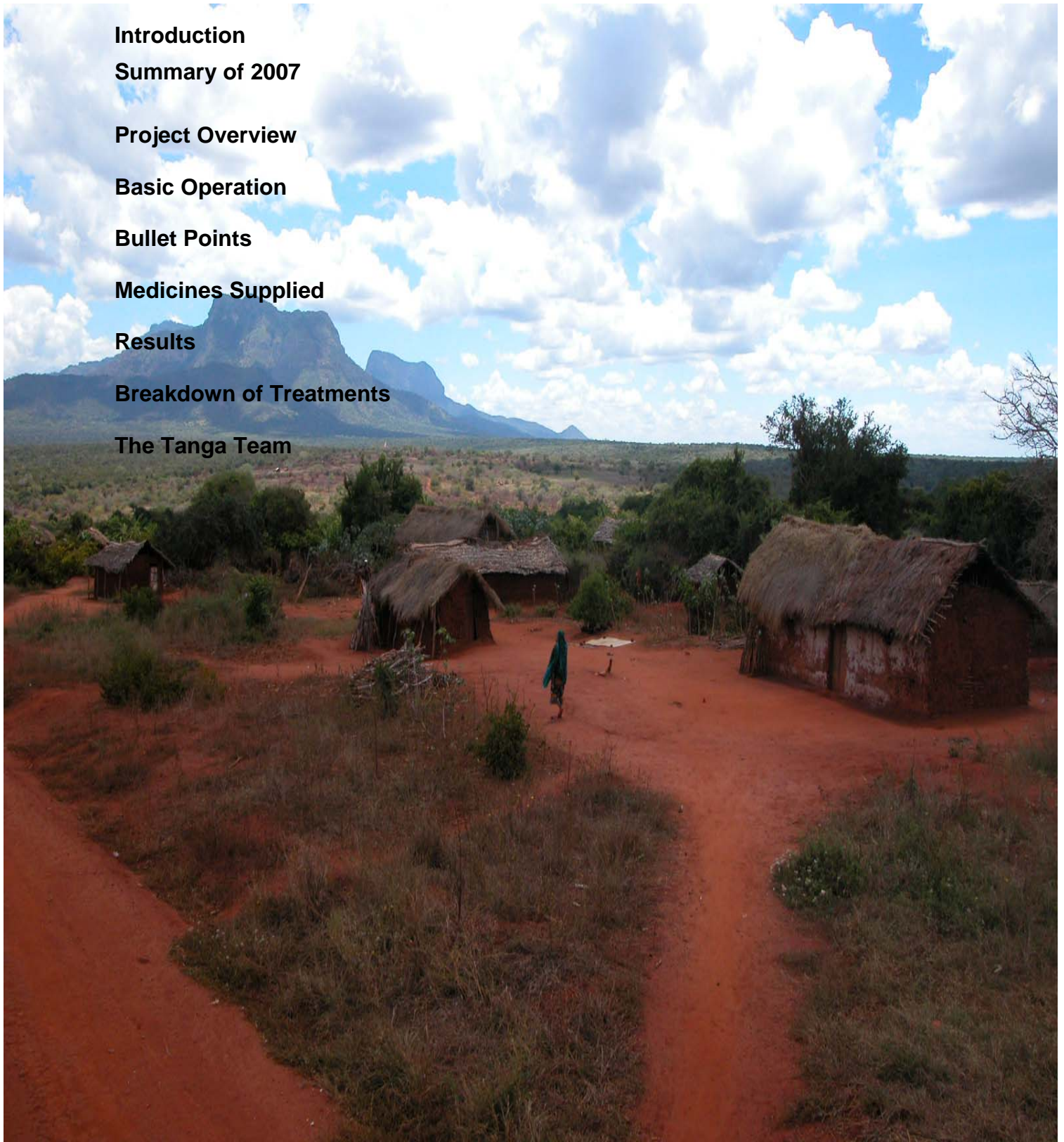
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# **Community Healthcare Direct.....**

## **Introduction**

At the end of 2007 CHCD celebrated its 14th year of operation. After 14 years we continue successfully to supply basic medicines to subsistence farming communities within Tanzania. No small achievement when one considers the fate of many other projects of this size attempting similar work.

Success has been achieved by holding true to the founding principle of supplying medicines to people in need by the most direct and expedient method possible. Our continued ability to achieve this relies on the loyalty of our sponsors and to the dedication of the small group of people in Tanzania who make it all happen.

Over the years our network of Village Health Workers (VHW's) has expanded from a handful to 265 by the end of 2006, serving 185 villages, in Muheza and Pangani districts of the Tanga region in North Eastern Tanzania. Our aim in 2007 was to expand further our coverage, and to try to ensure that each village had sufficient VHW support.

## **Summary of Trust Activities in 2007**

2007 saw a successful continuation of the Trust's main activity, which is to support a programme of drug and medical supplies to the network of Village Health Workers, which we train, and supply in Northern Tanzania. This programme has been in continuous operation since 1993, and has steadily expanded.

In 2007 we supported 280 VHW's with medicines and supplies for use in their villages, on a six weekly cycle. At the conclusion of each cycle, VHW's come in to a variety of centres to collect the next cycle's drug supplies, and to have the treatments they have concluded checked and discussed with our medical staff. This gives further opportunity to discuss the pattern of treatments and provide one to one training on their activities and performance.

We also provided refresher training to existing VHW's and initiation training to new workers, in a series of training sessions lasting three days.

A total of 296000 treatments was undertaken by our VHW's across the treatment areas we train them on and provide drugs and medical supplies. This is in a total

of 230 villages with a population of around 200,000, to whom the VHW's provide basic health support.

A new extension of our activities in 2007 was to use our distribution network of VHW's to supply anti-malaria bednets. While there are some extensive programmes aimed at providing bed nets across Africa, in the last resort, there are always problems with getting them to those who need to use them. Our area of Northern Tanzania is one of the world's hotspots for malaria, and anti-malarials are part of our standard medicines kit. The proven effectiveness of bed nets in preventing malaria especially in children under 5 where it can often prove fatal is clearly a benefit in the villages. How to get the bed nets to these villagers is an additional problem, since the cost of transporting them is considerable, even if there were sufficient resources available. However, we have started, thanks to a supply of bed nets from Rotary International from funds raised in the USA, to use VHW's to take them out to their villages in small quantities, which they can do every six weeks. All healthworkers have been given the opportunity to take up the bed nets themselves, so they can act as an example within their villages, and we also set up a system of vouchers for those in Tanga town who wanted to obtain them. In this way we distributed several thousand bed nets, and the system worked well. Nevertheless, there are still many thousands without the benefit of nets, whom we could reach when more supplies become available.

## **2007 Problems**

Operation in rural Africa is never straightforward, and we have had some issues this year, which have held up some of our ongoing development of the network. The most significant was the loss of our Landcruiser, which is used to take our supplies and staff to rural centres where VHW's can pick up their medicine kits (since they can be up to 50 km away). A major crash with another vehicle on a bush road resulted in the machine having to be written off. Fortunately no one was hurt, but this resulted in our having to cut distribution to two major outlets in Pangani and Amani, because of severe pressure on our funds. We managed to borrow the money to purchase a new vehicle, but there were various delays before we could get up to full operation again losing some three months on this part of the programme. Fortunately, we can report that all VHW's in these two areas are back with us and operating well.

The cost of the new vehicle remains with us as an important item, for which we shall need to obtain extra budgeted funds in this year.

There was also some fall away in the regularity of operation by certain healthworkers, which we are now addressing. This requires meeting and discussing the back up their villages are giving them. We already have a list of villages, which want to be on the programme, so replacements are available, but

we want to maintain the programme where we can in view of the training effort which has already gone in.

The recommended treatment for malaria was altered but availability of the new drugs proved to be nil, and imports were priced out of our reach. We compromised on maintaining the old treatment, and towards the end of the year prices improved on the new treatments, but for a period we had to cut the allowance, resulting in fewer treatments.

### **2008 Programme**

1. Re train and bring up to full effectiveness some 30 VHW's whose attendance has dropped off.
2. Train up to 20 new VHW's.
3. Update drugs for malarial treatment, and raise the amount for each VHW.
4. Finance the new Landcruiser, and expand the rural centres from which we operate to help VHW's keep on the programme and bring in new ones, by more intensive use of the vehicle.
5. Utilise VHW's for more bed net distribution, as supplies develop, from outside sources.

### **Project overview.**

CHCD solely funds a project, run by an NGO Medicines Education Africa, that supplies medicines directly to members of subsistence communities in the Tanga region, North Eastern Tanzania, East Africa. The project operates a network of 265 Village Health Workers (VHWs) across an area of approximately 15,000 Square Kilometres. The network provided in 2007 an annual total in excess of 296,000 treatments on a medical supplies budget of around 24,000 GBP and a total budget of around £45,000, including training, administration, and equipment.

The idea of VHWs had been tried across Africa and in the past has attracted a lot of donor funding. However, these efforts generally failed to produce any active health workers.

VHW projects were originally a joint initiative in the 1980's between large overseas organisations and The Ministry of Health. The idea was to extend the chain of health care down to the village level. The Village Health Post was



envisioned to deal with a limited range of problems using basic medicines supplied by the bottom level of the health service, the dispensary. This service would not only provide some treatments more conveniently to patients but also relieve some of the burden on the facility above.

However, the problem with this plan was that there was no way an already poorly supplied dispensary would ever find the resources to provide anything further down an already thin line.

This provided an opportunity for CHCD/MEA to help meet the demand for medicine in rural villages. March 1994, CHCD began contacting dormant VHWs, reviewing their skills and getting them operating by supplying medicines directly. As the network grew, new villagers were trained from scratch and an effective system to supply and supervise VHW's was developed.

## **Basic Operation.**

The medicines are supplied as a kit, allocated to individual VHW's for use by them under our supervision. Re-supply is conditional upon the VHW operating to our satisfaction and providing records of all patients treated, an account of all medicines dispensed and the return of all unused items.

Before a VHW can operate as part of the network, training is provided to ensure they know the correct use of the medicines and are able to comply with our accounting procedures. Additional refresher training takes place subsequently generally on an annual basis.

A kit stays in the field for six weeks, or one cycle, during which an average VHW will prescribe around 200 treatments. At the end of every cycle, each health worker undergoes a one-on-one interview during which compliance with standards of clinical and administrative practices are assessed.

## **Key Points About the CHCD system:**

### ***All resources purchased in Tanzania.***

Many other aid projects source key materials from the donor country resulting in part of the budget being repatriated, denying the local markets of revenue. Local sourcing of drugs and equipment by our project injects finance into the local economy.

### ***Locally operated***

MEA is a Non Government Organization registered in Tanzania, employing 6 Tanzanians who operated the network of village health workers

### ***Re-supply conditional.***

The kits are not handed over and forgotten about. The conditions we impose ensure that the kit has a 'value'. The threat not to re-supply is an incentive to VHWs to play straight.

One-on-One interviews every six weeks with our nurses allow us to review the VHW's work, spot problems, and work with them to improve performance.

## ***Not a parallel system.***

We are not in competition with any part of the local health care system; we add to it.

## ***Local Income generation.***

Kits are given free to the communities. However, we encourage the community to consider setting an optional contribution from the village for the treatments. This funds the cost of minor stuff (soap, pens etc), provides a place to work from, and some income



for the VHW. This key factor makes patients value the service and provides some sustainability their end of the project. This system is universally adopted and generates about £4/\$7 per kit in six weeks, a real incentive.

## ***Training***

Annual training programmes are provided for new VHW's and refresher courses for existing ones.

## **Medicines VHWs receive and treatments provided.**

This is very basic stuff, in African terms. No needles. The range of treatments is limited to 8:

- Malaria
- Pneumonia
- Anaemia
- Worms
- Conjunctivitis
- Dehydration
- Scabies
- First Aid



### Every six week a VHW receives:

Condition	Medicine	Amount and Type
1. Malaria	Sulphadoxine Pyrimethamine*	150 Tablets
	Aspirin	550 Tablets
	Paracetamol	650 Tablets
2. Pneumonia	Co-trimoxazole	45 Tablets
3. Anaemia	Ferrous Sulphate	300 Tablets
4. Worms	Albendazole	100 Tablets
5. Conjunctivitis	Tetracycline	5 tubes Ointment
6. Dehydration	Oral Rehydration Sachets	15 sachets
7. Scabies	Benzole Benzoate	400ml Lotion
8. First Aid	Bandages	10 rolls
	Plaster	1 5m roll
	Gauze	4 m
	Cotton Wool	100g
	Antiseptic	100 ml Solution

## Results

### Standard VHW Kits

During 2007 the VHW networks in Muheza and Pangani were supplied with 1,681 standard kits of medicines. In addition, Bilharzia treatments were arranged for relevant villages, although most are now receiving international aid through the schools. These kits and supplies were used by the VHWs to provide 296,000 treatments ranged across our Big Eight conditions covered by the kits and the VHW's training, which now includes worming.

We have made a number of visits to communities to treat people for Bilharzia, a parasitic worm which can result in 'river blindness'. The medicine we use is relatively expensive, so to ensure it is not wasted our mobile unit travels to specific locations and checks that treatment is necessary before supervising a blanket treatment days. This is now part of our general worming treatment programme.

*Bilharzia Day with VHW Daniel Cosmo at Upare, an old sisal estate*



### Income Generation

An important part of the project is the income generated by the communities to help pay for the operation of their health post. This normally comes in the form of patient contribution at the time of treatment. The average charge is 50 – 100/- TZ shillings ( 3-5 pence, 5-10 cents) This contribution is not compulsory and many receive treatment free of charge. Nonetheless, as a whole the networks generated over 11m shillings (£5000) during the year a significant amount in a rural economy.

## Breakdown of Treatments h

<b>Diagnosis</b>	
Malaria	84508
Anemia	23003
Pneumonia	16878
Dehydration	21137
Scabies	5251
Conjunctivitis	14718
1 <sup>st</sup> Aid	96606
Intestinal Worms	34436
Grand total	296,268

Overall this is down on 2006 by about 20%, principally in the area of malaria treatments and worms. ACT (Artemisinin Combination Therapy) has replaced SP as the recommended drug for malaria, in Tanzania, but we have faced considerable problems. Local production of SP has stopped and supplies are getting harder and more expensive to procure, while ACT was only available from overseas at an exorbitant price.

The amount of SP, still the only available drug, we gave to each VHW had to be cut to make stocks last, and this accounts for the drop in malaria treatments. By October SP became available again, but we have to plan for ACT even though supplies are not freely available yet.

The other factor, part of the usual series of crises that affects working in rural Tanzania, was the loss of our Land Cruiser which transports medicines and staff to the Pangani and Amani districts outside Tanga. A serious accident, in which fortunately no one was hurt, effectively wrote our vehicle off, and caused serious breaks in the delivery of drugs to these two areas. Fortunately we were able to obtain loans to purchase a new vehicle, and when this eventually arrived we managed to get our VHW's up to strength and operating well in the last quarter. This also contributed to the decline in treatments, but with a new vehicle our programme of kit distribution was back to normal by year end.

Malaria prevention is a big issue in Tanzania, especially for children, and we are able to provide a major distribution system to get bed nets out to the rural

villages. While there is a big international programme to provide bed nets, they are far from readily available in these areas. Our initiative to distribute bed nets took off when we took delivery of 1600 impregnated nets thanks to funding from the Rotary Club of Tanga, supported by a school in the USA. The direct ex factory cost is around 9500 Tsh (c £4.00) but this is too expensive for most villagers so these were offered at subsidized rates of 2500 Tsh (c £1.20) to VHW's for themselves and then for sale on to villagers. We also set up a voucher scheme where the urban population in Tanga could redeem them for bed net at a cost of around 3.000 Tsh. The cash from these is reinvested in more nets.

We continued our refresher training of VHW's, and also brought up to standard some lapsed VHW's who wanted to come back into the programme. With the distances of travel by foot or bicycle which many have, it is not perhaps surprising that some fall out. This does appear to have been a particular problem in the middle to end of the year, and we are carefully screening the 'no shows' and discussing with their village what the problem is. Signs in early 2008 are that this is starting to have an effect.

## **2008 Programme**

Our intention during 2008 is to consolidate our team of VHW's after the substantial increase last year, and increase our coverage of villages in the area, where this is possible. At the moment we cover rather more than half the villages in the area, so there is still considerable scope of for expansion of our established distribution system.

Our main concern is to supply recommended drugs for malaria, given the lack of supply and cost. We hope to be part of the government supplied scheme, which is not yet working well, and negotiations continue on this front.

Bringing the number of health workers operating regularly, up to previous levels is an important task, and expanding the number of villages just as soon as we have stabilized the current team.

Funding the new vehicle will be an important issue as the outlying districts cannot function without the visits we pay..

The other area of activity is more bed net distribution just as soon as the funding can be found for further stocks. The demand is high, and is to be counted in the tens of thousands, and we are a critical link in the distribution.

## The Tanga Team

Nothing would happen without our team of organizers and nurses who make the whole operation happen, with an efficiency of which we are proud.



*Mark Treserdern – Project Adviser*



*Clockwise –Hilda, Mwanakombo,, Halima, Judith, Angela, Dora*

### Medical Supervision

**Judith Mkondo (nurse)** organizes recruitment and training of new VHW's and oversees supervision of all operational health workers.

**Hilda Yohana (nurse)** interviews health workers checks details in their patient register books and assists with training.

**Mwanakombo Hamadi** promotes awareness of HIV/AIDS and organizes our voluntary counseling and testing programme. She is HIV positive.

### Administration

**Halima Msuri** issues new kits and audits those returned by health workers.

**Dora Boniface and Angela Boscoe** pack our kits and keep an audit trail of all medicines.

**Mark Treserdern** is CHCD adviser to the project and covers project development and fund raising plus anything else that needs doing, like making cupboards, un-jamming laminating machines, and the other few hundred issues that crop up on a daily basis.

## **Our Donors**

Finally many thanks to our donors, individuals, companies, and branches of Rotary International, who have supported this work.

A donation of £15.00 pays for one kit for six weeks, and treats 200+ patients, £120 provides medicines for a village for a year, £500 will treat 10 villages for bilharzia for a year, while £2000 pays to train 50 new health workers, to meet the expanding demand for village health care. We are looking to expand further in 2008 and contributions at all levels towards this work will go directly to supplying medicines and healthcare support to villages.

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