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Auditor General

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REPORT ON EXAMINATION

OF

TANZANIA MANPOWER TRAINING PROGRAM FOR

MATERNAL AND CHILD HEALTH AIDES

No. 621-11-580-121

Audit Report Number 3-621-76-48

Issue Date June 22, 1976

Area Auditor General Africa
Agency for International Development

TANZANIA MANPOWER TRAINING PROGRAM FOR MATERNAL AND CHILD HEALTH AIDES

I. INTRODUCTION

The Manpower Training Program for Maternal and Child Health Aides Project No. 621-11-580-121 started in June 1973. The goal is to assist the Government of Tanzania (TanGov) in achieving an institutional capacity to provide comprehensive Maternal and Child Health (MCH) services to the rural population as an integrated part of the Ministry of Health rural health program. As a means of achieving this goal, grant funds are used to finance the construction and equipping of 18 MCH aides' training centers and 51 outstations throughout Tanzania and to provide technical assistance to the Ministry of Health. Obligations and expenditures through December 31, 1975 were \$5,698,000 and \$2,271,000 respectively.

USAID/Tanzania has the basic responsibility for project implementation. The Regional Economic Development Services Office, East Africa (REDSO/EA) is involved in providing assistance to the construction phases of the project.

The purposes of our review were to (a) determine adherence to project agreement provisions, (b) measure to extent feasible achievement of project objectives, and (c) identify any problem areas requiring management attention.

II. SUMMARY

The most significant findings developed during the audit and presented in detail in the next section of this report are summarized below:

- A project contract technician arrived in country and began project duties some four months' prior to the contract amendment which established the position. We recommended that SER/CM review this situation and determine if a refund is due AID (page 2).
- The project contractor, Loma Linda University, has been remiss in providing USAID/Tanzania with required progress and financial reports. We recommended the reports be obtained (pages 2-3).
- Construction problems have caused 9 to 15-month delays in project implementation and there has been no formal project evaluation since inception in 1973. However, the USAID plans to conduct a comprehensive evaluation in mid-1976. We recommended that after completion of the evaluation, the PROP and other project documentation be revised as necessary (pages 3-4).

III. STATEMENT OF FINDINGS AND RECOMMENDATIONS

A. Project Contractor

AID may have paid for unauthorized services performed by a contractor employee.

Technical assistance to the TanGov's Ministry of Health (MOH) under this project is provided through a contract, AID/pha-c-1060, dated July 25, 1974, between AID and Loma Linda University, of Loma Linda, California. The original contract provided for the services of one doctor. A contract amendment, dated October 14, 1975, increased technician assistance by providing the services of two nurses. Although, as stated, the contract was not amended until October, 1975, correspondence indicates that one of the Loma Linda-provided nurses came on board in-country in late July 1975, some four months before the contract was amended to establish the assistance position.

USAID officials could not explain why there was delay in amending the contract or why the nurse came on board prior to the contract amendment. They stated further that communications between them and SER/CM concerning this contract have been, at best, poor. Contract data that might shed light on the subject is not available in the field. Therefore we do not know if the contractor was reimbursed for the four months of unauthorized service.

Recommendation No. 1

SER/CM should review the circumstances which may have permitted the hiring of, and payment for, a technician's services under contract AID/pha-c-1060 before the contract in question was amended to provide for such services. This review should be fully reported, including steps taken 1) to assure reimbursement for any funds expended incorrectly, and 2) to assure that steps are taken which would preclude the recurrence of such an event.

The contractor appears to be remiss in providing required progress and financial reports. We say "appears" because, as previously noted, communications with AID/W concerning this project have not been good. Thus, the contractor may have prepared the required reports, but they have not been received by USAID. In any event contract terms require

the contractor to provide reports directly to USAID and, if they have prepared progress and financial reports, they are remiss in not transmitting copies to USAID. These reports will enable USAID officials concerned to monitor contract and project implementation more effectively.

Recommendation No. 2

USAID/Tanzania should obtain from Loma Linda University the progress and financial reports required under the contract.

B. Implementation Delay

There are delays in construction of the 18 MCH aide training centers and of the 51 outstations. The reasons for these delays have been the reported shortage of building supplies and the lack of qualified contractors in Tanzania. As a result classes cannot be held and ultimately all the exigencies for which this project was approved, such as decreasing infant mortality, are set back.

Construction is 9-15 months behind the PROP schedule. By January 1975, 13 training centers were to be operational; yet only the first six centers had begun classes by September 1975 - a nine months' delay. The remaining seven are to be completed in the spring of 1976 or later - well over a year behind schedule.

The reason for this construction delay has been a shortage of building supplies in Tanzania, especially cement. Additionally, there is a lack of qualified contractors in remote areas of Tanzania.

As a result of these construction delays, classes cannot be held and MCH aides are not supplementing the staffs of rural dispensaries as planned. Ultimately the project goal is set back. A secondary result is escalating costs to the TanGov that come with delay.

We are making one recommendation concerning this finding which follows the next section.

C. Evaluation

There has been no comprehensive evaluation of the project since its inception in June 1973. The Mission commented that a full-scale evaluation has not been required because a monthly review is done by the Mission. However, the results of these reviews are summarized in Project Status sheets which are not specific and do not satisfy AID evaluation requirements.

We reviewed official records of the USAID and of REDSO/EA. In addition, we visited three training centers, one each in Bagamoyo, Morogoro, and Same. We discussed project activities with U.S. and host government officials. Our review covered the period from June 20, 1973 through December 31, 1975 for financial data and through February 29, 1976 for all other data. Project expenditures during the period under review amounted to \$2,271,000.

ANNEX D

MATERNAL AND CHILD HEALTH SERVICES IN TANZANIA

During the last decade, mainly as a result of the Arusha Declaration of 1967, Tanzania has pledged itself to rapid development of its large rural areas. This is in keeping with its national policy of socialism in which the government is attempting to spread the activities and benefits of development throughout its entire 15,000,000 population. Ninety three percent of this population is in the rural areas and still depends primarily on subsistence agriculture. One of the major steps in the rural development has been to bring scattered families together into cooperative villages where they can be reached with social services and can take part in community projects. More than 35 percent of the rural population now live in these ujamaa or "development villages".

All of these events carried significant implications for Tanzania's health care system. The already established pyramid of health auxiliaries needed to be rapidly expanded. The rural health units themselves needed to be increased in both quantity and quality. Both of these activities are already well underway as reported by Chagula and Tarimo (1974). By the end of 1975 there were nearly 1800 dispensaries and 160 health centres in the country. These were distributed so that 90 percent of the population lived within 10 km of some health facility, although coverage is considerably worse in some districts.

At the same time it was estimated that only 30 - 50 percent of the 3,000,000 children under five had had some contact with maternal and child health services. This resulted in an Infant Mortality Rate of around 160/1000 with an additional 90/1000 dying before five years of age, or a 25 percent under five mortality. Of the 650,000 mothers giving birth each year, it is estimated that 50 - 60 percent attend a clinic at least once for antenatal care, but a lower percentage actually deliver under trained supervision. This has resulted in an Institutional Maternal Mortality Rate of 2.5. Tanzania's Crude Birth Rate is now about 47 per 1,000, giving a Growth Rate of 2.3 percent.

A key issue was the kind of programs that should now be provided through these increased static units and/or the associated mobile teams to improve the level of health care. The existing pattern was of primary curative services being provided at the dispensaries and health centres and preventive programs operating mainly as mobile teams from a district and regional hospital base. Many of the preventive activities were organized as single disease oriented programs and a wide proliferation of auxiliaries had been trained for them. These included such cadres as the TB/Leprosy Home Visitor, the Malaria Orderlies and Assistants, Sleeping Sickness Orderlies/Auxiliaries, etc. Other categories such as the Health nurse, and later the Nutrition Instructors provided antenatal, nutrition and eventually immunization services.

In 1973 the Ministry of Health was reorganized into 3 divisions - Manpower Development, Hospital Services and Preventive Services. This made it possible to fulfill a long felt need noted by Titmuss (1964) and others for greater emphasis on preventive activities. But as existing programs were reviewed it became obvious that sufficient expansion of single purpose cadres to provide nation-wide coverage was unrealistic. Consequently the emphasis was shifted to multipurpose auxiliaries who would receive adequate basic training so they could cover a number of different primary care activities. These would be trained in sufficient numbers to allow them to be based at the dispensaries and health centres.

The three basic cadres which are now being trained for the dispensary based team are the Rural Medical Aid (RMA), the Maternal and Child Health Aid (MCHA), and the Health Auxiliary (HA). Students to be trained in each of these cadres are selected from primary school leavers, with a preference given to those who have had some experience in the health field. The RMA is trained for 3 years in simple curative and preventive services and functions as the team leader. The MCH Aid is trained for 18 months and provides comprehensive MCH services, including antenatal care, immunizations, family planning, nutrition services, health education and does simple deliveries. Health Auxiliaries also receive 18 months training and provide environmental sanitation services as well as various specific activities such as TB, leprosy, and malaria control. This basic dispensary team, along with 1 or 2 supporting staff provides primary health care for an average of 7-10,000 people.

The next level of health care above the dispensary is the health centre. This is a larger facility under the direction of a Medical Assistant, who is a secondary school leaver with 7 years of medical training. He is assisted by 1 or 2 RMA's, several trained nurse/midwives (primary school plus 3 or 4 years of training), several MCH Aids, and other supporting staff. A health centre has 20-40 beds for maternity cases, emergencies, and observations, a total work force of around 20-30 staff, and covers between 60,000 and 100,000 population. In principle it is the first line of referral from the dispensary and the Medical Assistant in charge is to provide supervision to those dispensaries in his catchment area.

Standardized curriculums and training programmes, as well as a complete scheme of services and upgrading pathways have been established for each type of auxiliary. A number of new training centres are being built with bilateral assistance to make it possible to meet the manpower projection goals for 1980. The following table shows the manpower figures and training centre expansion.

	1973		1976		1980	
	Training Centres	Output per year	Training Centres	Output per year	Training Centres	Output per year
Health Auxiliaries	1	33	1	44	6	380
MCH Aids/ Village Mid.	5	60	18	165	18	450
Rural Medical Aids	5	43	13	259	16	480
Medical Assistants	3	72	6	171	8	217

The older category of Village Midwives has been replaced by MCH Aids who are being trained in 18 new training centres.

MCH PROGRAMMES

As the complete health team becomes increasingly available in the rural areas it is possible and necessary to develop a new pattern of health care. This is particularly important for preventive activities, including maternal and child health services, for several reasons. First, the old pattern of intermittent visits by mobile teams to the rural areas resulted in rather poor coverage even where it was consistently maintained. This is partly because of the usual hesitation to readily accept newer services and also because it required special visits on particular days. Even those living near to established health facilities had to return on several different and specific days for the different services, such as under-5 clinic, antenatal clinic, and family planning clinic. The motivation that brings a sick child to a clinic for treatment was often not sufficient to bring a well child on another day for immunizations. And the newer and less understood services, like family planning, suffered even more. This problem occurred even in towns where distance was not a problem and the different clinics were operating several times each week. The attendances for curative services continued to climb, however, often exhausting both staff

and space. The disparity in coverage between it and preventive services even when it was being provided on the same day and in the same building. As is often the case, this sub-population was from the lower socio-economic levels and would have benefitted from the preventive services even more than the others.

Another major problem that threatened the old mobile clinic system was the world-wide oil crisis. The tremendous effects of these price increases on developing countries has been well documented. In Tanzania it meant that most of the district mobile teams exhausted their travel budgets within the first few months of the financial year and were idle after that. Even the usual problems of maintaining vehicles in adequate repair became increasingly difficult on tightening budgets.

It was in this context of severely limited budgets for the mobile teams, but increased numbers of rural health units and staff that the current program has developed. It was decided the primary preventive services should be provided as much as possible through the Rural Health Centres and Rural Dispensaries. This would be done largely by the use of MCH clinics to be run by MCH Aids and other auxiliary cadres. Each MCH clinic would offer comprehensive MCH services, including antenatal and postnatal care, immunizations, family planning, nutrition evaluation and advice, general health education, malaria chemosuppression, and simple treatment of diseases. More serious illnesses would be referred to the outpatient clinic to be seen by the RMA or Medical Assistant.

The other major decision was to try and increase the coverage of these clinics by making them more easily available to all mothers and children. It was felt to be particularly important to avoid the frequent occurrence of a child receiving treatment in an outpatient clinic, but then his mother being told to return on a "clinic" day for immunizations, antenatal care or other MCH services. Obviously an excellent opportunity to increase MCH coverage without transport or additional expense was being lost. To really capitalize on this, or in effect to exploit the drawing power of the most popular service - curative treatment - it was necessary to provide MCH services every day. This has now been initiated with the requirement that all mothers and children coming to the health unit for whatever reason must first pass through MCH clinic before they can be seen by the medical assistant or receive medicine. This mix of all mothers and children, sick and well, are individually weighed, evaluated, immunized, treated, etc. Only the more seriously ill ones are referred over to the front of the outpatient queue. There are obviously some exceptions to this general rule, such as the very sick child or one who is returning each day for treatment or dressings, but where the general pattern is now being followed the MCH coverage has noticeably increased.

The idea of a daily combined MCH clinic almost invariably met with resistance at first from the local clinic staff. They were often overworked in their weekly antenatal or children's clinic and saw a combination of these two on one day as impossible. The answer, of course, is that the MCH clinics are now every day so the work load is spread evenly throughout the week. This results in a more efficient use of both staff and facilities than the old pattern of overload one day and light work the next.

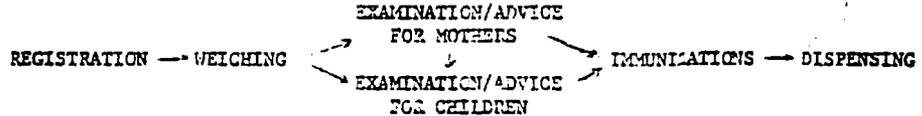
Experience has shown that it is best to effect the transfer from the old clinic pattern to the new one in 3 steps. The first step is to make comprehensive clinics out of the existing antenatal, children's or family planning clinics by adding the missing services, such as antenatal care and family planning to the children's clinics. This is done by encouraging mothers to bring all of their under-5 children with them at each visit. Again there are some exceptions to the general rule, such as the pregnant woman near term who is attending clinic each week. Mothers soon learn to check the return visit date marked on each child's Growth Card to know whether that child should be taken with them at that visit.

Once this first step has been accomplished and the staff and flow patterns have been reorganized to deal with the new system, the second step of starting new combined clinics on any remaining non-clinic days is taken. Although it usually takes some months to even out the workload with the new clinics, this can be hastened by giving return appointments for those days.

The final step is to require all mothers and children coming for outpatient treatment to pass first through the MCH clinic. This should only be done when the staff are familiar with the new pattern and have developed some degree of efficiency. This final step often results in a major shift of the workload of the institution away from the outpatient to MCH. With simple treatment being part of MCH services, only a small proportion of the sick mothers and children need to be referred to the medical assistant in outpatient clinic for further evaluation and treatment. In larger clinics, this change in workload often requires the reassignment of some staff from outpatient to MCH clinic.

FLOW PATTERN

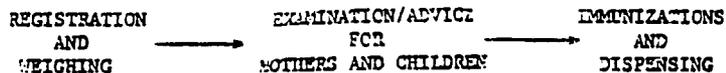
The activities of a combined MCH clinic are divided into 5 basic stations. First is Registration of mothers and children which is simplified by the use of an MCH report form based on the "5 nought" tally system. Then both children and pregnant mothers pass the Weighing station where their weight is recorded on their individual cards. Next is the Examination/Advice station, which in larger clinics is divided into separate stations for children and mothers. The final 2 stations are Immunizations, which provides the standard 5 immunizations for children and tetanus toxoid for pregnant mothers, and Dispensing, where chloroquine, folic acid and iron is given to all pregnant mothers, chloroquine to all children, and any other simple medications or food supplements that may be indicated. Diagrammatically, the system is as follows:



A woman attending without children would by-pass the Examination/Advice station for children, and likewise a mother bringing children who was not then pregnant or on a family planning method would bypass the mothers station. When both a mother and her children are eligible for MCH services, they pass first through one Examination/Advice, then the other.

The registration and dispensing activities are usually done by a Nursing or Dispensary Assistant without formal training, or even a non-medical worker such as a driver or sweeper. Taking the weights and recording them accurately, and immunizing, require more training and are done either by Nursing Assistants who have had specific orientation or Health Auxiliaries. This leaves the examination/advice station at the heart of the clinic, and this is manned by a qualified health worker such as an MCH Aid.

In a dispensary the clinics are smaller and the staff less. There the flow pattern is abbreviated into 3 stations:



All staff are encouraged to give individual health education at each of the different stations.

MCH SUPPLIES

A primary requirement for the success of the programme is its ability to provide consumable MCH supplies to the rural areas on a regular basis. Secondly and also important, this helps to maintain the health workers' morale and their status in the local community. These basic supplies include vaccines, certain medicines (chloroquine, folic acid and iron), cards and report forms, food supplements, and kerosene for the refrigerator and sterilizer.

Vaccines are probably the most important part of the programme as well as being the most difficult to deliver safely to the clinics. Our vaccine distribution system is based at a large central vaccine holding area that has been established in the Ministry of Health. This includes a walk-in cold room as well as a number of smaller refrigerators and freezers. All vaccines coming into the country are taken directly here from the airport. Then every 3 months a distribution list is made up specifying the amount of each vaccine to be sent out to each of the 20 regions. Each region's supplies are packed in insulated cold boxes that have been locally constructed. These are then distributed on the scheduled commercial flights of East African Airways to the various regions. Fifteen of the 20 regions have regular flights into their regional headquarters. For the remaining 5 regions, vaccines are distributed to the closest airport and then picked up by land transport. A region is always notified by telephone on the morning a shipment is sent, so the chances of vaccines being left at the airport without refrigeration is minimized. Refrigeration facilities are available at each of the regional and district hospitals where the vaccines are stored until they are further distributed in insulated boxes to individual clinics.

Because the clinics are now usually daily, the attendance on individual days is much smaller than the previous monthly clinics. This has required a shift away from the large 50 and 100 dose vials of vaccine in favor of the 10 or 20 dose vials. Though cost per dose increases, the drop in wastage rate partly compensates, and more importantly the local staff are much less likely to refuse immunizations to a few children because they don't want to waste the rest of the vial.

Most of the other supplies - medicines, cards and report forms, and food supplements - are distributed by commercial land transport. Experience has shown it profitable to distribute a 6-12 months supply of nonperishable items at a time. It is frequently possible to send back supplies to the regions in vehicles that have come to the capital for other business, but have extra room. A section of the monthly report from each district shows how much of each supply has been used and how much is remaining in stock at the end of each month. This can be used to establish the monthly usage rate and thus anticipate and meet demands.

Kerosene is the only other consumable supply and this is regularly being distributed to the district level by commercial companies. It is imperative to have two 20 litre tins for each refrigerator. One tin will last 1 month and can then be taken for refilling while the second one is being used.

CLINIC CARDS AND REPORTS

The difficulties of keeping any kind of useful clinic records in rural areas are considerable. The usual dusty register in which are written each patient's name, age, village, symptom or tentative diagnosis, and treatment absorbs considerable time without compensating usefulness. As in some other developing countries, Tanzania has adopted the system of individual MCH records for mothers and children which are kept in a plastic bag at each home. Usually within 6 months of starting a home based record system, the number of mothers who lose or forget their cards is down to 1-2%, so duplicate records are not kept at the clinic.

Three types of cards are used - a Growth Card for children, an Antenatal Card for mothers, and a Family Planning Card. Each child is issued with a Growth Card at birth, or at the first clinic visit if it was a home delivery. On one side this card contains a weight for age "Road to Health" chart along with a number of potential risk factors that should be evaluated at each visit. These risk factors and the weight for age areas of 60-80% are color-coded to show the appropriate action to take. Three levels of action may be indicated - more thorough and frequent evaluation at the MCH clinic itself, referral to the FMA at the associated outpatient clinic, or referral to the health centre or hospital. On the back of the Growth Card is the identifying information of the child, his immunization record and two columns for clinic notes. This card is to serve as each child's complete clinic record so all notes by any health worker, except for inpatient records, should be recorded on it only. If it is filled up, a continuation card is clipped inside. This is to avoid the old and confusing practice of 2 separate records for each child - one when he was well and attending child welfare clinic, and another when he was sick and attending outpatient clinic. It also makes available at any health care visit a complete summary of the child's immunization status, chloroquine use, weight change, and any previously treated diseases.

The Antenatal Card is also designed around the concept of identifiable risk factors with specific levels of action to take for different ones. There are 3 different groups of risk factors on the card - those associated with the medical and obstetric history, those arising during the antenatal period, and those coming from labor and delivery itself. Identification of the antenatal risk factors follows directly from the routine antenatal checks, where abnormal values are indicated for the various examinations. The labor and delivery section follows a similar system. The final section of the card is a complete summary of the current pregnancy which is filled in after delivery, then cut off the card and given to the mother to keep until she registers for her next pregnancy.

Education about child spacing is available in every MCH clinic and is particularly promoted throughout the antenatal period and during the first 2 years after birth. When a mother wants to start using a particular method, a child spacing card is issued and her program charted on that. Plans to revise this card to include simple criteria for method selection, along with associated risk factors, are currently under way.

MCH clinic statistics are collected from several stations in the clinic on a special tally sheet based on the "5 nought" system (00000). This sheet includes statistics for both mothers and children and is divided into 5 separate sections. The first section, filled at the registration station, records the number of first and reattendances of children and mothers. The second section asks for specific "indicator" diseases or complications. These include such things as underweight, kwashiorkor, marasmus, severe anaemia and measles for children and hypertension, severe anaemia and those with more than 3 pregnancies for pregnant mothers. By establishing the percentage of total attenders with these different conditions, a rough indication of the community situation is obtained. Other problems are treated or referred as necessary, with notes being written on individual cards. But only those specific conditions requested are reported centrally.

The third section of the tally sheet records the total child spacing acceptors and continuers by different methods. The fourth section is immunizations which includes BCG, smallpox, DPT, polio and measles for children, and tetanus toxoid for mothers. The final section includes the number of children receiving food supplements (given to malnourished children only) and whether that clinic is following the national plan of malaria chemosuppression for all pregnant mothers and under-5 children. Each clinic submits its completed monthly report to the district where a comprehensive district report is compiled and sent both to the region and Ministry of Health.

MCH EQUIPMENT

One of the major implications of this new MCH programme is in the area of equipment. If each health facility is to provide daily, integrated MCH clinics, it is imperative that they have their own equipment and ability to store vaccines. Neither electricity or natural gas is sufficiently available in rural Tanzania to make it possible to use them as an energy source. Consequently initial reliance is being put on kerosene refrigerators and a quantity of 700 has been purchased and distributed to the districts. The other equipment making up the basic "MCH kit" is a Salter hanging scale for weighing of children, a bathroom type scale for weighing of mothers, a sphygmomanometer, small kerosene sterilizer, stethoscope, obstetric stethoscope, and syringes and needles. With this basic equipment, an MCH clinic can be run. The initial 700 kits will be sufficient for all health centres and those 500-600 dispensaries with trained staff capable of providing MCH services at this time.

It is legitimate to question the advisability of such large scale dependence on kerosene refrigerators in view of widespread experience showing their low reliability. Obviously this was a matter of considerable discussion in Tanzania. Our current experience shows that where one person is given full responsibility for the refrigerator, and he receives careful training in its maintenance and cleaning, we have achieved an acceptable level of reliability. UNICEF has sponsored a special programme (Young Child Protection Programme) which provided this basic MCH equipment, including an 34-litre kerosene refrigerator, to all dispensaries in three "Model Districts". This project and equipment has been in operation for nearly a year now in a total of 58 health centres and dispensaries. Extra spare lamp glasses and wicks are available for the refrigerators as necessary, but very few have been needed. After a series of seminars introduced the MCH plan, including maintenance of equipment, these refrigerators have continued to function well with only occasional units being temporarily out of order. A greater concern is temperature fluctuation during normal running. An evaluation of this is under way by the use of both maximum/minimum thermometers and testing of vaccine potency after a period of time at the dispensaries. For the national programme, refrigerator maintenance has been included in the MCH Aid curriculum, and one of the standardized units is provided to each school for the students to practice with. It is hoped that continued technological development can increase the reliability of these units, or develop reasonable alternatives, as the need for rural non-electric refrigeration will remain great for some years.

A series of seminars for all health workers, from the doctors to the nursing assistants, has now been held throughout the country to introduce the MCH programme. These seminars have included such things as transport and care of vaccines, immunization and other clinical techniques, use of the MCH cards and report forms, and maintenance of refrigerators. The existing mobile teams are encouraged to gradually shift their function into a mobile supervisory/teaching/supply distribution unit. This is particularly important during the first few months as the equipment is distributed and the programme starts in different areas. Later a monthly or even every other month visit is sufficient for bringing supplies and maintaining supervision, and yet will control and in most cases decrease the petrol expenditures.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 73 to FY 82
Total U S Funding \$10,853,000
Date Prepared: October 30, 1974

Project Title: MANPOWER TRAINING PROGRAM FOR MATERNAL AND CHILD HEALTH AIDES Project No. 621-0121

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To assist the TanGov to expand and improve a country-wide health care delivery system as one of the components of rural development to increase the health, well being, and the quality of the life of the rural population.</p>	<p>Measures of Goal Achievement:</p> <ol style="list-style-type: none"> 1. Successful implementation of TanGov rural health program as outlined in the TanGov's Second and Third Five Year Development Plans (1969/74; 1975/80). 2. Use of various statistical parameters such as crude birth rate, crude death rate, and infant mortality rate as determined by sample surveys. 	<ol style="list-style-type: none"> 1. Expansion and improvement of RHCs and RDs. 2. Decrease in crude birth rate from 45.6 to 41.1, crude death rate from 17.7 to 16.1 and the infant mortality rate from 152/1000 to 137/1000 as determined by sample surveys. 	<p>Assumptions for achieving goal targets:</p> <ol style="list-style-type: none"> 1. Continued TanGov commitment to improvement in the health care delivery system. 2. Continued donor support to the TanGov health care program. 3. Improvement in other socio-economic and health parameters such as education, nutrition and transportation. 4. Ability and desire of the TanGov to perform measurements of various health parameters.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project: _____
From FY 73 to FY 82
Total U.S. Funding \$10,853,000
Date Prepared: October 10, 1976

Project Title: MANPOWER TRAINING PROGRAM FOR MATERNAL AND CHILD HEALTH AIDES Project No. 621-0121

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Project Purpose:</p> <p>To assist the TanGov achieve an institutional capability to provide comprehensive MCH and child spacing services to the rural population as integrated parts of the MOH rural health program.</p>	<p>Conditions that will indicate purpose has been achieved: End of project status.</p> <ol style="list-style-type: none"> 1. Approximately 80% of rural population within reach of MCH and child spacing services. 2. MCH facilities adequately supplied with drugs, contraceptives, etc. 3. 60-70% of women of child-bearing age utilize MCH facilities and personnel. 	<ol style="list-style-type: none"> 1. Comparison of RHC and RD sites with population concentrations. 2. Spot surveys of the availability of supplies at RHCs and RDs. 3. Sample surveys of use patterns in rural communities. 	<p>Assumptions for achieving purpose:</p> <ol style="list-style-type: none"> 1. RHCs and RDs are built or improved in areas where there is an unmet need for services. 2. Adequate transportation and fuel are available. 3. The quality of the services provided is acceptable to women and outreach activities are maximized.

**PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK**

Life of Project: _____
 From FY 77 to FY 82
 Total U.S. Funding \$10,831,300
 Date Prepared: October 14, 1976

Project Title: **MANPOWER TRAINING PROGRAM FOR MATERNAL AND CHILD HEALTH AIDES** Project No. **621-0121**

NARRATIVE SUMMARY	OBJECTIVE / VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>Outputs:</p> <ol style="list-style-type: none"> 1. Trained MCHAs. 2. Delivery of MCH and child spacing services. 3. Improved logistics/supply distribution system. 4. Improved supervisory capability within the MOH's MCH program. 5. Improved facilities and vehicle maintenance capability for the rural health program. 	<p>Magnitude of Outputs:</p> <ol style="list-style-type: none"> 1. 2250 MCHAs and village mid-wives trained and providing services. 2. The level of MCH and child spacing services is increased by 10% each year between FY74 and FY81. 3. No RHU or RC is without supplies for any period longer than two weeks. 4. An MCHA supervisor is assigned to each region and district. 5. Facilities and vehicle maintenance unit is established specifically for RIC and RD needs within each region. 	<ol style="list-style-type: none"> 1. Records from the MCHA training sites and the RICs and RDs. 2. Service records at each RIC and RD. 3. Supply records at each RIC and RD. 4. MOH staffing pattern. 5. MOH organizational chart. 	<p>Assumptions for providing outputs:</p> <ol style="list-style-type: none"> 1. Ability of the MOH to absorb the trained MCHAs into the health system. 2. Development and maintenance of a management information system. 3. Development of a supply distribution and data recording system. 4. Commitment of the MOH to improved supervisor and continuing education for its MCHAs. 5. Commitment of the MOH to a program of continuous maintenance for buildings and vehicles.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY 79 to FY 82
Total U.S. Funding \$10,853,000
Date Prepared: SEPTEMBER 1978

Project Title: MANPOWER TRAINING PROGRAM FOR MATERNAL AND CHILD HEALTH AIDES Project No. 621-0121

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS														
Inputs: (U.S. \$000)	Implementation Target (Type and Quantity)		Assumptions for providing inputs:														
<table border="0"> <tr> <td></td> <td style="text-align: right;"><u>TOTAL</u></td> </tr> <tr> <td>1. Personnel 1,083</td> <td style="text-align: right;">520</td> </tr> <tr> <td>2. Participants 561</td> <td style="text-align: right;">600</td> </tr> <tr> <td>3. Commodities 1,342</td> <td style="text-align: right;">843</td> </tr> <tr> <td>4. Other Costs 527</td> <td style="text-align: right;">600</td> </tr> <tr> <td>5. CONTRACT SERVICES</td> <td style="text-align: right;">1000</td> </tr> <tr> <td></td> <td style="text-align: right;"><u>TOTAL 17354</u></td> </tr> </table>		<u>TOTAL</u>	1. Personnel 1,083	520	2. Participants 561	600	3. Commodities 1,342	843	4. Other Costs 527	600	5. CONTRACT SERVICES	1000		<u>TOTAL 17354</u>	<ol style="list-style-type: none"> 1. 168 Person months of services rendered. 2. 600 Person months of participants training received. 3. Commodities (supplies, vehicles, equipment) delivered. 4. 18 MCHIA training facilities constructed. 5. 4 Local research projects performed. 6. 1 distribution system established. 	<ol style="list-style-type: none"> 1. Payroll records. 2. Invoices from training institutions. 3. Bills of lading. 4. Site inspections and contractor's invoices. 5. Project reports. 6. Quarterly and Annual Project Reports. 	<ol style="list-style-type: none"> 1. Continued USG priority for health and population support activities. 2. Continued TanGov priority for rural health programs. 3. Ability of TanGov to provide matching funds for USG input.
	<u>TOTAL</u>																
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<p>TOTAL US & TANGOV INPUT 90382 <u>91,883</u></p>																	

ANNEX F

COUNTRY:	PROJECT NO.:	PROJECT TITLE:	DATE:	() ORIGINAL (X) REVISION #i	APPROVED:
Tanzania	621-0121	Manpower Training Program for Maternal and Child Health Aides			
CPI DESCRIPTION					
1.	6/73	Project Design, PROP, 1st PROAG completed. PIO/Ts and PIO/Ps issued.	12.	8/76	Second group of participants departed for training at LLU.
2.	6/74	Construction started on first group of 18 MCHA Training Centers.	13.	10/76	11 Participants (including one short-term) returned and assigned to MCHA project or allied fields.
3.	8/74 7/76	Contract MCH Physician arrives. Replacement arrives.	14.	10/76	TanGov assumes 20% of recurrent costs for MCHIATCs.
4.	4/75	Construction all MCHIATCs under way.	15.	10/76	Public Health Nursing Upgrading program for Grade "B" nurses open - Graduates will work in MCHA program.
5.	7/75	First Nurse Educator (Contract) begins duties.	16.	11/76	PP Revision and Project Design updated for MCHA Project in line with recommendations of evaluation team, TanGov, Contract Team and USAID.
6.	9/75	Last of first group of participants (10) depart for one year training at Universities in U.S.	17.	11/76	Order 2-year supply contraceptives for delivery 1977 and use late 77 & 78.
7.	9/75	Six MCHIATCs opened for 6-month village midwife upgrading program (First Cycle).	18.	12/76	Contract for logistics and distribution specialist to determine needs for MCH/Child spacing supply system.
8.	3/76	8-week Principal/Nurse Tutor program completed.	19.	3/77	Consultant's design for MCH/child spacing supply system reviewed with MOH/USAID.
9.	5/76	<u>First cycle</u> of MCHAs graduates (161) assigned to field to provide MCH/child spacing services.	20.	4/77	Construction Basic Units 18 MCHIATCs completed (estimated).
10.	5/76	14 MCHIATCs open for regular 18-month Training Program (Second cycle).	21.	4/77	Supply Distribution system prepared and implementation started.
11.	8/76	<u>Second</u> Nurse Educator begins work - LLU Contract team now complete (MCH physician replacement in place. See (3) above.			

COUNTRY: Tanzania	PROJECT NO.: 621-0121	PROJECT TITLE: Manpower Training Program for Maternal and Child Health Aides	DATE:	() ORIGINAL (X) REVISION #1	APPROVED:
<u>CPI DESCRIPTION</u>					
22.	5/77	18 MCHATCs open for regular training programs (third cycle).	33.	6/78	All construction completed includes additional living quarters for staff.
23.	5/77	TanGov assumes 20% of recurrent costs for 8 MCHATCs.	34.	6/78	Approx. 10 participants return to work in the project (Total returned long term 31).
24.	7/77	First group of Public Health Nurses Grade "A", graduate - Assigned to MCH.	35.	8/78	Participants depart for training - Fourth group.
25.	8/77	10 participants return to work in the project (total returned long term 21).	36.	10/78	TanGov assumes 60% of recurrent costs for 6 MCHATCs.
26.	8/77	Third group of approximately 10 participants start one-year training in U.S.	37.	11/78	Third cycle of MCHAs graduate (approx. 450) and assigned to field. Total 1000 MCHAs now providing MCH/Child spacing services.
27.	10/77	TanGov assumes 40% of recurrent costs for 6 MCHATCs.	38.	11/78	Contraceptives arrive as ordered 11/77.
28.	11/77	<u>Second cycle</u> of MCHAs graduate (approx. 400) assigned to field. Total 560 MCHAs providing MCH/Child spacing services.	39.	11/78	Order one year supply contraceptives for use starting late 1980.
29.	11/77	Contraceptives arrive and their distribution begun.	40.	1/79	Second group of Public Health Nurses Grade "A" graduate and assigned to MCH.
30.	11/77	Order one-year supply contraceptives for use starting late 79.	41.	5/79	TanGov assumes 60% of recurrent cost for 8 MCHATCs, and 40% for 4 centers.
31.	5/78	TanGov assumes 40% recurrent costs for 8 centers, and 20% for 4 centers.	42.	5/79	18 MCHATCs open for regular training programs (Fifth cycle).
32.	5/78	18 MCHATCs open for regular training programs (Fourth cycle).	43.	8/79	Return of participants and sending participants as agreed.

COUNTRY: Tanzania	PROJECT NO.: 621-0121	PROJECT TITLE: Manpower Training Program for Maternal and Child Health Aides	DATE:	() ORIGINAL (X) REVISION #1	APPROVED:
<u>CPI DESCRIPTION</u>					
44.	7/79	Replacement or renewal of contract for MCH Nurse - education.	55.	10/80	TanGov assumes 100% recurrent expenses for 6 centers.
45.	11/79	TanGov assumes 80% of recurrent costs for 6 MCHIATCs.	56.	11/80	Fifth cycle of MCHAs graduate (approx. 450) and assigned to field (Approx. total 1800.)
46.	12/79	Fourth cycle of MCHAs graduate (approx. 450) and assigned to field (total approx. 1400)	57.	11/80	Contraceptives arrived as ordered 11/79.
47.	11/79	Contraceptives arrive as ordered 11/78.	58.	11/80	Order one year supply contraceptives for use starting late 1982.
48.	11/79	Order one year supply contraceptives for use starting late 1981.	59.	5/81	TanGov assumes 100% recurrent costs for 8 Training Centers. (Total 14 centers - see 52.)
49.	5/80	TanGov assumes 80% recurrent costs for 8 Training Centers.		5/81	TanGov assumes 80% recurrent costs for 4 Training Centers.
	5/80	TanGov assumes 60% recurrent costs for 4 Training Centers.	60.	5/81	MCHIATCs open for regular training programs (Seventh cycle).
50.	5/80	18 MCHIATCs open for regular training programs (Sixth cycle).	61.	8/81	Nurse educator completes assignment. LLU contract completed.
51.	7/80	MCH Physician completes assignment.	62.	11/81	Sixth cycle MCHAs graduate (approx. 450) and assigned to field (total approx. 2200).
52.	8/80	Third group of PH nurses Grade "A" graduate and assigned to MCH.	63.	11/81	Contraceptives arrive as ordered 11/80.
53.	8/80	One nurse educator completes assignment.	64.	5/82	TanGov assumes 100% recurrent cost for entire Training Program - Project completed.
54.	8/80	Return of participants and sending participants as agreed.			

ANNEX C

ESTIMATED RECURRENT COSTS FOR 18 MCHA TRAINING CENTERS
USAID/Tanzania

10/75 - 9/76	6 x *3000 x 12	=	\$216,000
10/76 - 5/77	6 x 2200 x 8 x .8	=	84,000
6/76 - 5/77	8 x *3000 x 12	=	288,000
			<u>\$588,000</u>

No Field Work.

* Includes provisions for corrections, alterations and additions to physical structures as requested by MOH.

6/77 - 9/77	6 x *2200 x 4 x .8	=	\$ 42,000
10/77 - 5/78	6 x *2200 x 8 x .6	=	66,000
6/77 - 5/78	8 x *2200 x 12 x .8	=	169,000
6/77 - 5/78	4 x *2200 x 12	=	<u>106,000</u>
			\$383,000

* Includes provisions for field training of 430 Trainees - supervision, travel, living allowance for 6 months

6/78 - 9/78	6 x 2200 x 4 x .6	=	\$ 32,000
10/78 - 5/79	6 x 2200 x 8 x .4	=	42,000
6/78 - 5/79	8 x 2200 x 12 x .6	=	127,000
6/78 - 5/79	4 x 2200 x 12 x .8	=	<u>84,000</u>
			\$285,000

6/79 - 9/79	6 x 2200 x 4 x .4	=	\$ 21,000
10/79 - 5/80	6 x 2200 x 8 x .2	=	21,000
6/79 - 5/80	8 x 2200 x 12 x .4	=	84,000
6/79 - 5/80	4 x 2200 x 12 x .6	=	<u>63,000</u>
			\$189,000

6/80 - 9/80	6 x 2200 x 4 .2	=	\$ 11,000
6/80 - 5/81	8 x 2200 x 12 x .2	=	42,000
6/80 - 5/81	4 x 2200 x 12 x .4	=	<u>42,000</u>
			\$95,000

6/81 - 5/82	4 x 2200 x 12 x .2	=	<u>\$21,000</u>
			\$21,000
Total all years		=	\$1,561,000

ESTIMATED RECURRENT COSTS FOR 18 MCHA TRAINING CENTERS
MINISTRY OF HEALTH

Note: estimates are calculated on a Fiscal Year basis starting during period
 1 July to 30 June 77 = FY 77

FY 77

10/76 - 6/77	6 x 2200 x 9 x .2	=	24,000
- 6/77	8 x 2200 x 1 x .2	=	4,000
			<u>\$ 28,000</u>
			(235,000 TSh)

FY 78

7/77 - 9/77	6 x 2200 x 3 x .2	=	8,000
10/77 - 6/78	6 x 2200 x 9 x .4	=	48,000
7/77 - 5/78	8 x 2200 x 11 x .2	=	39,000
6/78	8 x 2200 x 1 x .4	=	17,000
6/78	4 x 2200 x 1 x .2	=	2,000
			<u>104,000</u>
			(877,000 TSh)

FY 79

7/78 - 9/78	6 x 2200 x 3 x .4	=	16,000
10/78 - 6/79	6 x 2200 x 9 x .6	=	71,000
7/78 - 5/79	8 x 2200 x 11 x .4	=	77,000
6/79	8 x 2200 x 1 x .5	=	11,000
7/78 - 5/79	4 x 2200 x 11 x .2	=	19,000
6/79	4 x 2200 x 1 x .4	=	4,000
			<u>198,000</u>
			(1,663,000 TSh)

FY 80

7/79 - 9/79	6 x 2200 x 3 x .6	=	24,000
10/79 - 6/80	6 x 2200 x 9 x .8	=	95,000
7/79 - 5/80	8 x 2200 x 11 x .6	=	116,000
6/80	8 x 2200 x 1 x .8	=	14,000
7/79 - 5/80	4 x 2200 x 11 x .4	=	39,000
6/80	4 x 2200 x 1 x .6	=	35,000
			<u>323,000</u>
			(2,713,000 TSh)

FY 81

7/80 - 9/80 6 x 2200 x 3 x .8 = 32,000
10/80 - 6/81 6 x 2200 x 9 = 119,000

7/80 - 5/81 8 x 2200 x 11 x .8 = 155,000
6/81 8 x 2200 x 1 = 18,000

7/80 - 5/81 4 x 2200 x 11 x .6 = 58,000
6/81 4 x 2200 x 1 x .8 = 7,000

389,000

(3,268,000 TSh)

FY 82

7/81 - 6/82 14 x 2200 x 12 = 370,000

7/81 - 5/82 4 x 2200 x 11 x .8 = 77,000
6/82 4 x 2200 x 1 = 9,000

456,000

(3,830,000 TSh)

FY 83

7/82 - 6/83 18 x 2200 x 12 = 475,000

(3,990,000 TSh)

STATUTORY CHECKLIST
6 C (1) Country Checklist

A. General Criteria for Country

1. FAA Sec. 116. Can it be demonstrated that contemplated assistance will directly benefit the needy? If not, has the Department of State determined that this government has engaged in consistent pattern of gross violations of internationally recognized human rights? Yes. See social soundness analysis in PP.
2. FAA Sec. 481. Has it been determined that the government of recipient country has failed to take adequate steps to prevent narcotics drugs and other controlled substances (as defined by the Comprehensive Drug Abuse Prevention and Control Act of 1970) produced or processed, in whole or in part, in such country, or transported through such country, from being sold illegally within the jurisdiction of such country to U.S. Government personnel or their dependents, or from entering the U.S. unlawfully? No
3. FAA Sec. 620(b). If assistance is to a government, has the Secretary of State determined that it is not controlled by the international Communist movement? Yes
4. FAA Sec. 620(c). If assistance is to government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) debt is not denied or contested by such government? Not to our knowledge.

5. FAA Sec. 620(e) . If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities? The TanGov has nationalized a coffee estate (1973), a gasoline station and adjacent buildings (1972) and two houses (1972) previously wholly owned by U.S. citizens. The TanGov has taken some steps to resolving these obligations in recent months.
6. FAA Sec. 620(f): App. Sec. 107 Is recipient country a Communist country? Will assistance be provided to the Socialist Republic of Vietnam, Cambodia, Laos or Uganda? No
7. FAA Sec. 620(i). Is recipient country in any way involved in (a) subversion of, or military aggression against, the United States or any country receiving U.S. assistance, or (b) the planning of such subversion or aggression? Not to our knowledge
8. FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent the damage or destruction, by mob action, of U.S. property? No
9. FAA Sec. 620(l). If the country has failed to institute the investment guaranty program for the specific risks of expropriation, inconvertibility or confiscation, has the AID administrator within the past year considered denying assistance to such government for this reason? No

10. FAA Sec. 620(o). Fishermen's Protective Act, Sec. 5. If country has seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters,
- a. has any deduction required by Fishermen's Protective Act been made?
- b. has complete denial of assistance been considered by AID Administrator?
11. FAA Sec. 620(q): App. Sec. 504. No
- (a) Is the government of the recipient country in default on interest or principal of any AID loan to the country?
- (b) Is country in default exceeding one year on interest or principal on U.S. loan under program for which App. Act. appropriates funds, unless debt was earlier disputed, or appropriate steps taken to cure default?
12. FAA Sec. 620(s). What percentage of country budget is for military expenditures? How much of foreign exchange resources spent on military equipment? How much spent for the purchase of sophisticated weapons systems?
(Consideration of these points is to be coordinated with the Bureau for Program and Policy Coordination, Regional Coordinators and Military Assistance Staff (PPC/RC.)
- Over past few years military budget has remained about 12 percent of total Tanzanian budget. The FY 78 Budget devotes \$141 million capital and recurrent expenditures about half of which is foreign exchange. See Embassy reporting for information on purchase of sophisticated weapons systems.
13. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption? No

14. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget? Payments are current.
15. FAA Sec. 620A. Has the country granted sanctuary from prosecution to any individual or group which has committed an act of international terrorism? No
16. FAA Sec. 659. If (a) military base is located in recipient country and was constructed or is being maintained or operated with funds furnished by the United States, and (b) U.S. personnel carry out military operations from such base, has the President determined that the government of recipient country is authorized regular access to U.S. correspondents to such base? No such military base exists in recipient country.
17. FAA Sec. 666. Does the country object, on basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. there to carry out economic development program under FAA? No
18. FAA Sec. 669. Has the country delivered or received nuclear reprocessing or enrichment equipment, materials or technology, without specified arrangements on safeguards, etc.? No
19. FAA Sec. 670. Has the country delivered or received nuclear reprocessing equipment material or technology? Is the country not a "nuclear-weapon state" as defined in Article IX(3) of the Treaty on Non-Proliferation of Nuclear Weapons and which detonates a nuclear explosive device? No

20. FAA Sec. 901. Has the country denied its citizens the right or opportunity to emigrate? No

3. Funding Criteria for Country

1. Development Assistance
Country Criteria

a. FAA Sec. 102(c),(d). Have criteria been established, and taken into account, to assess commitment and progress of country in effectively involving the poor in development, on such indexes as: (1) small-farm labor intensive agriculture, (2) reduced infant mortality, (3) population growth, (4) equality of income distribution, and (5) unemployment.

Being satisfactorily considered.

b. FAA Sec. 201(b)(5),(7) & (8); Sec. 208; 211(a)(4), (7).

Describe extent to which country is:

(1) Making appropriate efforts to increase food production and improve means for food storage and distribution.

Country currently undertaking program with goal of reaching food self-sufficiency by 1981. Program includes grain storage and marketing components.

(2) Creating a favorable climate for foreign and domestic private enterprise and investment.

Tanzania's socialist policy and development strategy stress public investment. Tanzania has a Foreign Investment Protection Act and has entered into an Investment Guaranty Agreement.

(3) Increasing the public's role in the development process.

The government is attempting to implement decentralization plan which places decision making responsibility for development programs at the regional, district and village levels

(4) (a) Allocating available budgetary resources to development.

Satisfied. In recent years, recipient country has experienced difficulty increasing budget because of drought and balance of payments problems caused largely by oil crisis.

(b) Diverting such resources resources for unnecessary military expenditure and intervention in affairs of other free and independent nations.

(5) Making economic, social, and political reforms such as tax collection improvements and changes in land tenure arrangements, and making progress toward respect for the rule of law, freedom of expression and of the press, and recognizing the importance of individual freedom, initiative, and private enterprise.

(6) Otherwise responding to the vital economic, political, and social concerns of its people, and demonstrating a clear determination to take effective self-help measures.

c. FAA Sec. 201(b), 211(a). Is the country among the 20 countries in which development assistance loans may be made in this fiscal year, or among the 40 in which development assistance grants (other than for self-help projects) may be made?

d. FAA Sec. 115. Will country be furnished, in same fiscal year, either security supporting assistance, or Middle East peace funds? If so, has the Congress specifically authorized such funds, or is assistance for population programs, humanitarian aid through international organizations, or regional programs?

2. Security Supporting Assistance Country Criteria

a. FAA Sec. 502B. Has the country engaged in a consistent

Budgeted Defense expenditures have averaged about 12% of total since FY 75. Recipient country has a record of non-intervention into affairs of other free and independent nations.

Tanzania is committed to an egalitarian system of distribution for land and wealth. Tanzania is weak in conventional political and legal rights. The one party system controls internal media and does not allow dissent from basic party government policies. Detention without trial is not uncommon. In early 1978 the government released a number of detainees.

The TanGov development policy is specifically aimed at poorer classes and at improving equality of opportunity and welfare for all people.

Tanzania is in the latter group.

No. Recipient country will receive development assistance.

Not applicable.

pattern of gross violations of internationally recognized human rights? Is program in accordance with policy of this section?

b. FAA Sec. 531. Is the Assistance to be furnished to a friendly country, organization, or body eligible to receive assistance?

Not applicable.

c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made?

Project Checklist

A. General Criteria for Project

1. App. Unnumbered: FAA Sec. 653(b)

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the project;

(a) Project in FY 78 C.P.

(b) Is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than \$1 million over that figure plus 10%)?

(b) Assistance is within country allocation reported to Congress in OYB.

2. FAA Sec. 611(a)(1). Prior to obligation in excess of \$100,000, will there be
(a) engineering, financial, and other plans necessary to carry out the assistance and
(b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

(b) Yes. See Technical, financial analyses in PP for explanation of satisfaction of Section 646 (1).

3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? Further legislation not required.
4. FAA Sec. 611(b): App. Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per Memorandum of the President dated Sept. 5, 1973 (replaces Memorandum of May 15, 1962; see Fed. Register, Vol 38, No. 174, Part III, Sept. 10, 1973)? Not applicable
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed \$1 million, has Mission Director certified the country's capability effectively to maintain and utilize the project? Yes. See Part III-B.
6. FAA Sec. 209, 619. Is project susceptible of execution as part of regional or multilateral project? If so why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. If assistance is for newly independent country, is it furnished through multilateral organizations or plans to the maximum extent appropriate? Project is directed toward Tanzania's villagers. There are no known regional (inter-country) implications. Project not directly compatible with existing or planned multi-lateral programs.
7. FAA Sec. 601(a): (and Sec. 201(f) for development loans). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster (a) the project is not directed at the National level and it is unlikely that the project will increase international trade; (b - f) Not applicable to public health projects of this type.

private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.

8. FAA Sec. 601(b). Information and conclusion on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

Project will not likely encourage U.S. private trade and investment in Tanzania.

9. FAA Sec. 612(b); Sec. 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized to meet the cost of contractual and other services.

The government contributes local currency for support of projects on a pro rata basis for each project technician. The U.S. does not own foreign currencies in Tanzania.

10. FAA Sec. 612(d). Does the U.S. own excess foreign currency and, if so, what arrangements have been made for its release?

No. The U.S. does not own excess foreign currency.

B. Funding Criteria for Project

1. Development Assistance Project Criteria

- a. FAA Sec. 102(c); Sec. 111; Sec. 281a. Extent to which activity will (a) effectively

(a) The primary focus of project activity is at the village level. However, though health has general

involve the poor in development, by extending access to economy at local level, increasing labor-intensive production, spreading investment out from cities to small towns and rural areas; and (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions?

benefits for development and economy, these are too indirect to allow this project to be defined in economic terms as given.

(b) Not applicable to this project.

b. FAA Sec. 103, 103A, 104, 105, 106, 107. Is assistance being made available: (include only applicable paragraph--eg., a, b, etc.--which corresponds to source of funds used. If more than one fund source is used for project, include relevant paragraph for each fund source.)

(2) Sec. 104 - for population planning or health; if so, extent to which activity extends low-cost integrated delivery systems to provide health and family planning services, especially to rural areas and the poor;

The project is a component of a program aimed at providing low cost health delivery systems to the entire rural population.

c. FAA Sec. 110(a): Sec. 208(e). Is the recipient country willing to contribute funds to the project, and in what manner has or will it provide assurances that it will provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or has the latter cost-sharing requirement been waived for a "relatively least-developed" country)?

Tanzania is a relatively least developed country, however the ^{25%} cost sharing requirement is met by the TanGov.

d. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing?

Yes. Length of project described in FY 78 and FY 79 Congressional Presentation.

e. FAA Sec. 207: Sec. 113. Extent to which assistance reflects appropriate emphasis on: (1) encouraging development of democratic, economic, political, and social institutions; (2) self-help in meeting the country's food needs; (3) improving availability of trained workers-power in the country; (4) programs designed to meet the country's health needs; (5) other important areas of economic, political, and social development, including industry; free labor unions, cooperatives, and voluntary agencies; transportation and communication; urban planning and public administration; urban development, and modernization of existing laws; or (6) integrating women into the recipient country's national economy.

(1-3) Not applicable

(4) Specifically designed to provide health services to areas of greatest need.

(5) Not applicable

(6) Project, while benefiting women, does not aim at their integration into Tanzania's national economy.

f. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

Recognizes acute need for extension of medical services into rural areas and popular desire for these; utilizes Tanzanian trainers for health-aid training at in-country institutions. Other questions not applicable to this project.

- g. FAA Sec. 201(b) (2)-(4) and -(8); Sec. 201(e); Sec. 211(a)(1)-(3) and -(8). Does the activity give reasonable promise of contributing to the development: of economic resources, or to the increase of productive capacities and self-sustaining economic growth; or of educational or other institutions directed toward social progress? Is it related to and consistent with other development activities, and will it contribute to realizable long-range objectives? And does project paper provide information and conclusion on an activity's economic and technical soundness?
- h. FAA Sec. 201(b)(6); Sec. 211(a) (5), (6). Information and conclusion on possible effects of the assistance on U.S. economy, with special reference to areas of substantial labor surplus, and extent to which U.S. commodities and assistance are furnished in a manner consistent with improving or safeguarding the U.S. balance-of-payments position.
- Yes. The accomplishment of this objective will be difficult to measure. An on-going monitoring system has been established. See Pt IV-3. The project is consistent with both the Tanzania development objectives and the Congressional guidelines for assistance.
- Yes. A major portion of project funds (approximately \$1.1 million) will be for U.S. Technical Assistance. Other costs (training and commodities) are requested from various sources; however, in most instances, these are of local or U.S. source.

61(3) - STANDARD ITEM CHECKLIST

Listed below are statutory items which normally will be covered routinely in those provisions of an assistance agreement dealing with its implementation, or covered in the agreement by exclusion (as where certain uses of funds are permitted, but other uses not).

These items are arranged under the general headings of (A) Procurement, (B) Construction, and (C) Other Restrictions.

A. Procurement

1. FAA Sec. 602. Are there arrangements to permit U.S. small business to participate equitably in the furnishing of goods and services financed? Yes. Small business will be eligible for prime contract financed under project.
2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under delegation from him? Yes. Procurement will be undertaken in accordance current delegations and waivers as authorized.

3. FAA Sec. 604(b). Will all commodities in bulk be purchased at prices no higher than the market price prevailing in the United States at the time of purchase?

No bulk commodity purchases are to be financed under project.
4. FAA Sec. 604(c). Will all agricultural commodities available for disposition under the Agricultural Trade Development and Assistance Act of 1954, as amended, be procured in the United States unless they are not available in the United States in sufficient quantities to supply emergency requirements of recipients?

No such procurement is to be financed under this project.
5. FAA Sec. 604(d). If the cooperating country discriminates against U.S. marine insurance companies, will agreement require that marine insurance be placed in the U.S. on commodities financed?

Procurement will be done by USAID or U.S. contractor. Condition will be satisfied.
6. FAA Sec. 604(e). If offshore procurement of agricultural commodity or product is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity?

Not applicable.
7. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?

Yes.
8. FAA Sec. 901(b). (a) Compliance with requirement that at least 50 per centum of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S.-flag commercial vessels to the extent that such vessels are available at fair and reasonable rates.

Yes.
9. FAA Sec. 621. If technical assistance is financed, will such assistance be furnished to the fullest extent practicable as goods and professional and other services from private enterprise on a contract basis? If the facilities of

Technical assistance will be from U.S. private firm. No Federal agencies will be involved.

other Federal agencies will be utilized, are they particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs?

10. International Air Transport. Fair Competitive Practices Act, 1974

If air transportation of persons or property is financed on grant basis, will provision be made that U.S.-flag carriers will be utilized to the extent such service is available?

Yes, all contracts financed under the grant will contain a provision requiring utilization of U.S. Flag carriers to extent such service is available.

B. Construction

1. FAA Sec. 601(d). If a capital (e.g., construction) project, are engineering and professional services of U.S. firms and their affiliates to be used to the maximum extent consistent with the national interest?

Yes, Although this is not a capital assistance project,

2. FAA Sec. 611(c): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable?

Not applicable

3. FAA Sec. 620(k). If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million?

Not applicable.

C. Other Restrictions

1. FAA Sec. 201(d). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

Not applicable.

2. FAA Sec. 301(d). If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?

Not applicable. There will be no contributions to an international organization under this project.

3. FAA Sec. 620(h). Do arrangements preclude promoting or assisting the foreign aid projects or activities of Communist-Bloc countries, contrary to the best interests of the U.S.?
- No foreign aid projects or activities of Communist-Bloc countries are being undertaken or planned in project area.
4. FAA Sec. 636(4). Is financing not permitted to be used, without waiver, for purchase, long-term lease, or exchange of motor vehicle manufactured outside the U.S. or guaranty of such transaction?
- Yes. The grant agreement will so provide.
5. Will arrangements preclude use of financing:
- a. FAA Sec. 114. to pay for performance of abortions or to motivate or coerce persons to practice abortions.
- Yes. Project activities are defined sufficiently to preclude such use.
- b. FAA Sec. 620(g). to compensate owners for expropriated nationalized property?
- Yes "
- c. FAA Sec. 660. to finance police training or other law enforcement assistance, except for narcotics programs?
- Yes "
- d. FAA Sec. 662. for CIA Activities?
- Yes "
- e. App. Sec. 103. to pay pensions, etc. for military personnel?
- Yes "
- f. App. Sec. 106. to pay U.N. assessments?
- Yes "
- g. App. Sec. 107. to carry out provisions of FAA Sections 209(d) and 251(h)? (transfer to multilateral organization for lending).
- Yes "