AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: _____

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: United Republic of Tanzania

3. PROJECT NUMBER: 621-0143

4. BUREAU/OFFICE: AFRICA AFR 06

5. PROJECT TITLE (maximum 40 characters): Arusha Village Health Project (Arusha Planning and Village Development Project Health Component)

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 03 DD 31 YY 87

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 81 B. Quarter 4 C. Final FY 83

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total						
(Grant)	(2229)	(2229)	(4458)	(3306)	(3267)	(6573)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country	–	943	943	–	1391	1391
Other Donor(s)						
TOTALS	2229	3172	5401	3306	4658	7964

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) PH	582	520				6573		6573	
(2)									
(3)									
(4)									
TOTALS						6573		6573	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510 | 530 | 540 | 562

11. SECONDARY PURPOSE CODE: 532

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BR	INTR	PART	TNG	EQTY		
B. Amount	6573	6573	6573	500	6573		

13. PROJECT PURPOSE (maximum 480 characters)

To develop in the Arusha Region a replicable process whereby villagers, through their Development Councils and Health subcommittees, identify, understand and resolve community public health problems, with a minimum of outside financial assistance.

14. SCHEDULED EVALUATIONS

Interim MM 12 YY 83 | MM 05 YY 85 | Final MM 18 YY 87

15. SOURCE/ORIGIN OF GOODS AND SERVICES

☐ 000 ☒ 941 ☐ Local ☒ Other (Specify) See Annex F.

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

N.A.

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17. APPROVED BY

Signature: Barry M. Riley

Title: Acting Director

Date Signed: MM 06 DD 12 YY 81

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION

MM 06 DD 22 YY 81

AID 1330-4 (8-79)

PROJECT PAPER

TANZANIA

ARUSHA VILLAGE HEALTH PROJECT

June, 1981

Project Design Team:

Government of Tanzania

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AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT IDENTIFICATION DOCUMENT FACESHEET (PID)

1. TRANSACTION CODE: C (A = Add, C = Change, D = Delete) — Revision No. 1

DOCUMENT CODE: 1

2. COUNTRY/ENTITY: United Republic of Tanzania

3. PROJECT NUMBER: 621-0143

4. BUREAU/OFFICE: AFRICA — A. Symbol: AFR — B. Code: 06

5. PROJECT TITLE (maximum 40 characters): Arusha Village Health Project (Arusha Planning and Village Development Project Health Component)

6. ESTIMATED FY OF AUTHORIZATION/OBLIGATION/COMPLETION

A. Initial FY: 81

B. Final FY: 83

C. PACD: 87

7. ESTIMATED COSTS ($000 OR EQUIVALENT, $1 =)

FUNDING SOURCE		LIFE OF PROJECT
A. AID		6573
B. Other U.S.	1.	
	2.	
C. Host Country		1391
D. Other Donor(s)		
TOTAL		7964

8. PROPOSED BUDGET AID FUNDS ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	C. 2. Loan	D. 1ST FY 1. Grant	D. 2. Loan	E. LIFE OF PROJECT 1. Grant	E. 2. Loan
(1) PH	582	520		4458		6573	
(2)							
(3)							
(4)							
TOTALS				4458		6573	

9. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 510 | 530 | 540 | 562

10. SECONDARY PURPOSE CODE: 532

11. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BR	INTR	PART	TNG	EQTY		
B. Amount	6573	6573	6573	300	6573		

12. PROJECT PURPOSE (maximum 480 characters)

To develop in the Arusha Region a replicable process whereby villagers, through their Development Councils and Health subcommittees, identify, understand and resolve community public health problems, with a minimum of outside financial assistance.

13. RESOURCES REQUIRED FOR PROJECT DEVELOPMENT

Staff: 3 design team members: Epidemiologist
Anthropologist
Design Specialist

Funds: No PDS necessary

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14. ORIGINATING OFFICE CLEARANCE

Signature: Barry M. Riley — Barry Riley

Title: Acting Director USAID/Tanzania

Date Signed: MM 6 DD 12 YY 81

15. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM DD YY

16. PROJECT DOCUMENT ACTION TAKEN

S = Suspended
A = Approved
D = Disapproved
CA = Conditionally Approved
DD = Decision Deferred

17. COMMENTS

18. ACTION APPROVED BY

Signature

Title

19. ACTION REFERENCE

20. ACTION DATE: MM DD YY

AID 1330-2 (8-79)

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Acknowledgements

USAID/Tanzania would like to thank all those involved in the preparation of this paper for their efforts and time, which often stretched into hours following the close of business. Concerned officials of the Tanzanian Government from the Arusha Region, as listed on the Design Team were able to give attention to the Project at an especially busy time for them. The efforts of Dr. E.E. Moshi are especially appreciated, as he made himself available for discussions at any time in his office and at his home.

The support of Dr. A. E. Henn, Chief of the Human Resources Development Office of the USAID/T Mission was also specially valuable in the provision of ideas and thoughts during design, suggestions on format, and help in reading through the final draft.

Typing, most of which was accomplished following normal business hours was completed by Mrs. Patricia Ruiz de Gamboa, with valuable help by Ms. Anki Skoog and Mrs. Elieshi Kombe.

Paul G. Ehmer
6/12/81

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I. Summary and Recommendations

A. Grantee and Implementing Agency

The Grantee will be the Government of the United Republic of Tanzania and the executing agency will be the Office of the Regional Development Director of the Arusha Region. The Project will be implemented by local level Government of Tanzania civil servants, who will be selected by the Project and who are presently involved in implementing rural Government programs.

B. Recommendations

1. That a grant to the Government of the United Republic of Tanzania in the amount of $6,573,000 be approved for the Arusha Planning and Village Development Project Health Component (621-0143) to be implemented over a five year period from January, 1982 through December 31, 1986. (Note: the PID title for the proposed Project was Arusha Village Health Project - No. 621-0159. However, since this Project provides funding for a health component to an integrated regional development program presently being financed by AID, the Project title and number above reflects the fact that this is an amendment to that already existing AID project. The AID cost of the existing Arusha Planning and Village Development Project, exclusive of this proposed amendment, is $14,591,600).

2. That the source origin waivers for the purchase of 10 Landrover type vehicles, 52 motorcycles and spare parts of an approximate value of $370,000 be approved. (Justification contained in Annex F.)

C. Issues

The issues raised during the AID/W PID review and PP preparation process are presented and discussed in Annex D.

II. Project Description

A. Background

1. Summary

The Government of Tanzania and the United States Agency for International Development have collaborated in designing the Arusha

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Village Health Project (AVHP)* to help rural Tanzanian villages deal with some of their basic health problems within the context of existing and projected resource constraints. The project described herein fits into the framework of the existing social and administrative organization of the Arusha Region and the development activities already being implemented there. It will strengthen the abilities of existing village, district and regional structures to identify, understand and respond to locally perceived health problems through a process of facilitating the work of village health committees. The Project responds to the priorities and stated objectives of the Government as they relate specifically to health and more generally to social and economic development in the country.

2. Introduction

In 1967 the Government of Tanzania embarked upon a new development course based on the ideas and concepts set forth in the Arusha Declaration. At this time a strong commitment was made toward the goal of growth with equity, which was seen as only being possible through self-reliance at all levels. In the implementation of programs to achieve this goal, it was the Government's experience that too high a degree of centralization focused on the Ministries in Dar es Salaam did not allow enough involvement of the rural areas where 90% of Tanzania's population is located. In response to this problem the Decentralization Act of 1972 established a mechanism for delegating authority for the planning and implementation of government programs and projects to the Regions. An administrative structure has been created that leads from individual 10-cell leaders (balozi) in the villages, to village development councils and then up through Wards, Divisions, and Districts, directly to the office of the Regional Development Director (RDD), who administers all the regional programs. (See Administrative Feasibility for organizational chart and further discussion.) This structure has been utilized by the Government in the preparation of the Third Five Year Development Plan, which is presently being implemented.

This Plan covers the period 1976-1981 and emphasizes the importance of mobilizing the entire population in the planning and implementation of development projects and the identification and utilization of local resources for attacking local problems. It reinforces the principles of self-reliance and encourages local initiative in the development process. The main objectives of the Plan include: raising the standard of living throughout the country, self-reliance, and an emphasis on the development of forms of economic activity which encourage collective and cooperative effort.

In the area of social services the objectives are to complete and strengthen Universal Primary Education and to provide basic water and

*For the purposes of the remainder of this paper the proposed Project will be referred to as the Arusha Village Health Project, although administratively it will be an amendment to the ongoing Arusha Planning and Village Development Project, as discussed in Section I above.

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medical services throughout the country, accomplishing these ends partly through the establishment of village planning mechanisms. In the strategy for achieving these objectives, leaders at all levels are expected to insure that program implementation utilizes self-help activities whenever possible.

The Plan for the health sector emphasizes the provision of clean water to every village (with as much of the construction activities as possible being undertaken through self-help), the promotion of environmental cleanliness, the continued construction of dispensaries in rural areas, the expansion and consolidation of preventive health services within the already established rural health infrastructure, and the strengthening of the health service system to make it available to more people.

The policy in the health sector of the Chama Cha Mapinduzi (CCM), Tanzania's one political party, is to encourage the expansion of health services to cover the villages with an emphasis on preventive programs designed to attack the root causes of poor health. The Party and the Government both emphasize the participation of villagers in defining and solving their own health problems.

As an outgrowth of the decentralization process, each of the twenty regions of Tanzania has been asked to develop its own Regional Integrated Development Plan (RIDEP). Several donors were asked to assist with this effort in different regions, with USAID being requested to become involved in the Arusha Region. This request led to the development of the Arusha Planning and Village Development Project APVDP (621-0143), which began activities in 1979. The planning process leading to the regional plan involves all sectors, in keeping with the philosophy of regional integration and coordination for administrative, planning and implementation purposes. The ultimate goal of the Government's development strategy is to further decentralize planning, decision making, and administrative responsibilities to the Ward and village levels so villagers will participate in the decision making that affects their lives. While the structure for accomplishing this end has been created and exists at all levels, the ability of villages and villagers to enter into the process and be effectively involved is limited by a lack of trained people, the low level of local resources, and poor communication and coordination between villages and higher administrative units.

What this means is that the government commitment to having health services reach the rural areas, receiving planning input from the villages, and encouraging village self-help activities has not yet been implemented throughout the country. The process of involving local jurisdictions in the activities described above is being strengthened in the Arusha Region at the present time by the APVDP. The APVDP does not presently contain a health component aside from a provision for the collection of health related information for inclusion in the Regional Plan itself. The design team has concluded that the present Project adds a necessary health component and fits logically into the APVDP as it is presently being implemented.

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3. General Setting

Annex G. presents a map of Arusha Region showing the location of certain health facilities.

The Arusha Region is divided into 7 Districts (of which 6 are rural and 1 urban), 26 Divisions,]33 Wards and 463 villages. It is located in the north of Tanzania at an altitude of 1,200 to 1,450 meters above sea level. The Arusha Region is one of the larger of Tanzania's 20 mainland regions. It had a 1978 population of 928,478 in a total land area of 82, 423 square kilometers.

Average rainfall is between 500-800 mm, with long-rains occuring in the January/February through May/June periods, and the short-rains from October through December. Although there are zonal temperature differences, the temperature generally ranges from between 21° C to 24° C, with an annual average temperature of 22.5° C.

It is estimated that 95% of the people in the Arusha Region practice mixed farming of different food and cash crops. The main food crops are maize (which is the staple food for most of the region's inhabitants), beans, bananas, rice, millet, cassava, sweet and round potatoes, and a variety of fruits and vegetables. The main cash crops include coffee, pyrethrum, wheat, cotton, seed beans finger millet, and oil seeds.

The Arusha Region development budget for the period of 1980/81 was examined during discussions with regional officials to give some indication of the relative allocations to the various sectors. The total budget is approximately 51.2 million TShs. ($6.3 million). Livestock and agriculture account for the majority of the budget, with health receiving 2.8%. The amount allocated for health is shown in the budget as follows:

Health Treatment	Total (in 000s TShs)
Maintenance of Dispensaries	50.0
Maintenance of Hospitals	613.0
Building of Dispensaries	150.0
	813.0
Health Centers	
Maintenance of Health Centers	621.4
Total Budget Allocation to Health	1,434.4

Regional officials regret the paucity of funds allocated to health and cite budget constraints. Agriculture and Livestock are the basis of the Region's productive activities, and the major part of the development budget is directed toward increasing production.

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4. The Arusha Planning and Village Development Project

In May 1978, the Arusha Planning and Village Development Project (APVDP) No. 621-0143 was approved by A.I.D./Washington. The A.I.D.-financed APVDP has two main purposes: 1) to improve the capacity of the Arusha regional administration to write development plans and produce the Arusha Region Integrated Development Plan document; and 2) to encourage village level development.

The APVDP focuses on the following major activities:

a) strengthening the planning, implementation and evaluation capabilities at regional, district and village levels;

b) improving agricultural production;

c) identifying and promoting other economic activities; and

d) improving the social and economic infrastructure directly related to productive activities.

The principal emphasis of the Project is on institution building, planning, and economic improvement through increasing agricultural production.

The APVD Project works through the Village Development Councils, particularly those subcommittees that deal with agriculture and other productive activities in the villages. Rural Development Specialists (RDSs) assigned to each District utilize one or more of three major models of interacting with villages developed for use in the Project from the literature and experience in community development. Seminars and training sessions in these approaches have been provided for Government personnel working in the rural areas, who accompany and assist the RDSs in their work with Village Development Councils. Reports are available from the Project that detail the experience to date in utilizing these development approaches and in the training programs that have been implemented to encourage village level dialogue concerning development. The particular approach used in a given village depends on the state of organization of the village, the background and experience of the Government representative working in that village and the skills he has been provided for this work through prior training. The result of this village dialogue is the preparation of project proposals, which are submitted for review and approval through the established Government structure to review committees at the District and Regional levels. Eventually, projects developed by villages which have been approved through the Regional Planning Office level are submitted to the APVDP for funding.

During the design of the APVDP it was felt that there was no need to include specific health interventions, because of extensive efforts of the Government of Tanzania to reach the rural areas in this sector. However, during the initial data gathering phases of the Project, Development Alternatives Inc. (DAI) contract personnel and regional Tanzanian officials determined that health problems remain a major concern of villagers and that there is no effective mechanism for addressing many of these problems at the local level. Government health

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facilities often do exist, but the participatory preventive approaches favored by the Government health policy are not being effectively implemented. A formal request for a health component to the APVDP has been received from the GOT Regional Development Office. (See Annex C).

5. AID Health Strategy

USAID/Tanzania in February 1980 produced a document entitled the Tanzania Health Sector Strategy to which the reader is referred for a more detailed presentation of the background and rationale of AID assistance to Tanzania in the health sector. The discussion that follows merely highlights those sections that directly pertain to the proposed Project.

Two areas of emphasis detailed for AID support to the health sector are:

1. support to efforts to enhance communities' understanding of their health problems and how to deal with them; and

2. support to community initiated health interventions.

These two areas will be addressed by the present Project in an effort to overcome the tendency within the present health care system to foster in the people a dependence on the system for the provision of basic health needs. The majority of the population have not yet learned to use sanitation, nutrition and other basic preventive health care measures which they can take to improve their own health. The Project is intended to increase the self-reliance and productivity of people in the rural areas of Arusha Region by making them better able to deal with their own health problems.

In addition, the 1983 CDSS states that one of the broad objectives of the AID assistance program to Tanzania is to support decentralization through the testing, demonstration and replication of effective approaches to rural development undertaken at local levels. Most of the Mission's efforts to support this decentralization will be centered in the Arusha Region and will support the village development base already established with AID assistance through the Arusha Planning and Village Development Project. The present Project will support decentralization at the village level by increasing the ability of villages to identify their health problems and take action to remedy them through already established planning mechanisms from the local level up to the regional level.

This Project fits into the AID development strategy for Tanzania generally, will specifically support efforts to remove constraints to development in the health sector and is to be located in the area of AID's principal geographic focus - the Arusha Region.

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B. Summary Project Description

The Arusha Village Health Project will provide assistance to the Government of Tanzania through the Arusha Regional Development Office for the development of a "process" at the village level that will activate and then support through training and material assistance the work of Village Health Committees. At a cost of $6,573,000 AID will contribute two long term technicians, short term consultants, training, commodities and certain operating costs for a five year period beginning during FY 1981. This Project, resulting in villages working to identify and remedy their local health constraints to development, will include the following activities:

1. Holding promotional workshops for Government and Party personnel at all levels in the Region to discuss Project goals and objectives;

2. Selection and training of candidates from existing categories of government community agents to work as "Facilitators" with Village Health Committees in their areas;

3. Activation of Village Health Committees leading to the planning and implementation of community initiated public health interventions to solve local health problems;

4. Selection of a Village Health Representative to be the permanent link in the village between the existing health structure and the village; and

5. Increased involvement of existing government health workers in health related discussions and activities at the village level.

This Project works through the existing administrative structure of the Arusha Regional Development Office. In the health sector it will strengthen individual villages' abilities to participate in and direct the planning and implementation of development activities. As such, it supports the Government's initiatives to encourage participation and self-reliance at the village level and supports similar activities being undertaken by the APVDP in other sectors. The Detailed Project Description and Technical Feasibility, Section IIC and IIIC respectively, provide further information with respect to how this project is integrated into the existing plans and administrative structure of the Arusha Region, the roles and selection criteria for village health interventions, criteria for determining eligibility of proposed village activities for Project financial assistance, and parameters for evaluating the relative success of the Project in different types of village settings.

C. Detailed Project Description

1. The Problem:

The process of expansion of the health infrastructure to the rural areas through the building of rural health centers and dispensaries and the training of paramedical personnel to staff them has been proceeding as quickly as possible through Government efforts in the past few years. These facilities and personnel are now able to provide a minimum level of health services to much of the rural population. Health related indices have improved in recent years. The life expectancy has risen from 41 in 1967 to 78 in 1978 and the infant mortality rate has fallen from 161/1000 live births to 152/1000 in the same period. The introduction of community-initiated preventive public health programs, although a stated priority of the Government, has lagged behind the provision of facilities. The reasons for this include the following:

a) continuing shortage of trained health personnel;
b) difficulties in attracting, assigning and keeping good people in the isolated rural areas;
c) communication constraints;
d) tendency of health personnel to remain at the health facility rather than going out to the villages due to:
   i) lack of experience in community work;
   ii) too much pressure to provide treatment, rather than preventive health services;
   iii) lack of demand from villagers for their services in the villages;
   iv) lack of transport; and
   v) lack of understanding of effective preventive health interventions that would be appropriate at the village level;
e) lack of management/supervision/support for rural paramedical personnel;
f) lack of awareness at the village level of reasons for health problems leading to lack of interest or knowledge of possible public health interventions; and
g) absence of responsible liason at the village level to follow up on activities initiated.

Outreach from rural health facilities to the villages is a critical element in the provision of community public health services that will affect the people's health status.

Through decentralization, as discussed in Section IIA above, the administrative system exists for villages to affect the course of their development. The APVDP is presently strengthening this process in the Arusha Region. In the health sector in Arusha a barrier to the success of this process has been the inactivity of the subcommittee of the Village Development Council charged with dealing with health matters. This subcommittee is referred to throughout this paper as the Village

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Health Committee to facilitate smoother reading and easier understanding, even though in the present village administrative structure there is not a specific committee dealing only with health. This committee is presently designated as the Education, Culture and Social Welfare subcommittee. "Health" is not directly included in the title, making it difficult for members to recognize that some of their responsibilities fall into this area. In most villages in Arusha Region this five member subcommittee of the 25 member Village Development Council is appointed, but seldom meets to discuss or take action on matters under its jurisdiction. This is probably most often due to:

a) lack of knowledge regarding responsibilities of the subcommittee;
b) lack of technical knowledge in the areas of responsibility;
c) lack of administrative skills necessary to hold community discussions leading to the clear definition of problems;
d) lack of knowledge of locally available resources that might be used to help solve local problems; and
e) lack of planning skills necessary to present a problem, suggest a solution and compete for available resources.

If this already established structure could be activated, supported, and encouraged, the Government goal of enabling villagers to better understand their health problems and to take the initiative to solve them could more easily be achieved. The Arusha Village Health Project has been designed to address the problem of activating Village Health Committees.

2. Sector Goal:

The sector goal of this Project, as with all AID health projects in Tanzania, is to help Tanzania develop a health services system which can improve the health status of the people sufficiently for them to enjoy life, participate fully in community development activities, and contribute to the national goal of self-reliance.

3. Project Purpose:

The purpose of this Project is to develop in the Arusha Region a replicable "process", whereby villagers, through their Development Councils and Health subcommittees, identify, understand, and resolve community public health problems, with a minimum of outside financial assistance.

The mechanism by which the Project will establish this process at the village level will be through the selection, training and utilization of Ward Health Facilitators, who will be responsible for initiating the process and interacting with the appropriate village subcommittee leading to the implementation

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of health interventions in the village. A Village Health Representative will also be chosen to make the final connection between the Project and each village. Although resources from the Project will be available to support some aspects of village health interventions, it is not the intention of the Project to emphasize this feature for fear of making the process unreplicable in the absence of outside resources. It is understood that all areas of Tanzania are presently operating under severe resource constraints, which will probably continue for the foreseeable future. There is no sense in providing an unrealistic amount of resources to one Region when it is clear that similar levels of resources will not be available to other areas. It is understood and accepted that this constraint will probably lead to the planning and implementation of smaller, simpler projects than might otherwise be the case.

The Project will achieve its purpose of activating Village Health Committees by working toward the following objectives:

a) establishment of support for the Project initially at the Regional, District and Divisional levels;
b) assignment of explicit responsibility for health matters in the village to the appropriate administrative structure at that level;
c) identification and preparation of already existing civil servants at the Ward level to function as catalysts in the villages for the initiation of discussions about health problems;
d) establishment of a process in the village, directed by the Village Health Committee that will result in local people beginning to understand their health problems and taking actions to remedy them;
e) identification of one member of the Village Health Committee, who will be responsible for support of Project activities in the village; and
f) strengthening the ability of local health workers to provide advice and support to villages in the area of preventive health.

4. <u>End of Project Status</u>:

a) all Regional, District and Divisional level Government staff and Party officials familiar with the Project, its purpose and methods;
b) a Regional policy set forth establishing a subcommittee of the Village Development Council as the Village Health Committee, in function if not in name;
c) one Ward selected in each of the 23 Divisions of Arusha Region (exclusive of Arusha town) in which Project activities will be initiated;
d) two Ward Health Facilitators chosen from each Ward identified;
e) forty-six Ward Health Facilitators trained;
f) at least 92 villages in Arusha Region incorporated into the Project with at least 80% of these with active VHCs;

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g) at least 92 Village Health Representatives chosen, one from each incorporated village;
h) 80% of the active villages have completed at least one public health project;
i) locally assigned health personnel at the dispensary and rural health center level spending the required time designated by the Government in the field interacting with VHCs and providing health education in the villages.

5. Outputs:

The following outputs are listed here to be described in more detail in (7) below.

a) the involvement of Government and Party leaders in the definition of the need for active Village Health Committees and the elicitation of their support in seeing that such committees are created and supported;
b) the issuance of official notification from the Government clarifying the role and delegating responsibility for health issues at the village level to the Education, Culture and Social Welfare subcommittee or its equivalent;
c) the establishment of a selection process at the Ward level to choose candidates who will act as Ward Health Facilitators in working with Village Health Committees;
d) the establishment of both basic and in-service training programs for Ward Health Facilitators;
e) the activation of the Village Health Committee in at least two villages per Ward Health Facilitator;
f) the selection of a Village Health Representative in each Project village;
g) the initiation of public health interventions at the village level, emphasizing the use of locally available resources;
h) the provision of health education to Village Health Committees and villagers involved in planning and implementing health interventions;
i) the integration and increased use of already in place, locally available Government health personnel in the preventive health deliberations and activities described above;
j) the recognition by villages and Government leaders of the value of community initiated and planned public health interventions; and
k) the enhancement of the ability of communities to identify and take action to remedy locally perceived health problems.

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6. Inputs:

To achieve the objectives of the Arusha Village Health Project, AID will provide two long term technicians for the full five year period, one short term consultant for six months during the initial phases of the Project, other short term consultants as required, commodities, training, and support for certain operating costs. The specific character and quantity of these inputs is presented in more detail in the Financial Plan and Analysis (Section IV), the Logical Framework (Annex A), and the Detailed Budget (Annex B). The total value of AID support to this Project is $6,573,000 and the Government of Tanzania is contributing $1,391,000, in the form of personnel salaries of existing civil servants who will be contributing to the Projects's activities, the village self-help contributions to projects undertaken, and certain operating costs.

The two long term technicians will be attached to the office of the Regional Development Director and will take part in the planning, implementation and monitoring of all Project activities, while at the same time building an ongoing capability within the RDD's office of effectively administering Project activities at the end of the initial five year phase.

The first technician will be a senior health administrator/planner with experience in initiating and implementing community development activities in the health field, who will be assigned to the office of the Regional Medical Officer. He will be responsible for coordinating all AID inputs into the Project and will cooperate with his counterparts to develop, implement and monitor all the activities of the Project as described above. He will be responsible for maintaining contact with all appropriate Government and Party personnel in the Region, eliciting their support and keeping them informed about Project activities in their areas.

The second long term technician will be an expert in the area of adult education/community development and will serve as Director of Training for the Project. This person will be assigned to the Office of the Regional Medical Officer and will work with the Regional Health Officer, who is responsible for health education and sanitation activities in the Region. He or she will coordinate specifically with staff of the Continuing Education for Health Workers Project, together with other personnel of the RMO's office and the Regional Adult Education Officer to insure that a Regional training capacity for Ward Health Facilitators and Village Health Representatives as defined under this Project is created. This technician will assist in the development of the curriculum and the coordination of all training to be provided by the Project.

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Both long term technicians and their counterparts will be responsible for orienting all appropriate personnel in the Arusha Region during the first six month phase to establish the necessary framework and support for future implementation and to gain consensus on the need for and objectives of the Project.

A short term consultant in the area of training will also be provided, who will be a specialist in using the facilitator method of community development. This person will assist the Training Director and his Tanzanian counterparts to set the training schedule, develop the curriculum and perform the initial training of the candidates selected to become Ward Health Facilitators. In addition, health educators, training specialists, engineers, sanitarians, nutritionists, public health physicians and other experts as necessary will be employed as short term consultants to help implement or evaluate the Project. A more detailed presentation of the qualifications and job descriptions for the long term technicians is presented in Annex L.

Commodity support by AID includes vehicles, educational equipment and materials for the support of Facilitator training sessions, office equipment, and furniture. Training costs, including costs for transport, per diem and other support costs in connection with Ward Health Facilitator training sessions, will be borne by AID. In addition AID will make available funds to be used in the support of selected village initiated public health interventions. These funds will be used to finance commodities and/or services that could not be financed or provided either by the Government or other sources as explored by villages in the project preparation process. These funds will be made available to the Regional Development Director, who will utilize them as necessary following the submission, review and acceptance of village project proposals. Vehicle support costs will be borne by AID, as well as certain per diem and honorarium support for Ward Health Facilitators and Village Health Representatives. The per diem and honorarium support will be gradually undertaken by the Government and individual villages until the end of the Project, when Tanzania will cover these costs entirely.

The Government of Tanzania will provide support to the Project through the salaries of existing Government personnel who will be involved in Project activities. This includes the 46 Ward Health Facilitators to be chosen by the Project. Existing civil servants and Party officials will also be used to explain the goals of the Project, to act as resource persons to village governments, and to assist in the implementation and evaluation of specific health projects as they are identified. Support of Ward Health Facilitators through the payment of per diem costs for nights out in the villages will be shared by the GOT and AID as outlined in the Detailed Budget. The Government of Tanzania will provide office space for the technicians in the RMO's office, and will provide housing for the two long term technicians.

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7. Explanation of Outputs:

Each output, as listed above in part 5 of this section, will now be described separately in more detail to permit more complete understanding of Project activities.

INVOLVEMENT OF GOVERNMENT AND PARTY LEADERS

Because of the long time period that normally occurs between project paper preparation and actual implementation of any project, it will be necessary to remind those local Government and Party leaders who were involved with project design about the Project. At the same time the rest of the Government officials and other leaders will need to be oriented to the Project. This period of building commitment to the Project and its objectives is expected to take six months and is considered an essential stage. Because existing civil servants will be utilized as Ward Health Facilitators, it will be necessary to have the support of their supervisors, who must agree to make them available and to help sustain their efforts to carry out the Project's activities. As a result of the size and diversity of the Arusha Region, it will require the first six month period to allow the two Project technicians and their counterparts to personally interact with officials throughout the entire area. Contacts must be made not only with functional managers (health, agriculture, water..), but with their staff and Party officials down to the Ward level. Seminars for these Government staff will be carried out at the Regional, District, and Divisional/Ward levels. Information regarding the Project will be disseminated through normal Government communication channels from Regional officials in the Regional Development Director's Office, but direct contact with Project personnel will reinforce this and begin the deeper process of commitment that results from personal contact.

DELEGATION OF RESPONSIBILITY FOR VILLAGE HEALTH MATTERS

As mentioned in Section IIC (1) above, there is presently no subcommittee of the Village Development Council specifically named as a "Village Health Committee". Health is somewhat loosely covered in the responsibilities of the Education, Culture and Social Welfare subcommittee. It is expected that through early discussions in the Office of the Regional Development Director, it will be agreed that the Government formally endorse this delegation of responsibility, thus clarifying the situation with respect to health. The actual mechanism of this endorsement will be finalized during the first six month phase, and will provide the legal, and administrative basis for the structure that will then function as the Village Health Committee.

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There are several options which may be considered during this period:

1. a separate subcommittee may be created with only health related responsibilities;

2. the already existing subcommittee may be renamed to include health; or

3. the present subcommittee's health responsibilities will be clarified.

Whichever option is chosen will depend on an analysis of the present legal foundation that created the Village Development Councils and their subcommittees and a decision by the RDD regarding the best course of action consistent with Government policy. The Hanang Village Health Project has already encountered this problem in Hanang District and their experience will be utilized by the present Project.

SELECTION OF WARD HEALTH FACILITATORS

The key to initiating Project activities will be the selection and training of Ward Health Facilitators, who will activate and interact with Village Health Committees, stimulate discussion about health in the villages and gain the support of respected village leaders for Project activities. To be effective in this role this person must be recognized by the village as knowledgeable and credible as a health resource. In order not to create an administratively unwieldly and expensive new cadre of personnel to perform these functions, it was decided to utilize already existing Government personnel. In the health sector the quality and quantity of all categories of personnel are still highly variable. Therefore, instead of identifying one specific cadre from which to choose candidates, a number of different categories will be eligible (See Technical Feasibility).

In some areas there may not be sufficient health personnel available to assume this role, so it was determined that Ward Health Facilitators should be chosen from a "pool" of available Government personnel, with health personnel being given first priority, but with other categories also being eligible, depending on availability, training, experience, background and demonstrated skills and attitudes in working with villagers. Because some health background is considered essential, the other categories to be included are:

1. adult educators, who have had experience in the health field through national campaigns such as "Mtu ni Afya" (Man is Health), "Chakula ni Uhai" (Food is Life) and campaigns against cholera and other diseases related to the environment; and

2. local teachers, who have been involved with teaching about health in the schools.

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These people are considered to be generally respected by the villagers and recognized to be knowledgeable about health. The use of Government workers from other sectors such as agriculture, water, livestock, forestry, etc. was not thought to be feasible due to their probable lack of credibility in the health sector in the villagers' eyes, and their lack of experience and confidence in the area of health.

During the initial six month orientation period, as Project personnel are travelling through the Region, one Ward from each Division will be selected for the initiation of Project activities. District and Divisional Government and Party leaders will indicate appropriate Wards for Project selection. It has been determined by the APVDP that the Ward is a locally effective administrative unit which can be usefully worked with (See Section III D, Administrative Feasibility). At the Ward level an ad hoc selection committee will be created, charged with the responsibility of identifying prospective candidates and then choosing 2 Facilitators from each Ward for Project training. This selection committee will consist of the Divisional Secretary, the Ward Secretary, representatives from each Ward village, the District Health Officer and the District Medical Officer.

WARD HEALTH FACILITATOR TRAINING

Because of the expected diversity in background of candidates selected for training. it will be necessary that they be provided with a common pool of knowledge and skills which they will utilize in their work with Village Health Committees. They will receive an initial intensive three week training course which will cover methods of group interaction to stimulate discussions of community development, and basic public health concepts and principles (See Section III C). The emphasis in the initial session will be on the process of stimulating village discussion. Since some of these people may not have a formal health background, some basic health concepts will also be covered.

Additional technical training and follow-up sessions on group discussion techniques, the planning process and project proposal preparation will be provided by the Project through continuing education workshops that will take place 6 times per year. Project technical experts will collaborate with Government officials and utilize existing Tanzanian expertise as available and necessary to provide this training. It is expected that through this Project and the Continuing Education

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for Health Workers Project, a Ward Health Facilitator training capability will be created, which will be able to expand and continue training Facilitators following the end of the Project, eventually reaching the rest of the villages in the Arusha Region.

ACTIVATION OF VILLAGE HEALTH COMMITTEES

Following initial training as described above, the Ward selection committees, already established for Facilitator selection, will choose one village in the home area of each Facilitator in which work with the Village Health Committee will begin. Village selection criteria will be established by the Project according to the guidelines set out in Section III C. The Facilitators will make contact with the selected village leaders, utilizing methods and procedures developed by the Project and discussed during the initial training phase. Experience already gained by the APVD Project in working with villages at various stages of development will be utilized during this process. It will be necessary to use different methods of approach in specific villages, according to the background and experience of the Facilitator, the village leadership and the level of activity of the Village Development Council. As the Project itself gains experience in this area, the Facilitators will use their continuing education sessions to share methods and experiences and discuss what works and what doesn't.

The goal of the Facilitator will be to establish an active Village Health Committee in each selected village. This will involve the following steps:

1. the five members of the Village Health Committee will be named and a schedule of regular meetings will be established;

2. the Village Health Committee will meet at least monthly to discuss health-related matters;

3. initial discussions will take place in the village, coordinated by the Village Health Committee, to discover the current patterns of health and illness and present responses taken by villagers to health problems. This will be an exercise in making public the knowledge and patterns of behavior that exist. Through this process the Ward Health Facilitator and villagers together will recognize which illnesses are most common, when they tend to occur, and what groups of people are involved. They will discuss the current options for treatment and the most frequent responses to illness. The main thrust of this process is to help people recognize what they know and do not know about health and

illness. The role of the Facilitator is to listen and elicit this knowledge from the villagers. The people best prepared to lead the way in obtaining this knowledge may be the traditional healers and village midwives. The Facilitator will be expected to share this knowledge with all appropriate local health personnel at the nearest health center or dispensary. This important phase will provide the information base for the subsequent planning of behavioral changes regarding preventive health measures. Any behavioral modifications planned must be based on what people actually do from day to day and how they interpret their own actions;

4. discussions will take place, coordinated by the Ward Health Facilitator with technical input from other appropriate local health personnel regarding which health problems are most important to the village and what possible courses of action might be taken to remedy the problems. This process will involve the provision of health education to the Village Health Committee and to groups of villagers to help gain consensus regarding what causes certain health problems and therefore what interventions might be appropriate to alleviate the situations.

The process of the Ward Health Facilitator gaining the trust of the villagers and building the necessary commitment to any activities initiated will require a period of time similar to that allocated initially in building awareness of the Project throughout the Region. It will be necessary for the trained Facilitators to become familiar with their new role by spending time in the villages interacting with the villagers. Since this person will already have a job, a schedule will be worked out by the Facilitator in cooperation with his or her supervisor to allow the necessary village level interactions to take place. This schedule must allow the Facilitator to set aside blocks of time during which full time will be devoted to Project activities.

In the majority of cases where the Facilitator is a Government health worker, those cadres whose job description already includes responsibilities for public health activities in the villages will be used. As discussed in Section II C (1), in many cases, these people are not now fulfilling their mandated preventive health functions and the Project will help to strengthen their abilities in these areas. It is expected that this breaking-in process for the Facilitator and the villages will require approximately six months following completion of their initial training. At the end of this period the Facilitator will have worked out a regular schedule of village visitation that will be integrated into his or her ongoing job and the discussions described above in this section will have taken place.

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SELECTION OF A VILLAGE HEALTH REPRESENTATIVE

During the six month process just described above, while the Ward Health Facilitator is establishing contact with the village and beginning to hold discussions with the Village Health Committee, one member of this Committee will be selected to be the Village Health Representative. This person will act as the counterpart in the village for the Ward Health Facilitator. He or she will be present at all times when the Ward Health Facilitator is working in the village and will be responsible for seeing that any necessary follow-up activities are completed. This person will be the Project link to the village and as such is considered essential for the necessary continuity and commitment at that level.

Tanzania is just embarking on a formal Primary Health Care Program with one objective being the selection and training of two people from each village to act as Village Health Workers. These people will provide the final link in the health care system that will bring some form of health services to the villages, thus extending the system to the actual areas where people live. The Arusha Village Health Project is not proposing that the Village Health Representative described in this section function as a Village Health Worker, as defined by the Government program. Instead, this person will receive only one week of initial training and yearly refresher courses by the Project carried out by the Ward Health Facilitators. These training sessions will introduce the Project and detail the Village Health Representatives' responsibilities in the village but will not enable them to carry out all the activities detailed to Village Health Workers. However, it is expected that when the Government program begins, Village Health Representatives will be obvious first choices to become Village Health Workers.

In Hanang District, where Village Health Workers have already been trained and are presently functioning in approximately 80 villages, one of these people may be chosen as the Village Health Representative. In this District, as a result of the Hanang Village Health Project, it is anticipated that many of the activities detailed in this paper will be easier to implement, because of the groundwork already completed.

INITIATION OF PUBLIC HEALTH INTERVENTIONS

After the necessary deliberations have taken place regarding health problems, the Village Health Committee will study the options for solving a selected priority health problem, and will decide on a health project they would like to undertake to attack this problem. The VHC then will work with the Village Development Council to determine what inputs will be required to carry out the chosen intervention. Discussions will take place to determine what resources the village itself can offer (these might include monitary contributions in more well

off villages, or the provision of labor and/or locally available materials), what resources are available in the area through Government or private organizations, and what resources, if any, may be required from outside the local area. This information will be assembled and a project proposal formulated. The Ward Health Facilitator will provide guidance in the preparation of the proposal and will be responsible for seeing that it is forewarded to the District Development Director's Office. It will then be reviewed by the District Development Planning Committee. If accepted, it will be forewarded through the District Development Council to the Regional level, where it will again be reviewed. The Regional Management Team will review the proposal and submit it for consideration to the Regional Development Council. Projects which are approved at the Regional level and which require outside funding will be submitted to a Project Review Committee, which will make the final determination on levels of Project funding that can be made available to support the proposal. The criteria to be used in determining which proposals will get this funding are discussed in Section III C (8). Once a project has been approved through the above mechanism, the VHC will begin mobilizing the resources necessary for implementation. The primary responsibility for activities in the village lies with the VHC. The Ward Health Facilitator with assistance by the Village Health Representative will monitor the progress of obtaining approval as well as implementation and provide assistance when necessary. It will take the combined efforts of the Facilitator, the Village Health Representative, and the VHC to maintain interest and commitment in the village during actual implementation.

PROVISION OF HEALTH EDUCATION

During the stages of activity described above, the Ward Health Facilitator will be responsible for involving appropriate Government health personnel to provide the necessary health education or technical advice in support of the Project's activities. The present problems impeding effective action in the public health area were cited above in Section II C (1). A number of these problems could be alleviated through the provision of effective health education at the village level. Since some Facilitators may not have all the specific technical knowledge required, it will be necessary for them to maintain a working relationship with the other health personnel in their area and use them for technical backstopping.

INCREASED INVOLVEMENT OF LOCAL HEALTH PERSONNEL

Most Ward Health Facilitators will be chosen from the ranks of already existing health personnel. Their responsibilities already include initiating community public health

activities, but due to the constraints detailed in Section II C (1), they are not effectively carrying out these responsibilities now. The Project will encourage and enable them to fulfill these duties through the following:

1. the provision of transport to enable them to reach the villages in which they must work;

2. the provision of training to bolster and support their technical backgrounds; and

3. the provision of per diem support to enable them to spend the necessary time in the villages.

The Regional Medical Officer strongly supports this Project and will provide the administrative pressure from above that will make it possible for local health workers to spend more time in the villages. Aside from the Ward Health Facilitators themselves, other health personnel will become involved in the Project through the increased demand for their services that will be created by the Village Health Committees. The necessity for health education coordinated by the Facilitator will also bring health workers to the villages more frequently.

RECOGNITION OF THE VALUE OF COMMUNITY PUBLIC HEALTH INTERVENTIONS

Due to limited manpower and Government resources, it is not expected that actual health facilities will reach every village for several decades. To promote Primary Health Care, even without a dispensary in every village, the Government is planning to embark on a national Village Health Worker training program in the near future. These Village Health Workers will be expected to provide basic health services to the villages and to initiate preventive public health projects. Through this mechanism villages can hope to address some of the causes of poor health with the avialable resource base. Through the activation of Village Health Committees and the undertaking of successful community initiated and planned health interventions under this Project, Government leaders and villagers will begin to recognize the ability of local villagers to take a significant level of responsibility for their own health, and will be better prepared to participate in the upcoming Village Health Worker Program.

ENHANCEMENT OF ABILITY OF COMMUNITIES TO UNDERSTAND AND RESPOND TO LOCAL HEALTH PROBLEMS

Discussed above.

8. Beneficiaries

The Project proposes to work in at least 92 villages in Arusha Region, which amounts to approximately 20% of the Region's villages. Using this figure as an average, the Project should directly affect approximately 186,000 people. These people will be reached through the public health projects implemented by their Village Health Committees. Aside from the long term health benefits that will result from the Project interventions, these villagers should also benefit in other ways from the increased ability of their Village Development Councils to plan and take action against locally identified development constraints. This will result from strengthening the administrative and planning abilities of individual members of the Village Health Committee, which also deals with other matters relating to education and social welfare. If the Village Health Committee is successful in organizing and mobilizing resources to carry out visible and effective projects, other committees will be able to use that experience as a model in their own areas of responsibility.

Government health workers at all levels will also benefit from the Project. Direct beneficiaries will be the 46 Ward Health Facilitators who will be trained and supported to improve their preventive health work in the villages. Their colleagues, especially at the dispensary and rural health center levels will also benefit from a sharing of their village experiences. Increased village exposure will give them a better understanding of the problems of the rural areas and practical experience in working to solve them. This will result in the health system becoming more effective in it's stated goal of strengthening preventive health services in the rural areas.

The health system will also benefit from the Project's work throughout the Arusha Region, which represents many of the diverse ecological and social conditions that are found throughout Tanzania. Instead of concentrating only on certain areas or districts, which might have been easier administratively and logistically, the Project has chosen the more difficult task of entering all districts. The level of Project activity will surely vary from area to area depending on many social, cultural and economic factors. In any case the experience gained in attempting to work under these varying conditions will improve the Government's ability to respond to similar differences found elsewhere in Tanzania.

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A. Economic Feasibility

The purpose of this Project is the establishment of a process at the village level leading to greater village capacity for responding to health problems. It is expected that the health interventions implemented will result in long term benefits in the health status of the affected population, but these benefits are difficult to quantify. Like most projects in the health sector, the Arusha Village Health Project is not designed to generate any revenue. It will therefore not be possible to develop a quantifiable economic analysis from which to base conclusions regarding its economic worth. It must be justified on the basis of being reasonably costed out, less expensive than alternative approaches, within the Government's ability bear the present and future recurrent costs, and directed toward a reasonably large number of beneficiaries, thus providing maximum benefits for the Government and the people of Arusha Region at a reasonable cost.

1. Reasonable Costs

The detailed budget for the Project is presented in Annex B, with individual inputs costed on the basis of the most recent information available to the Government and the Mission as of May 1981. In those instances where costs are relevant to the situation in Tanzania and the Arusha Region, officials from the office of the Regional Development Director have collaborated in the establishment of cost estimates. Experience gained in the ongoing APVDP with regard to certain operating costs has been incorporated. On the basis of experience with other projects in the Tanzania Mission portfolio, including the APVDP, overhead which includes the contractor's fee, has been included in the projected costs for technical assistance. A contingency factor of 10% has been applied to the AID budget in keeping with established AID procedures, while a contingency of 5% has been applied to the Government of Tanzania budget, according to their normal procedures. The contingency factor has not been applied to salaries because these figures are considered reasonably firm, based on extensive AID experience worldwide. A constant inflation rate of 12% compounded annually has been applied to all but personnel costs, for which 5% was used. On the basis of Mission experience, it is deemed essential to make a reasonable provision for inflation, even though this category will account for a substantial portion of the budget.

2. Least Expensive Alternative Providing Maximum Benefit

Ward Health Facilitator:

The establishment of the village capacity to plan and implement public health projects will occur only in so far as the work of the Ward Health Facilitators is effective. This makes these people the key element upon which Project success will depend. Given this important role, the establishment of the Ward Health Facilitator position as a separate manpower level, working full time on village level activities was considered.

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However, to accomplish this, a sufficient pool of experienced candidates in the health sector would have to be available from which Facilitators could be chosen. Following training they would then be lost to their previous jobs and the Government would have to pick up paying their salaries over the long term. If they were not already health sector personnel, a more extensive, longer training course would have to be developed to give them the necessary health background, which would be time consuming and expensive. Given the short supply of trained manpower in the health sector and the costs associated with the establishment of a new cadre of personnel, it was thought to be more efficient and less costly to utilize existing personnel in this role.

Village Health Representative:

Preliminary design work indicated that from a cost and logistics point of view, utilizing the Ward Health Facilitator alone as the Project link to the village would be the best alternative. Following more careful examination of the objectives of the Project with Regional personnel, it was determined that final success would depend on the establishment of a more permanent liason at the village level. This liason needed to be someone from the village who would be available to follow up on Project activities there. The logical alternative for this person would be a village health worker in those areas where such a person exists. In most areas of Arusha Region, village health workers do not yet exist and it is neither economically feasible nor within the scope of this Project to provide them. The Government is presently planning it's own program to provide these workers. Therefore, it was felt that the best way to get the essential Project representation in the village in the interim period at the lowest cost was the selection of a Village Health Representative, who would receive some specific training by the Project, and receive on the job training through working closely with the Ward Health Facilitator. Instead of paying this person a regular salary, which would create a larger long term burden on the Government, Regional officials suggested the payment of a smaller monthly "honorarium", similar to the mechanism used to pay adult educators. Over the course of the Project this honorarium will be picked up by the Government, with the later expectation that this person will most likely become one of the Village Health Workers under the coming Government program.

Transport:

A key constraint to the functioning of the health system in the rural areas presently is the lack of transport for field personnel. It was originally proposed that Landrovers be provided for the District Medical Officer and District Health Officer for all Districts to enable them to properly support the

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Project. Given initial purchase price, petrol and maintenance costs and the long term implications for the Government recurrent budget, it was not considered feasible to provide this level of transport support.

The Project has chosen instead to provide Landrovers for the long term technicians and key Regional health personnel, with motorcycles for supervision at the District level. Since it was considered essential for Ward Health Facilitators to be able to reach the villages, the least costly way of doing this was to provide them with motorcycles. It was found under the APVDP that the best way of assuring their long term usefulness and maintenance at the lowest cost is through a purchase arrangement in which the assigned person actually buys the motorcycle from the Project through a loan agreement and becomes personally responsible for it's operation and maintenance. This mechanism will also be instituted by the Project.

Technical Assistance:

Given the size and diversity of the Arusha Region and the required amount of training and related travel that must be undertaken by Project personnel, it was felt that a minimum of two long term technicians as described earlier would be necessary. The short term training consultant will leave after initial Ward Health Facilitator training has been completed. Because of the high costs associated with the support of long term technicians, the need for their services was carefully assessed and discussed with Government officials, and the established level of this assistance was agreed upon.

Training:

The training costs of this Project are minimized through the exclusive use of in-country, competency based training for the Ward Health Facilitators and the Village Health Representatives. Existing District and Regional health personnel will be utilized in the training sessions to insure that a continuing capacity for undertaking this type of training is created. The Ward Health Facilitators themselves will be used during the Village Health Representative training. Existing health or training facilities at the district level will be utilized to carry out the training. Short term continuing education sessions provided often throughout the year will be emphasized following the short, initial basic training. This will minimize the costs associated with taking people away from their jobs for long periods of time and the low level of practical field applicability associated with longer term training efforts. The emphasis will be on sharing field experience and providing a feedback mechanism to spread the word about what works and what doesn't under specific conditions. All training will be done in the field as close as possible to the actual places where the field personnel work.

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Village Sub-Project Support:

As described earlier, it is expected that the activation of the Village Health Committee leading to the implementation of sub-projects should rely on the identification and utilization of local resources as much as possible. It is not intended to establish a Project which could not exist without the provision of a high level of outside resources. Still, on the basis of the APVDP experience and discussions with Government officials on this subject, it has become clear that some level of resources must be made available as an incentive for the establishment of the desired process. Because of the resource constraints facing Tanzania generally, which are even more extreme in most rural areas, some level of support will be necessary. For planning purposes it was assumed that approximately $14,000 per village would be the minimum amount that would reasonably fulfill this support requirement. At this level, larger infrastructure development projects will in most cases not be possible , but support for smaller, more reasonable ones will. This will make it more likely that the established process will be applicable for spreading to other areas. The criteria developed by the Project for allocating support to village proposals will be the most important mechanism for controlling the types of proposals submitted and therefore for keeping the level of projects reasonable in terms of initial cost and replicability in Tanzania.

3. Recurrent Cost Implications:

A presentation of the total Project budget, which includes only those items considered to be long term operating expenses is shown in Annex J. All categories of recurring expenses which will be necessary to maintain Project activities at the same level following the termination of AID support have been included in this analysis. Costs associated with technical assistance were not included because the Project has been designed to build up the capacity of the existing administrative structure to maintain activities following the initial five year start-up phase. The sub-project support fund is also not included because the purpose of the Project as designed is not specifically to undertake health sub-projects, but to strengthen the capacity of local village government structures to effectively search out and successfully compete for locally identifiable resources to address their problems. These resources may come from the Government, private voluntary sources or outside donors following the termination of AID funding. The important activities that must continue and which are included in the presentation are those associated with the continuing education, supervision and transport of those health personnel responsible for providing outreach services to the rural areas.

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A comparison of these figures to the Government of Tanzania contribution to the Project yields the following results:

Percent of Recurrent Costs Paid Each Year by GOT

fiscal year	82*	83	84	85	86	87*
percent	28	44	57	54	60	76

*Note: FY 82 and 87 represent 6 months of Project activities.

As can be seen from this analysis, in the final year of AID funding, the Government of Tanzania will be supporting the Project at a level equivalent to 76% of the recurrent costs. Further analysis of the data shows that nearly 50% of the projected recurrent costs in the final year are represented by allowances made for contingency and inflation factors. In addition, all the initial and continuing education seminars have been included in the cost estimates. Following the first five year phase, the level of seminars planned, especially at the Regional and District levels could be reduced, if budget constraints required it. This is because by that time all Regional and District personnel would have been thoroughly trained and a maintenance level of continuing education would suffice. It is therefore concluded that the present Project as designed fits within the long range financial capacity of the GOT to maintain activities following the termination of AID support.

4. Number of Beneficiaries

Based on the minimum number of villages to be covered, the AID project cost will be $2.94 per beneficiary per year. This compares favorably with most AID projects in the health sector. Based on the analysis made in Annex Q of the final year's recurrent costs, the Government will need to support the Project at the end of AID funding at the level of $1.49 per beneficiary. This level of support should be well within the ability of the Government to maintain the Project following termination of AID funding.

B. Social Soundness Analysis

1. Introduction

Since its accession to independence, the government of Tanzania has been committed to a policy of development of social services according to socialistic principles that promote equitable distribution of benefits to the rural population. In the health sector there has been a steady investment in the construction of health care facilities throughout the country to provide curative medical services. In the last few years the government has emphasized the importance of investing in preventive health measures, but has found implementation difficult. The preventive side of medical care receives little funding despite GOT interest in it. In short, this Project fits closely with the GOT's priorities for investment in the health sector, as well as the emphasis upon self-reliance.

2. Overview of Tanzania

The 1978 census showed that Tanzania had a total population of 17,016,000, with an annual growth rate of 3.3%. Most Tanzanians are engaged in subsistence farming, with 88% of the population being rural. The more than 120 languages spoken in Tanzania belong to four of the major linguistic groups found in Africa (Bantu, Nilo-Hamitic, Cushitic, Khoisan). The country includes a wide variety of ecological zones, from the fertile highlands in the north and south to wet coastal lowlands, to near desert conditions in the central plain. The variations in ecological zones are reflected in the modes of production and social organizations in those zones. The pattern of diseases and the health status of the population is typical of other countries in tropical Africa. The common diseases are infectious, communicable and parasitic in nature. Malnutrition causes 10,000 deaths among children annually, and is the underlying cause of another 50,000 deaths each year.

3. Arusha Region

The population of Arusha Region in 1978 was 928,478, with a growth rate of 3.8%, making it one of the fastest growth populations in Tanzania. Ninety Five percent of the inhabitants live in rural areas and engage in either agriculture or livestock keeping. The remaining 5% are involved in business, manufacturing or small industries. The Regional per capita income is Tsh 1,500/= per year. Population pressure on available farm land is now evident in some parts of Arumeru District and also in north-central Mbulu District. The expanding population, along with the government resettlement schemes, have greatly reduced the grazing land available for pastoralists in southern Hanang, Kiteto, and Monduli Districts.

A. Climate and Ecological Zones

Arusha Region has a moderate climate which favors intensive

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agricultural production. Average rainfall is between 500-800 mm divided into two rainy seasons: short rains in October to December and long rains from January/February to May. During the short rains, coffee, maize and beans are planted, and during the long rains all other crops. Average temperature varies with altitude, but generally favors crop production most of the year.

The region can be divided very generally according to type of soil and altitude. In the higher areas of Arumeru, northern Mbulu, and part of Hanang Districts, there are volcanic soils with high rainfall, permitting intensive production of both food and cash crops. In these areas the land has reached its maximum carrying capacity with present productive techniques. In Monduli, much of Hanang, and southern Arumeru Districts, one finds a loamy soil at an altitude of 3-4,000ft. This area supplies much of the region's food crops. In all of Kiteto and the low areas of Arumeru Districts, the soil may be sandy or loamy but rainfall is unreliable making it impossible to grow other than drought-resistent crops (millet, cassava, cotton, etc.).

Recognition of intra-regional ecological variations is important for two reasons: 1) the modes of production suitable to each zone are different and the social organizations are correspondingly different, and 2) the kinds of health problems will differ according to the ecological context. For example, in the arid areas of Monduli and Kiteto water is frequently difficult to obtain; thus, most health concerns relate to the lack of water.

B. Ethnic Background

Arusha Region has been occupied by several major ethnic groups whose origin, languages, historical experience, and modes of production vary tremendously. The majority of Mbulu Distric is inhabited by the Iraqw, sedentary agriculturalists, whose mixed farming methods are highly adaptive. In southern Mbulu and in Hanang one finds the pastoral Barabaig who have a history of competition for land and cattle with the Iraqw. The language of the Barabaig is of Nilotic origin, while that of the Iraqw is Cushitic. In Arumeru District one finds Arusha, Meru and Chaggá engaged in cash crop production, particularly in the area near Mt. Meru. In the three districts known as the "Masai Districts" (Ngorongoro, Monduli, and Kiteto), the Masai are the majority population. They are exclusively pastoralists and speak a language of Nilotic origin. In the western part of Mbulu, one finds a few (less than 1000) Hadza, who are hunter/gatherers and keep to themselves completely.

Throughout the non-Masai districts one finds ethnic distinctions decreasing in importance, as Swahili becomes more widely used and as people from different origins are resettled in new villages. However, the Project must take note of major differences among the main groups because attitudes and knowledge about health and illness will differ.

C. Village Settlement

There are now 453 registered villages in Arusha Region which

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encompass more than 95% of the population. The "villagization" program of the mid-1970s has been successful in making almost everyone a member of one village. In parts of Arumeru and Mbulu this resettlement consisted primarily of drawing appropriate boundaries around existing settlements. In other parts of these districts and in Hanang, people were sent to areas previously uninhabited and were told where to construct their homes and where to farm. In the Districts where pastoralism has been supreme, the government has established villages for the herds. Thus in some parts "villagization" and the establishment of a viable village government has been achieved; in some other areas it is an on-going process.

The goal of the GOT's villagization plan, which made resettlement obligatory in November of 1973, was to create villages with from 250-600 households with each head of household having rights to six acres of arable land. Actual village size fluctuates according to population density and mode of production. The variations in village size and or organization that are crucial to tailoring this project to local conditions exist more at Ward level than at District level.

D. Sociopolitical Organization

The identity, functions, and rights of corporate groups within and among villages are changing rapidly as the GOT establishes new political organizations within each village. All villages have a Village Development Council (VDC) composed of 25 members, headed by a Village Chairman. Villages are sub-divided into "kitongoji" (about 100 households) and 10 household groups with an elected leader for each unit. The VDC is divided into five sub-committees, each with specific responsibilities in village government set out by the GOT for all villages. One of these sub-committees is the committee for Education, Culture and Social Welfare, and issues related to health fit closest with the mandate of this committee. Since each village is a corporate and legal unit empowered to enter any kind of contract with other parties, the VDC constitutes the main decision-making body for the village. All matters of general concern must go through the VDC. The elected chairman of the VDC is responsible to the Ward Secretary, who is appointed by the Party. His superior is the Division Secretary, also appointed by the Party (see Administrative Feasibility).

There are many other social groups within villages that are important decision-making bodies in particular domains, but it is impossible to generalize about them for the entire Region. The importance of groups with a traditional basis of authority varies with the pattern of resettlement, the ethnic group involved, and the functioning of the VDC. How each Ward adapts to government reorganization of political activity is slightly different. The Project will need to ascertain what the real pattern of decision-making is for each Ward in order to work effectively.

E. Health Status of Population

The health status of the population of Arusha Region is greatly affected by diseases commonly found in rural areas of tropical

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Africa. Without accurate indices of health status (levels of morbidity, disability, etc.), we are left with statistics from hospital admissions and treatments at dispensaries, and most of these are available for the entire country. For instance, in 1977 nearly half of patients treated or admitted to hospitals in Tanzania suffered from infections or nutritional disorders. The most frequently recorded cases of mortality in hospitalized persons from 1977 were pneumonia, measles, and gastroenteritis. Children under five in Tanzania are highly susceptible to the synergistic effects of malnutrition, malaria, gastroenteritis and intestinal parasites. In the Arusha Region the importance of malaria varies inversely with altitude. Malnutrition is more a problem of nutritional styles rather than shortages of food. Intestinal disorders are related to water-borne disease vectors and parasites.

A major study of health problems in Tanzania prepared in 1980 as part of a Health Sector Strategy paper for USAID shows that Arusha Region has higher levels of productivity and lower levels of mortality and morbidity than most other regions of Tanzania. It also demonstrates that current health problems are related primarily to problems of environmental sanitation and life style. This indicates that investments in the health sector should be directed to preventive health measures of the type proposed by this Project.

F. Health Facilities

Health care facilities in Arusha Region are of four types: Hospitals, Rural Health Centers, Dispensaries, and Village Health Posts. These are administered by the government, by Voluntary Agencies (churches) or by parastatals. Government targets of one Dispensary per 10,000 people, one Rural Health Center per 50,000, and one Hospital per district are nearly achieved. The target of one Village Health Post (VHP) per village is far from being satisfied, with only 140 VHPs for 453 villages in 1980.

The major constraints to health care delivery cited by Regional Medical Officials are lack of transportation, lack of drugs and essential materials, and serious understaffing. Although we know that traditional healers and traditional midwives provide a great deal of medical services, very little information is available about the actual pattern of the utilization of medical resources.

4. Socio-Cultural Feasibility

A. Design

The feasibility of this project will be determined by whether or not villagers perceive that their participation in the "process" described earlier can lead to fewer illnesses for themselves and their families. We can expect good participation under the following conditions:

1) the operation of the Project remains sensitive to local

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conditions;

a) the Ward Health Facilitators work through existing patterns of leadership;

b) the Ward Health Facilitators maintain good rapport with the village leadership

2) the Project gains the active support of government and Party officials before implementation begins;

3) the work of Ward Health Facilitators remains geared to what people actually know and think rather than what they "should" know or think.

The Project has been designed to maximize these conditions. The greatest single danger to the Project's feasibility will be the temptation to move too rapidly, to loose patience with the pace of the activities that occur, to begin telling villagers what to do rather than continue assisting them in making clear what they know and want. This danger can be avoided if the Facilitators avoid using a didactic approach in their interactions. If this temptation is avoided, the great diversity in ethnic origin, social organization, and historical experience will not prove to be barriers to the feasibility of the Project.

B. Implementation and Maintenance

As village leaders become involved in teaching the Ward Health Facilitators their knowledge of illness and its treatment, and as the Village Health Committee learns to address itself to health issues, Facilitators must carefully monitor the on-going interactions associated with the Project. Although the Project has described a number of activities that will be taking place at the village level, these activities must not be considered as discrete, separate phases. There is a continual need to repeat activities to ensure that support is elicited and understanding has been established. Facilitators will be faced with situations of apparent slowdown or stopping of all activities of the Project and must anticipate the need to rekindle interest in the work of the Village Health Committee. The periodic workshops for Facilitators will address this problem directly. The guiding principle in villagers' participation will be to maintain someperiodic interactions recognizable as part of the main phases of the Project.

C. Behavioral Changes

Through the Ward Health Facilitator training sessions benchmarks will be established to identify and monitor behavioral changes that affect the health status of the village, however indirectly. These indicators include the following:

1) general recognition of the patterns of utilization of medical resources of all kinds;

2) meetings of the Village Health Committee to discuss health issues;

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3) decisions by the village government to prepare proposals for health interventions;

4) village commitments to implement particular health interventions; and

5) the gathering of funds and of labor for specific health interventions.

Some of these behavioral changes are actual events and can be counted; others are attitudinal changes that do not lend themselves to quantification. The latter type of change is primarily an increased awareness of the relationship between life style and disease incidence, and a willingness to propose and take action on health problems through the Village Health Committee.

5. Spread Effect (the diffusion of innovation)

The potential for increasing the numbers of participants in the Project beyond the original selected villages falls into two categories: the expansion of the Project from one village to another in the same Ward, and the expansion into other Regions of Tanzania. With regard to the first type, the decision to choose as Ward Health Facilitators, civil servants who already have one Ward as their locus of operation, makes such expansion very likely. Each Ward contains 2-6 villages. If a Facilitator works in only one village for two years and village participation is high, the neighboring villages will soon learn about those activities. Such a Facilitator may well be asked to begin work in another village, since he or she is already known through other duties. This mechanism will insure that news of the Project spreads throughout the area. In addition to this process, which should build as the Project progresses, the uniformity of government structures in all villages increases the chances that lessons about procedure and methods of operation learned in a Project village may be transferred to other villages. Government officials at the District and Regional levels will be aware of the Project's activities in their areas and will be alert to make information on effective methods and materials available to other villages.

The Project has also been designed to maximize the chances of being replicated in other Regions of Tanzania, for it depends more on training of personnel, involvement of Government officials, and emphasis on self-help activities than on the injection of a level of resources unlikely to be present elsewhere. The wide variety of ecological contexts and social groupings also makes it likely that the lessons learned in Arusha Region will be applicable to other regions. Given the Government's commitment to preventive health services, any successes of this model in the Arusha Region will be immediately available for application elsewhere. The strengthening under this Project of the existing health manpower will be of immediate benefit in supporting the upcoming Village Health Worker training program, since these people will supervise the Village

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He lth Workers.

6. Social Consequences and Benefit Incidence

The Project seeks to involve all members of participating villages in the process of recognizing what illnesses are common, what are the current patterns of utilization of medical resources, and how these resources might be better used. The Ward Health Facilitators will work first with village leaders (both men and women) to discover the disease patterns of the villages. Since the actual pattern of leadership varies greatly according to ethnic background, mode of production, and settlement patterns, it is impossible to be specific about identifying village leadership at this stage. One cannot expect to work in the same manner with coffee growers in Arumeru, wheat farmers in Mbulu, Masai pastoralists in Monduli, and Barabaig pastoralists in Hanang. However, the village government, primarily the Village Development Council (VDC) takes the lead in planning activities for the entire village. The level of activity of the VDC varies greatly from one area to another, yet the basic structure is the same. In addition to the village leadership, the Village Health representative will bring all levels of villagers into the process through informal discussions and the follow up of Project activities on an individual level.

The major beneficiaries of the Project will be those villagers who gain increased awareness of health problems and who develop a capability through village government to take appropriate action. The Project anticipates working in at least 20% of the villages of the Region, which will affect approximately 186,000 people. To the extent to which their awareness of health problems is increased, they will be able to both reduce their susceptibility to certain infectious and parasitic diseases and make better use of whatever health resources become available in the future.

Aside from the direct health benefits that will affect individual villagers, as a result of any Project initiatied activities, the experience gained by the village government in organizing itself to address specific problems will lead to benefits for the population in other areas as well. The process of identifying and applying scarce local resources to priority problem areas in the village is appropriate in all sectors. Therefore, it is expected that strengthening the abilities of the Village Health Committee in this area will also have a positive effect on village government as a whole.

The improvement in the abilities of local health personnel to effectively interact with villages under their jurisdiction will strengthen the health system itself. This process also potentially spreads the benefits to people outside the direct influence of the Project.

7. Conclusion

This project has been carefully designed to follow the guidelines for village development as set out by the central government of Tanzania. It depends upon the existing government administration,

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Party structure, and traditional patterns of leadership for its operation. The project recognizes that village development depends upon self-reliance, but that local resources must at times be augmented by outside resources. The Design Team believes that the feasibility of the project is directly proportional to the amount of realistic local input into the shaping and implementation of the Project, along with an accurate assessment of village capabilities. Thus, there will be a great deal of variation in the pace and operation of the project in different areas of the Region. If flexibility can be maintained, it is anticipated that the Project will lead to the full range of benefits outlined above. Socio-cultural differences present in the Arusha Region have been considered during the design of this Project and will continue to play a major role in it's implementation. It is considered likely that effects of the Project will spread as outlined above and that the Project will reach a significant number of beneficiaries. Therefore it has been concluded that the Project as designed is socially sound.

C. Technical Feasibility

This Project has been planned to address specific constraints in the health sector now present in the Arusha Region which are impeding the Government's efforts to improve the health status of the rural Tanzanian population. It fits into and works through the existing administrative structure of the Region and is consistent with Tanzanian Government and USAID health policy. The Project will utilize a number of different "technologies" that have been identified and developed in the field of public health. These technologies fall into three broad categories:

1. the training and management of community change agents;
2. the process of initiating and encouraging community involvement in the planning and implementation of activities to solve local problems; and
3. the specific public health interventions that are generally regarded as effective in the prevention of diseases prevalent in the developing world.

Training programs have been initiated throughout the developed as well as the developing world to utilize less highly trained health personnel in the extension of adequate health services to the whole population. It has been found that through a careful analysis of the necessary tasks to be performed, competency based training programs can be developed that enable trainees to be extremely effective in specific areas of concern. Once trained, these paraprofessional workers need adequate support and supervision to continue functioning. The present Project was developed to be consistent with the present state of knowledge in the area of training agents of change and it is expected that developments in this field will be taken into account and modified to fit the existing situation by Project staff as implementation proceeds.

There is also a body of knowledge, already being utilized and adapted by the APVDP, centering on group dynamics and the methode of stimulating popular involvement in the decision making process in the Arusha context. These techniques are considered to provide an important foundation for this Project and will be the basis of much of the training provided. The Ward Health Facilitators will be the initiators of the group dynamics process at the village level and as such will play a key role in the Project. Success or failure will hinge on their ability to activate the Village Health Committees as described in Section II C(7) above. Leading group discussions and being able to resolve divergent opinions will be important elements of their job so they will study these techniques during their training period. Again, with experience, the group process skills applied will be modified to be appropriate to actual situations encountered.

The planning and implementation of activities designed to address health problems requires a knowledge of the technical issues involved in community public health interventions, some examples which might be: the development and protection of village water systems; latrine construction; other village sanitation measures; the destruction of disease vector breeding sites; other communicable disease control measures, such as immunization; and emphasizing the importance of good nutrition. These technical issues will be reinforced during the training to be provided by the Project. Since it is impossible to expect that the Ward Health Facilitators will be equally conversant with all of these technical areas, it is expected that they will be assisted in these matters by the health staff of the nearest health centers or dispensaries or by the appropriate functional managers

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(agricultural, livestock, water, etc.) from the area.

The Project approach to a number of issues listed below reflects the application of present knowledge to specific problems encountered in the Arusha Region.

1. Responsibilities of Ward Health Facilitators

The role to be played by these people in the Project is represented by the following illustrative list of responsibilities:

a) present Project objectives to village through village leaders and Village Development Councils;

b) initiate and attend meetings of Village Health Committees;

c) explain responsibilities of Village Health Committee to members;

d) stimulate discussion of present health situation in villages;

e) record and organize information about health situation and verify accuracey with villagers;

f) assist villages in identifying priority health problems;

g) provide or arrange for appropriate health education in areas of villager concern;

h) assist villages in preparation of proposals to address health problems;

i) act as liason between villages and other government personnel at Ward or District levels to bring in expertise in technical areas as needed; and

j) monitor and report all activities pertaining to the Project in the villages, utilizing reporting mechanism to be developed by Project

Because these activities are extensive and will require time to become comfortable and familiar with, initially only one village per Facilitator will be chosen for Project activities to begin in. It is expected that at least one additional village per Facilitator will be added during the five years of AID funding. It is important to begin slowly because it will not be possible for the Facilitator to spend full time on Project activities, given the additional responsibilities of his or her present job.

2. Selection of Ward Health Facilitators

Because of the severe material and personnel constraints Tanzania presently faces, new projects should be undertaken without the introduction of new cadres of workers who would place additional demands on the Government budget. For this reason the Ward Health Facilitators will be selected from already existing categories of workers. First priority in this selection process will be given to health personnel located at health centers or dispensaries in the selected Wards. Reasons for this are

presented in Section II C(7). The following categories of health personnel will be considered:

a) health auxiliaries (HA)

b) maternal and child health aides (MCHA)

c) public health nurses (PHN)

d) rural medical aides (RMA)

e) rural dispensary assistants (RDA)

Because of the importance attached to this program, the Regional Medical Officer has stated that consideration will be given to transferring people in the above categories from Ward to Ward to be sure that all Wards are sufficiently covered and there will be enough personnel to choose from. However, if it is not possible to identify a health worker to fill the role in a given Ward, the Ward Selection Committee will then consider either adult educators or teachers from the area for the reasons set forth in Section II C(7). In any case this selection committee, as described in the Detailed Project Description, will apply the following selection criteria to the choice of the Ward Health Facilitator:

a) The candidate must have a close working relationship with the villages in his area of responsibility and be perceived by the villagers as a helpful colleague and not as a policer, enforcer or reporter;

b) The candidate should have a demonstrated talent for understanding group dynamics in the village context and for motivating villagers to act in their own behalf;

c) The candidate should already be familiar with or be able to learn the general principles of community public health and use these effectively in working with villages;

d) The candidate must understand and be committed to the objectives of the Project;

e) The candidate must have sufficient time and energy to add serving as a Facilitator to his present role;

f) The candidate should be someone who is <u>not</u> likely to be transferred outside the Arusha Region during the life of the Project; and

g) The candidate should have a demonstrated ability to see a project or activity through to completion in spite of difficulties.

3. <u>Training of Ward Health Facilitators</u>

As already mentioned in Section II C(6), an expert in the training of community change agents will be employed as a short term

consultant for six months during the first year to help develop the curriculum and teaching materals for the training of Ward Health Facilitators. This person will also participate with Project staff in the initial training sessions. The 46 Ward Health Facilitators will be trained in three different groups at sites to be identified by the Project according to geographic proximity. One site will be chosen for Arumeru and Monduli Districts, one for Hanang and Mbulu Districts and one for Kiteto and Ngorongoro Districts. The sites will be the administrative center of one or the other of the two districts.

Each Ward Health Facilitator will receive three weeks of initial training prior to being introduced to the villagers in his new role. These three weeks will be conducted intermittently, as indicated in the provisional training schedule below:

a) Two month period during which the consultant training specialist develops the curriculum and training materials;

b) Three months during which the three groups of Facilitators receive their initial training:

	Facilitator Group		
Week	A	B	C
1	x		
2		x	
3			x
4 preparation			
5	x		
6		x	
7			x
8 preparation			
9	x		
10		x	
11			x

c) One month during which the consultant gets feedback from Facilitators at work in the villages and prepares a schedule and materials for the intermittent in-service training the Facilitators will receive throughout the Project.

Content of the first sessions of Facilitator training will be similar to that which is used during the initial phase of project

implementation to acquaint regional and divisional officials with the design and objectives of the Project and gain their active support. The remaining time will focus more directly on the knowledge, attitude and skill requirements of the Facilitator role. Training topics will include:

a) Community development, emphasizing the Facilitator role

1. group dynamics, leadership and motivation

2. political philosophy with respect to self-reliance

3. political and administrative organization of divisions, wards and villages, including duties and responsibilities of the Village Health Committee.

4. non-formal techniques for engaging in dialogue with non-literate populations

b) Community public health

1. cultural, social, economic and religious factors contributing to local conceptions of health and disease

2. process and importance of discovering villager beliefs and responses to disease

3. GOT policy on health

4. major health problems in the area

   a) causality and transmission patterns

   b) groups at risk

   c) prophylaxis

5. community health education

6. review of existing cadres of health personnel including positions and responsibilities

c) Community health program development

1. determining relative importance of different health problems

2. planning community self-help interventions

   i) project proposal preparation process
   ii) role of village government in process

3. matching project proposals with resource capacity

4. project management issues for implementation

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5. involving local health workers in community health activities

d) Evaluation techniques

1. parameters of success

a) indices of "process" establishment

b) health indices

2. information collection

3. analysis and reporting

Wherever appropriate and feasible, regional, district and division officials will take part in the training of Facilitators. The Project will draw upon the Ministry of Health's Education Unit, the Institute for Adult Education, and the APVDP personnel in the development of training materials to be used in Facilitator training and in villages.

After Facilitators have begun to work with their respective villages, they will continue to receive in-service training. In addition to correspondence courses, the Facilitators will be brought together with selected local officials for two day workshops six times every year. This in-service training will provide an opportunity for Facilitators to call for additional training related to their on-going experience and to learn more about specific public health categories such as sanitation, shallow wells, nutrition, first-aid, vector control, audio-visual communication, non-formal education, etc. In addition, these sessions will assist the Facilitators in identifying and organizing any additional outside expertise required to assist villages in planning and implementing their projects. They will also be used as a mechanism to strengthen the regular evaluation and monitoring process to be carried out by the Ward Health Facilitators. The participants themselves will be encouraged to help with planning their own in-service training so the content will be appropriate and of use to their field work. Coordination in the planning and implementation of the in-service training will take place between this Project and the Continuing Education for Health Workers Project to assure a long term capacity in the Arusha Region to undertake such activities.

4. <u>Supervision of Ward Health Facilitators</u>

The lines of authority and the positions of all Project personnel in the Regional structure are discussed in the Administrative Feasibility, Section III D. Because it is likely that varied cadres of health personnel will become Ward Health Facilitators, it will be necessary to establish one supervisory mechanism which will be easy to manage and can apply to all Facilitators in their Project roles. Preventive health activities, particularly in the area of environmental health and the support of health education in the villages, are now administered by the District Health Officers.

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Therefore, the Project will make use of this existing structure for supervision and support of the Ward Health Facilitators. In addition, Facilitators will maintain their normal reporting and supervisory relationships with their present supervisors when they act in their non-Project roles. The appropriate District Health Officer will be responsible for ensuring that the Facilitators coordinate their Project activities with other job responsibilities and for maintaining the enthusiasm of the Facilitator's regular supervisors for Project work in the villages. Technical support will be provided by the appropriate technical officers in the area.

5. Motivation of Ward Health Facilitators

Since existing cadres will be utilized in this key Project role, it is important to address the issue of motivation. Facilitators will be expected to undertake Project activities over and above those they are presently performing. In most cases, responsibility for village outreach activities will already be an important part of their existing job descriptions. The Project will merely strengthen their ability to carry out these functions. The Ward Health Facilitators will be encouraged to undertake Project activities through the following mechanisms:

a) provision of transport - each Facilitator will be provided a motorcycle on a loan basis as described in annex P;

b) "nights out" allowance to cover village activities in villages other than the Facilitators' homes will be assured under the Project;

c) Project provided training will strengthen job skills and increase individual effectiveness in working in village settings; and

d) higher visibility in the new role will lead to increased opportunities for promotion.

The issue of staff motivation has been discussed with appropriate Tanzanian officials during Project design and it was agreed that the factors listed above would provide sufficient motivation to attract skilled candidates and to maintain their interest.

6. Village Health Representatives

Although the Ward Health Facilitator as described above will be the pivotal technical resource and coordinator for Project activities, the Village Health Representative will be the crucial permanent link within the village for Project follow-up. This person will receive a short initial orientation to the Project and his responsibilities, followed by regular annual continuing education, but the most important training will be on-the-job while acting as the village counterpart to the Ward Health Facilitator. His duties will include:

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a) liason with Ward Health Facilitator

b) attend all Village Health Committee meetings

c) initiate informal contact with villagers to discuss health problems

d) move about the village in support of Project activities such as information exchange and follow-up on sub-project implementation

Village Health Representatives will be selected by the village government, according to the following criteria:

a) must be member of village (male or female) but age 40 is upper limit

b) should have at least standard 7 education, but if person can read and write and commands respect of villagers, may also be considered

c) should be married, with roots in village

d) village health worker who is operating effectively in village given priority

7. Village Selection Criteria

Although the Project will be undertaken in each of the Arusha Region's 23 divisions in order to ensure that experience is gained in working in the full range of cultural, economic and geographic variation offered, only a few villages will be selected from each division for involvement in the Project. Once the Facilitators are selected as oulined above, committees of District, Division and Ward officials will select two villages in the working area of each Facilitator according to the selection criteria below:

a) the village should be accessible by road and within a reasonable distance of the home of the Ward Health Facilitator;

b) the village should have an active Village Development Council;

c) the village should have a strong Party organization;

d) the village should not be more than 5 km in diameter;

e) villages with active village health workers will be given priority; and

f) villages that have undertaken self-help projects in any sector, either with or without Government assistance will be given priority.

Upon the completion of initial training the Ward Health Facili-

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tators will be introduced to the selected villages by the Ward Party Secretary through the Village Development Council. As discussed in Section II C, the Facilitator will then develop a schedule that will include blocks of time to be spent in the village to begin to develop a dialogue with the villagers and to begin the process of activating the Village Health Committee.

8. Village Project Selection

There will be two different sets of criteria applied to selection of projects to be undertaken by the villagers. The first set of criteria will be applied by the villagers themselves in order to select which specific health interventions they will attempt to implement in response to the priority public health problems they have indentified. The second set of criteria will be applied by the Regional Development Director's staff for determining whether financial support to a village health project should be granted.

Once the villages have identified their priority health problems and considered alternative ways of dealing with them, the Facilitator will continue his work by guiding the villagers in applying the following crieteria to decide which of the alternative interventions should be undertaken:

a) does the proposed intervention address the root cause of the problem or merely respond to symptoms of a more basic underlying problem?

b) does an appropriate technology exist for dealing with the problem in the village context?

c) are the resources for project implementation available to the village? e.g.,

   1. materials?

   2. labor?

   3. expertise (technical, managerial)?

   4. funds (transport, material, recurrent costs)?

d) does the project affect a significant number and type of beneficiaries?

e) is there a satisfactory plan for evaluating the impact of the project ? and

f) is the project consistent with the health policies and general philosophy of the government?

It is expected that many of the projects selected by the villages using the above criteria will be able to be undertaken without requiring outside financial support, which is very important, given

the need for the Project to enhance the self-reliance of the villages and to be replicable outside the Project region. Nevertheless, it is also important that the Project be able to provide financial assistance to selected village projects when it is necessary to support the "process" development objectives of the Project. The following selection criteria will be applied to village requests for financial support of their projects in order to avoid having the provision of outside funds undermine the self-reliance objectives of the Project:

a) Has the village done a good job of applying the above criteria in selecting the project?

b) Has the village exhausted all other possible sources of the resources needed?

c) Are there other priority interventions which could be undertaken by the village at this time without the use of outside financing?

d) Is there a significant self-help aspect to the project - is a sufficient percentage of the necessary resources being provided by the village to assure their committment to the project?

e) Will the use of outside funds create a recurrent cost obligation beyond the means of the village?

f) Will the use of outside funds significantly undermine the establishment of a belief in self-reliance in neighboring villages?

9. Project Proposal Preparation

The Ward Health Facilitators will be responsible for guiding the Village Health Committees through the process of problem definition and prioritization, followed by the preparation of proposals to address selected health problems. The Facilitators will be aware of the criteria for project selection as described above and will be responsible for coordinating the preparation of proposals that meet these criteria and contain the following sections:

a) clear definition of the health problem

b) analysis indicating why selected health problem is top priority

c) identification of factors contributing to problem

d) clear definition of activities required to address the problem, including all required inputs

e) clear assignment of implementation responsibilities

f) plan for measuring project effectiveness

g) identification of all resources available to village for supporting project

h) demonstration that village will be able to maintain project

These proposals will then be submitted through normal Government channels as described in Section II C(7).

10. Illustrative List of Projects

It is difficult at this time to specify exactly what types of projects will be proposed for implementation by individual Village Health Committees. Differences in the social, physical and cultural environments of villages will lead to different problem identification and different perceived needs. However, there are enough similarities in the conditions of most areas of rural Tanzania to be able to predict the general categories of interventions that might be proposed. Preliminary surveys already undertaken by the APVDP have indicated certain areas of general concern in many villages regarding health matters. The Regional Medical Officer has stated that most health problems encountered in the villages can be attributed to a combination of poverty and ignorance. Many diseases now prevalent could be prevented through increased knowledge and motivation to make certain fundamental changes in the environment. Given this knowledge and the information already available about conditions in the villages, the following types of projects are likely to be identified by a number of villages in the Region:

a) excreta disposal

i) construction of latrines appropriate to the soil conditions and environment
ii) health education to increase motivation to use latrines

b) safe water

i) protection of surface or sub-surface water sources
ii) rehabilitation or upgrading of existing water systems
iii) provision of shallow wells
iv) provision of small scale water systems

c) nutrition

i) setting up nutrition survey to identify malnourished and borderline malnourished children
ii) nutrition demonstrations
iii) local weaning food preparation
iv) follow up on children identified above

d) immunization

i) education as to importance
ii) provision of mobile clinics in villages or encouraging mothers to bring children to nearest MCH clinic

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iii) providing support for cold chain

e) local midwife training in areas of high neonatal death rates

f) environmental improvements aimed at acheiving vector control against

   i) rats
   ii) mosquitos
   iii) snails

g) housing improvements in areas of high tuberculosis incidence

h) education on malaria prophylaxis and provision for malaria case treatment

It can be appreciated that there now exists the appropriate technology necessary to deal with many of the public health problems that will be identified by the villages. In addition, there is a wealth of relevant experience to be drawn upon in the training and support of community change agents - in this case the Ward Health Facilitators. Furthermore, the process of community participation in problem identification, planning and project implementation will be adequately addressed through the appropriate training of the Ward Health Facilitators and the application of the criteria set out above for project proposal preparation and selection. In sum, the Project is considered technically sound.

D. Administrative Feasibility

The executing agency for the Project will be the Office of the Regional Development Director of Arusha Region. It will operate through the existing administrative structure of the Government of Tanzania in the Region. An organizational chart of the Tanzanian Government is presented as Figure 1, which shows the relationships between Government organizations from the President's office to the villages.

Under the system of decentralization each Region has an administrative structure which includes all sectoral areas of responsibility. The Regional administration is responsible for implementing development activities and administering the recurrent budget of the Region, a yearly allocation of funds which it receives from the central government. The line of governing extends from 10 cell leaders in the villages up through the Districts and Region to the Prime Ministers' Office.

Ten cell leaders ("balozi") are chosen by village residents to represent 10-15 households in the village. They are responsible for settling disputes and helping to carry out government policy. A larger group of 100 households, "kitongoji", is replacing the 10 cell as the smallest unit of government in the villages due to problems of finding and supporting a sufficient number of 10 cell leaders.

All residents of a village over the age of 18 are members of the Village Assembly, which elects a Village Development Council, usually of 25 members. This Council is further subdivided into 5 committees, comprising 5 members each, presently identified as follows:

1. Education, Culture, and Social Welfare*
2. Defense
3. Planning
4. Finance
5. Agriculture

*as discussed previously, responsibilities of this committee include health and it is expected to function under the Project as the "Village Health Committee".

Villages submit ordered development priorities, a development plan, and requests for assistance to the District Development Director through the District Planning Officer each year.

The Ward is an administrative unit of from 3 to 8 villages. The Ward Secretary, a Party appointee, attends village committee and council meetings and is responsible for administration of ward affairs. Government functional managers in areas of agriculture, livestock, water and health are being assigned at the Ward level as part of the decentralization program.

The District government is responsible for formulating district development plans and for carrying out national and regional policy. The political party is represented at this level by the

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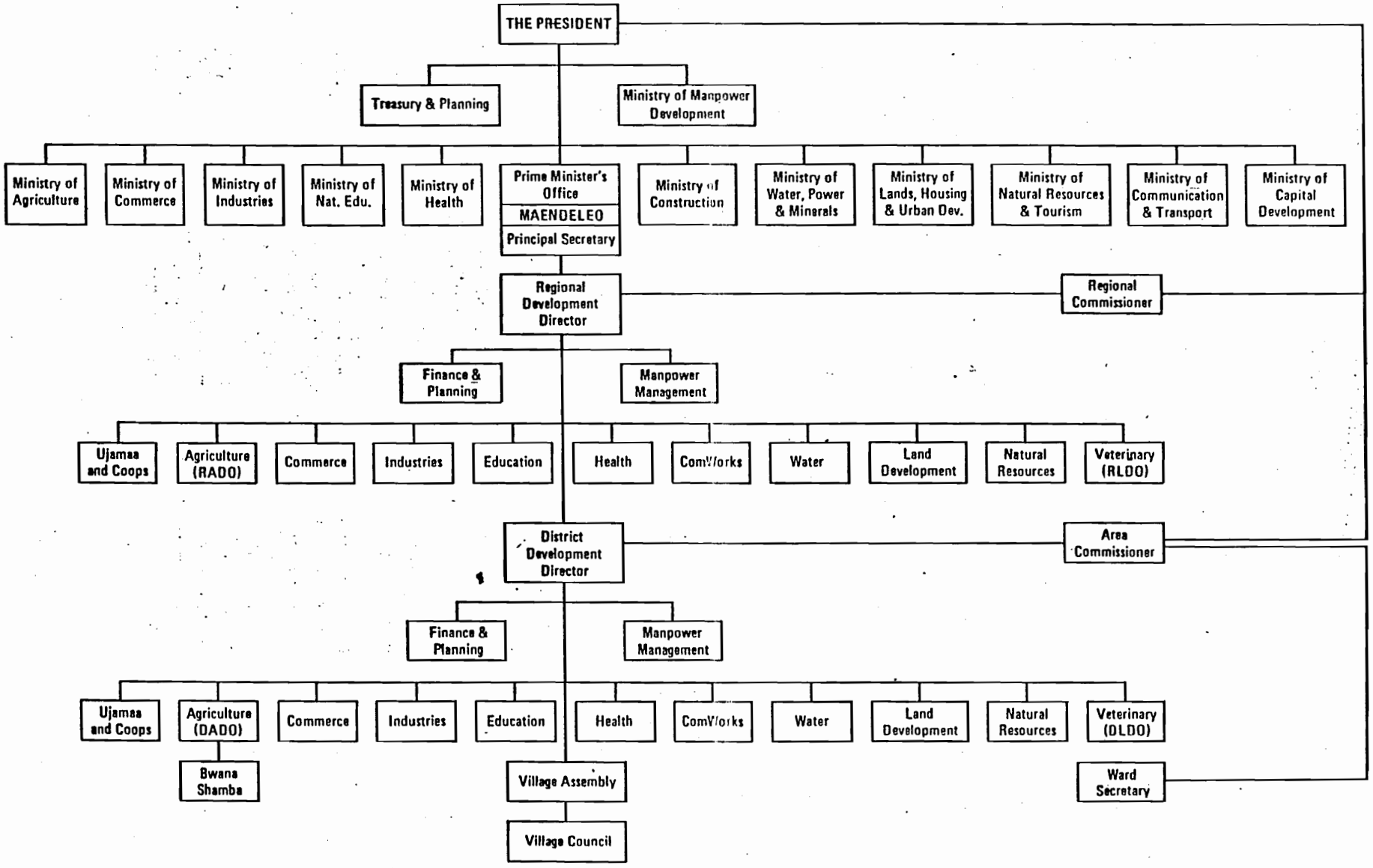
Tanzania Government Organization:
Development Ministries, (National, Regional and District Levels), Ward and Village Officials



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Area Commissioner, a political appointee, who serves as the District Secretary of the CCM and, in theory, works under the popularly elected CCM District Chairman. The civil services section of district government is headed by the District Development Director (DDD), who is responsible to the Regional Development Director (RDD). The DDD is the head of the District Management Team which is made up of heads of departments (functional managers responsible for specific sectors) and the heads of parastatals. This same structure is mirrored at the Regional level under the RDD. The following table details the administrative breakdown of the Arusha Region:

	District	No. of Divisions	No. of Wards	No. of Villages	Area Km. 2	Population (000s)
1.	Arumeru	6	29	131	2,896.0	238.0
2.	Hanang	4	28	112	8,405.0	231.3
3.	Kiteto	4	15	52	35,256.0	59.8
4.	Mbulu	4	21	88	7,652.0	193.8
5.	Monduli	3	13	40	14,201.0	71.7
6.	Ngorongoro	2	12	29	14,036.0	47.0
7.	Arusha*	3	15	11	82.5	86.9
	TOTAL	26	133	463	82,428.5	928.5

*The Project will not be active in Arusha Urban District.

Implementation activities of the Project will fall under the jurisdiction of the Regional Medical Officer and will rely on Project identified and trained Ward Health Facilitators. These people will in most cases be already existing health personnel located at the rural health center or dispensary levels of the Primary Health Care System (See Section III C, Technical Feasibility). An expanded organizational chart is presented as Figure 2. It focuses on the health system from the regional to the village level, and indicates the positions of Project personnel.

All Ward Health Facilitators will continue receiving their salaries from the Government. The term Ward Health Facilitator has been chosen for convenience of presentation in this paper, but in reality no new level of personnel will be created. As already discussed in Section II C (7), these people will be strengthened and supported by the Project to undertake village activities that they are already mandated to perform under their present job descriptions. Table 1 indicates a breakdown by

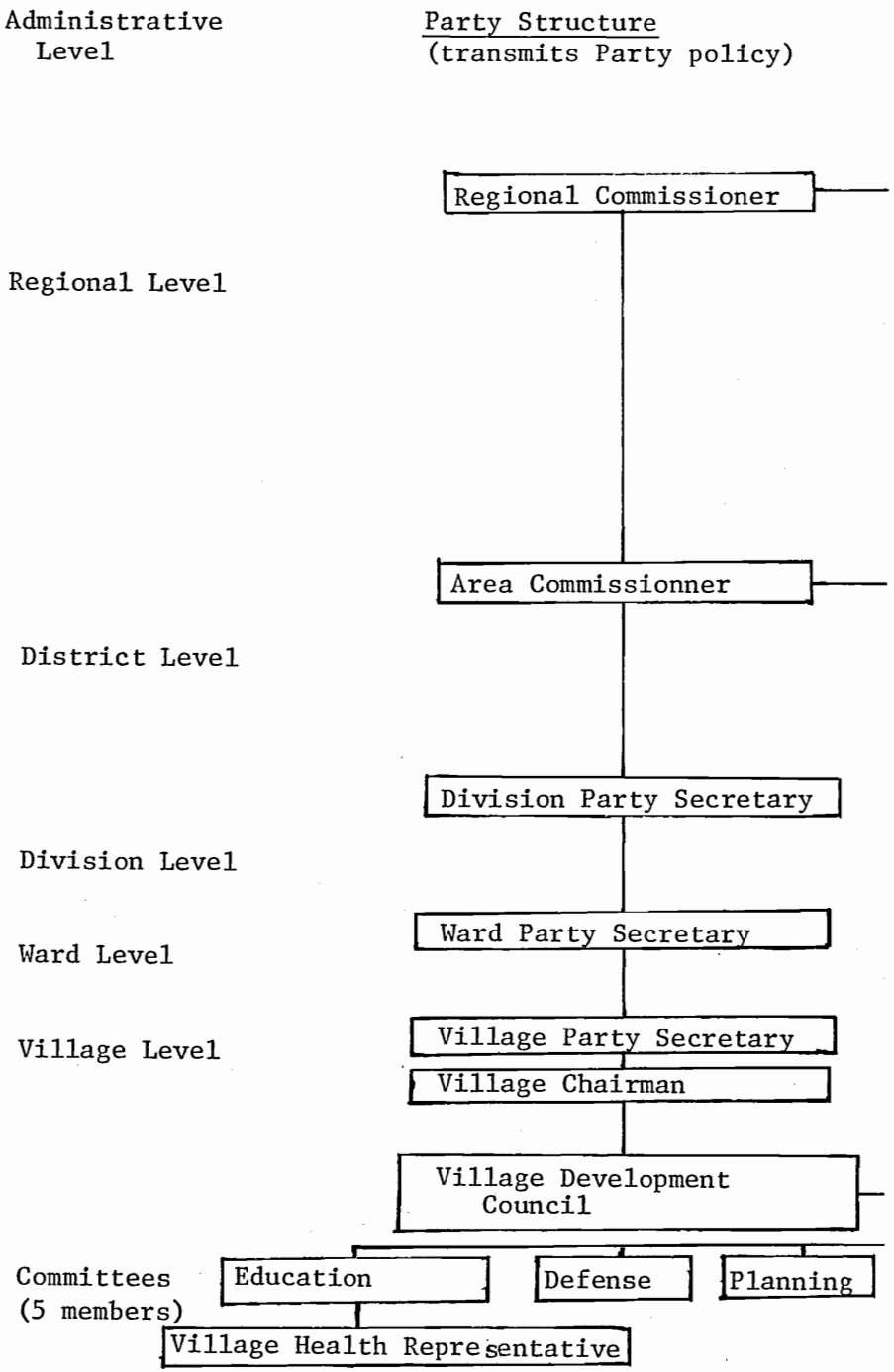
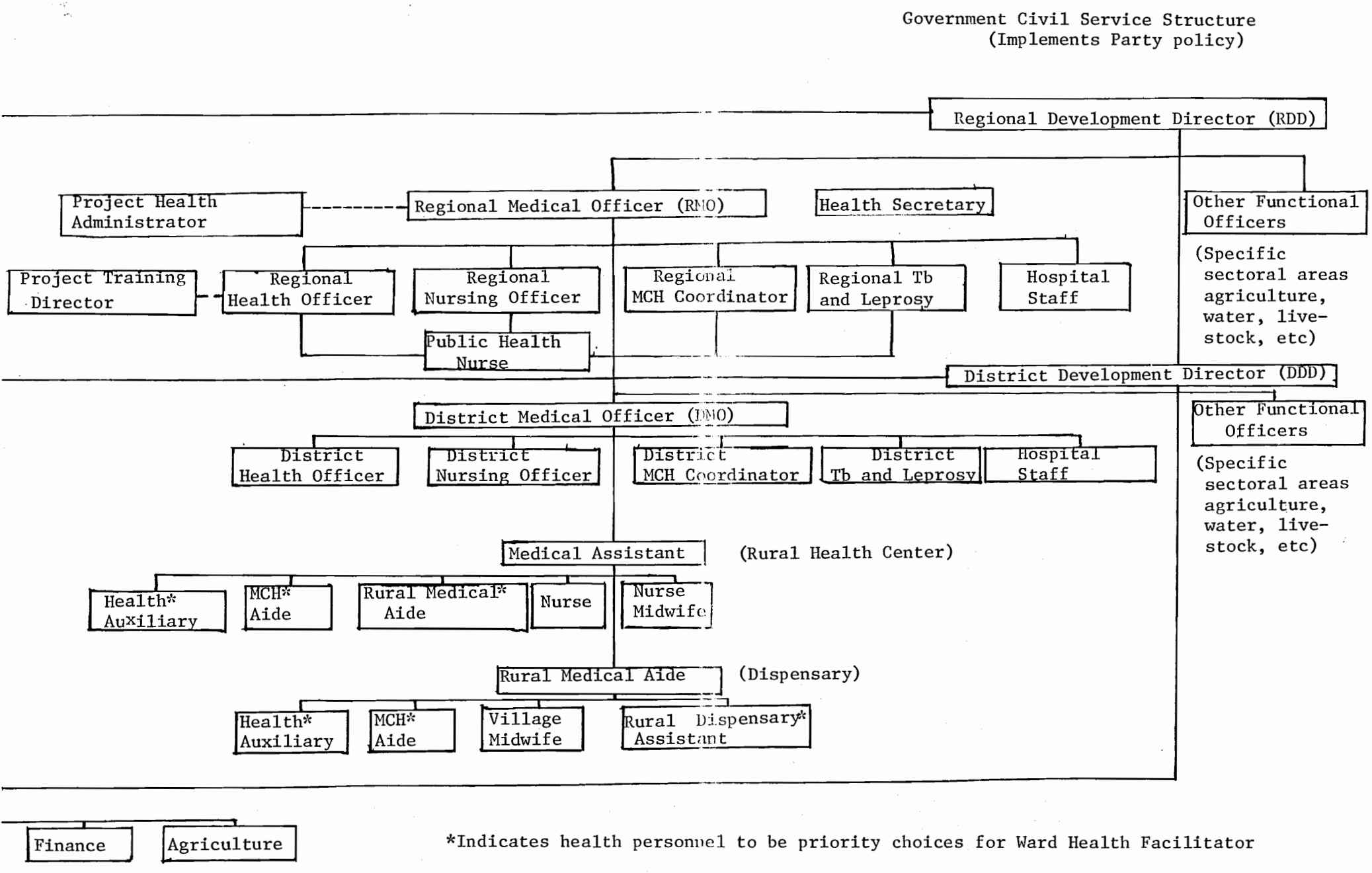

Administrative Level
Party Structure
(transmits Party policy)
Regional Commissioner
Regional Level
Area Commissionner
District Level
Division Party Secretary
Division Level
Ward Party Secretary
Ward Level
Village Party Secretary
Village Level
Village Chairman
Village Development Council
Committees (5 members)
Education
Defense
Planning
Village Health Representative

Figure 2

Government of Tanzania Organization From Regional Level
(emphasizing Health Sector)



*Indicates health personnel to be priority choices for Ward Health Facilitator

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TABLE 1

Health Manpower Levels by District
(personnel from which Ward Health Facilitators will be chosen)

	Numbers of Health Personnel				
	RMA	RDA	HA	MCHA	PHN
ARUMERU (6 Divisons)					
Health Centers (3 total)					
Kaloleni				3	1
West Meru	1	-	7	4	-
Mbuguni	1	-	-	4	-
Dispensaries (13 total)	14	-	-	22	-
HANANG (4 Divisions)					
Health Centers (3 total)					
Babati	3	-	5	6	-
Magugu	2	1	8	3	-
Katesh	1	2	1	2	-
Dispensaries (20 total)	7	21	2	17	-
MBULU (4 Divisions)					
Health Centers (2 total)					
Endabash	1	1	-	3	-
Dongobesh	1	1	1	2	-
Dispensaries (16 total)	10	17	-	16	-
KITETO (4 Divisions)					
Health Centers (1 total)					
Kibaya	2	-	2	6	2
Dispensaries (12 total)	5	10	-	7	-

MONDULI (3 Divisions)	Numbers of Health Personnel				
Health Centers (2 total)	RMA	RDA	HA	MCHA	PHN
Longido	1	2	1	1	-
Mto-wa-Mbu	1	2	1	3	-
Dispensaries (9 total)	9	8	-	8	-
NGORONGORO (2 Divisions)					
Health Centers (0 total)	-	-	-	-	-
Dispensaries (7 total)	-	4	1	3	-

SOURCE: A Survey of the Health Services in the Arusha Region, Edith Alger 1980.

RMA - Rural Medical Aide
RDA - Rural Dispensary Assistant
HA - Health Assistant
MCHA - Maternal and Child Health Aide
PHN - Public Health Nurse

number and district of the health personnel now available in the Region to be selected as Ward Health Facilitators.

Supervision of the Ward Health Facilitators will be undertaken by the District Health Officers, one for each District, who are responsible for environmental health and sanitation activities and public health education in their districts. There is one Regional Health Officer (RHO) under the RMO, who will oversee the Project at the Regional level and who will act as the counterpart to the Project Training Director. The RMO will have overall responsibility for the Project and will be assisted by the Project Health Administrator.

The Village Health Representatives will be chosen from the Village Health Committees, trained under the Project and supervised by the Ward Health Facilitators. These people will be the permanent link in the village to follow-up when necessary on Project activities at this level. They will be paid a monthly honorarium by the Project which is expected to be taken over by the village by the end of the Project. This village payment has proved to be feasible under the Hanang Village Project where the work of the Village Health Worker trained under that project was recognized as valuable by the village. This will mean that under the present Project also, the Village Health Representative will have to prove his worth to the village before the termination of AID support.

Through training, provision of transport and strengthening supervisory capabilities, the Project will activate and support existing Government structures charged with carrying out preventive health activities in the villages. The only personnel category under the Project which does not already exist is the Village Health Representative. This person may later become one of the Village Health Workers under the upcoming government Primary Health Care Program.

The Project funds set aside for support of village projects will be held at the Regional level under the jurisdiction of the RDD. Any village project proposal will follow the same channels which all proposals submitted for Government funding follow. This process is outlined below:

1) Village Health Committee prepares proposal;

2) Village Development Council reviews and approves;

3) Proposal submitted by Ward Health Facilitator to the District Development Planning Committee;

4) Proposal submitted to the District Development Council for approval;

5) Proposal submitted to Regional Management Team for approval;

6) Proposal submitted to Regional Development Council for approval.

Following approval by the Regional Development Council, the proposal will be submitted to the Project Review Committee, consisting of the RMO, RHO, Project Health Administrator and Project Training Director, which will evaluate the proposal according to criteria to be developed by this committee and described in the Technical Feasibility, Section III C.

The provision of technical services and procurement of commodities for the Project will be arranged through a standard services procurement contract negotiated between AID and a suitable contractor chosen through normal AID contractor selection procedures with the Government of Tanzania represented by an appropriate Regional official from the Arusha Region and USAID/Tanzania participating in final contractor selection. Administratively within AID the Project will be considered as an amendment to the APVDP and will thus have the same Project number (621-0143), although contractor selection will take place through normal competitive procedures as outlined above.

All Project personnel will use existing health facilities as their base of operation and will not require any additional office space. The Ward Health Facilitators will utilize the rural health centers and dispensaries that are currently operating and will maintain their present positions in these facilities. Offices at the Regional level for the Project technicians will be provided by the Regional Administration and will be located on the Regional Hospital compound in close proximity to the RMO and RHO. The Government will also provide housing for the 2 long term technicians by making available to them houses which the Government controls at the Regional level. The short term training consultant will utilize the present AID guest house facility if available or other commercial accomodations to be identified on his arrival.

The provision of motorcycle transport to the Ward Health Facilitators will be arranged where possible through a loan agreement similar to that instituted in the APVDP. This mechanism has been found to lead to better and more responsible upkeep and maintenance of these motorcycles in the APVDP and other donor projects in Tanzania. This arrangement is described in Annex M.

Given that the Project will utilize the existing health system's administrative structure as described above, will strengthen the present management structure through training, and will provide long term technical assistance in the areas of planning, administration and management, the design team feels that the Arusha Village Health Project is administratively feasible.

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E. Environmental Concerns

The Project Identification Document (PID) submitted to AID/Washington in March 1980 contained an Initial Environmental Examination (IEE), which recommended a negative determination. The Assistant Administrator for Africa concurred in the negative determination as reported in AID/Washington's PID approval cable of April 1980 (see Annex D). The environmental impact of the Project was evaluated in the PID as follows: "Most of the community initiated public health interventions supported by this project will be designed to improve the environment from a health standpoint. Over time, the project will have a decidedly beneficial environmental impact".

The Project as described in this paper has not deviated in any significant manner from that which was proposed in the PID. As noted in the Technical Feasibility Section, it is expected that many of the sub-projects undertaken at the village level will be designed to improve environmental conditions that are presently resulting in disease and poor health. Therefore, the recommendation of the IEE is still valid and no further environmental analysis is warranted necessary.

IV FINANCIAL PLAN

This section will be a presentation of tables 1,2, and 3 which present the Summary Cost Estimate and Financial Plan, the Projection of Expenditures by Fiscal Year, and The Projection of Obligations by Fiscal Year, respectively.

TABLE 1: SUMMARY COST ESTIMATE AND FINANCIAL PLAN

(U.S. $000)

Arusha Village Health Project (621-0143) Project Paper

SOURCE	AID		TANZANIA		OTHER		TOTALS
USE	FX	LC	FX	LC	FX	LC	
Technical Assistance*							
Long Term	1100	60					1160
Short Term	200						200
Training							
Seminars		315					315
Facilitator/Representative		80					80
Commodities	869	867		433			2169
Other Costs	146	714		444			1304
Contingency (AID 10%; GOT 5%)	160	140		43			343
Inflation (5% salaries, otherwise 12% (compounded))	831	1091		471			2393
Sub-Totals	3306	3267		1391			
TOTALS	6573		1391		-0-		7964

* overhead is included in technical assistance costs

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TABLE 2: PROJECTION OF EXPENDITURES BY FISCAL YEAR

(U.S. $000)

Arusha Village Health Project (621-0143) Project Paper

SOURCE	AID		TANZANIA		OTHER	TOTALS	
FISCAL YEAR		**		**			**
FY 82*	609	714	24	27		633	741
FY 83	614	773	108	136		722	909
FY 84	945	1356	209	297		1154	1653
FY 85	977	1563	198	312		1175	1875
FY 86	775	1339	221	390		996	1729
FY 87*	431	828	117	229		548	1057
Contingency (AID: 10%; GOT: 5%)	300		43			343	
Inflation (5%, 12%, compounded)	1922		471			2393	
TOTALS	6573		1391			7964	

* FY 82 and FY 83 will each have only one half year of Project activities

** This column represents FY expenditures including contingency and inflation factors

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TABLE 3: PROJECTION OF AID OBLIGATIONS VS. EXPENDITURES

(U.S. $000)

Arusha Village Health Project (621-0143) Project Paper

FISCAL YEAR	OBLIGATIONS	EXPENDITURES	PIPELINE
FY 81	4458	0	4458
FY 82	1500	714	5244
FY 83	615	773	5086
FY 84	0	1356	3730
FY 85	0	1563	2167
FY 86	0	1339	828
FY 87	0	828	0
TOTALS	6573	6573	

V. Implementation Schedule

Upon completion of project design by the Government of Tanzania and USAID/Tanzania the Project will be reviewed by the Mission and then submitted to AID/Washington for approval. This approval will require approval of the design, approval of the requested grant, and approval of the waivers requested. The following is the proposed implementation schedule from the time of Mission review and approval.

Date	Activity	Action Agents
1. June 1981	- PP amendment submitted to AID/W for review	USAID/Tanzania
2. July 1981	- PP amendment approved and Project authorized	AID/Washington
3. Aug. 1981	- Project Agreement signed and PIL No.1 issued	USAID/T, GOT, RLA
4. Sept. 1981	- RFTP issued - Furniture/appliances ordered	USAID/T, REDSO USAID/T PIO/C
5. Dec. 1981	- Contractor selected - Vehicles ordered	AID/W, USAID/T, GOT GOT
6. Jan. 1981	- Contract signed - Technician Swahili training	REDSO, Contractor Contractor
7. April 1982	- Arrival of long term technicians - Arrival of vehicles and appliances/furniture - Motorcycles ordered	Contractor Contractor GOT
8. May 1982	- Submit workplan for Phase One (first 6 months) - Begin Phase One activities - (Orientation of GOT and Party leaders) - Local personnel hired	Contractor Contractor, GOT Contractor
9. June 1982	- Educational equipment ordered	Contractor
10. Aug. 1982	- Arrival of short term (6 month) training consultant	Contractor
11. Sept. 1982	- Begin preparation of curriculum and training schedule - Bicycles ordered	Contractor GOT

	Date	Activity	Action Agents
12.	Oct. 1982	- Phase One complete: Ward Health Facilitators selected; All introductory workshops completed; and Framework for implementation established & consensus gained at Regional, District, Divisional levels	Contractor, GOT
		- Legal framework for Village Health Committee established	GOT
		- Ward Health Facilitator training begins	Contractor, GOT
13.	Nov. 1982	- Ward Health Facilitator Motorcycles arrive	Contractor, GOT
14.	Dec. 1982	- Training of Ward Health Facilitators completed	Contractor, GOT
		- Evaluation of Phase One	USAID/T, Contractor, GOT
15.	Jan. 1983	- Submit first annual workplan	Contractor
		- Preparation of plan for curriculum and schedule for continuing education	Contractor, GOT
		- Ward Health Facilitators begin village activities	GOT
16.	Feb. 1983	- Short term training consultant departs	Contractor
		- First Continuing Education session for Ward Health Facilitators (repeated every 2 mo. throughout Project)	Contractor, GOT
17.	April 1983	- Village Health Representatives selected	Contractor, GOT
		- Bicycles arrive	GOT
18.	June 1983	- Village Health Representative training completed	Contractor, GOT
		- Submit annual report	Contractor
19.	July 1983	- First sub-project proposals received from Village Health Committees (proposals will continue to be received according to GOT budget cycle throughout Project)	VHC, GOT, USAID/T

	Date	Activity	Action Agents
20.	Sept. 1983	- First sub-projects implemented	VHC
21.	Dec. 1983	- First Project evaluation	USAID/T, Contractor, GOT, Outside Evaluators
22.	Jan. 1983	- Submit Second Annual Workplan	Contractor
23.	June 1984	- Submit Annual Report	Contractor
24.	Dec. 1984	- Vehicles ordered (replacements)	GOT
25.	Jan. 1985	- Submit Third Annual Workplan	Contractor
26.	April 1985	- Vehicles arrive	
27.	May 1985	- Second Project evaluation	USAID/T, Contractor, GOT, Outside Evaluators
28.	June 1985	- Submit Annual Report	Contractor
29.	Jan. 1986	- Submit Fourth Annual Workplan	Contractor
30.	June 1986	- Submit Annual Report	Contractor
31.	Jan. 1987	- Final Project evaluation	USAID/T, Contractor GOT, Outside Evaluators
32.	Feb. 1987	- Final evaluation report due	Contractor
33.	March 1987	- Project Assistance Completion Date (PACD) - Submit final report	 Contractor

VI. Evaluation Plan

Three formal project evaluations have been scheduled for this Project. The first will occur in December 1983, the second, May 1985 and the third, January 1987. In addition, there will be one smaller "in house evaluation" conducted in Dec 82/Jan 83 to assess progress following completion of six month phase one activities.

The evaluation team for the formal evaluations should include at least two outside members aside from contractor, GOT or USAID/ Tanzania personnel. One individual should have public health experience in a developing country setting, and one should have experience in community development using the facilitator method. Experience in Africa and Swahili language capability are required. The members comprising the evaluation team should be the same for all three evaluations to the extent possible.

Because of the importance of laying the proper groundwork for the Project throughout the Region, the design team recommends that a small "in house" evaluation be undertaken at the conclusion of the first six months of implementation to check the progress of building the necessary commitment among all levels of government personnel. This process is essential given the objective of the Project to utilize existing personnel for all aspects of implementation. A survey will be made of key personnel at the Regional, District and Ward levels to assess their current understanding of the Project and it's objectives and an analysis of this survey will indicate whether more work will be necessary before proceeding with further implementation.

The formal evaluations will explore the factors and conditions, especially at the village level, that influence the establishment of the desired process of community participation in the deliberations of the Village Health Committee. The success or failure of individual self-help village projects will also be examined, but this will be considered as only one part of a series of phases, all of which must be accorded equal importance in the establishment of the total process. The temptation to merely count health interventions or only attempt to measure their impact as an indication of the effectiveness of the process must be avoided. As discussed in the Detailed Description, Section III C, the phases of the process that is be be established in the villages can be considered as follows:

1. local health knowledge explored
2. health beliefs and practices explicitly defined
3. health problems identified
4. health problems prioritized
5. cause and effect relationships explored

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6. resources identified

7. proposal prepared

8. intervention implemented

9. intervention evaluated

These phases will actually form a continuum, which has been artificially broken down above for purposes of discussion.

The Project will develop a monitoring and reporting system for use by the Ward Health Facilitators, which will form the basis of the evaluation of the process. The format of this system will be devised by Project staff during the first six months of the Project and will be introduced to the Ward Health Facilitators during their initial training period. This system may be revised as experience is gained and Project implementation proceeds. It will essentially consist of some type of simple checklist that can be filled out over time and reviewed to pinpoint areas where the process is not working.

Aside from evaluating the effectiveness of the process itself, a second important area for evaluation will be the Ward Health Facilitator training program. A small sample of Ward Health Facilitators will be observed in their interactions with villagers and the Village Health Committees to gauge their abilities to use the group process skills which will form an important part of their training. Since different categories of workers will be utilized, it will be necessary to determine generally whether one group is operating more effectively than another in the Project.

Following the initiation of village activities by the Ward Health Facilitators and the selection and training of the Village Health Representatives, these two individuals will undertake a baseline survey of the village, which will include the collection of data in the following areas:

1) common health problems
2) some indication of levels of morbidity from the common problems identified
3) environmental conditions in the village
   a) water supply
   b) excreta disposal system
   c) general conditions

This baseline survey will then serve as the reference for similar surveys to be undertaken throughout the Project.

Finally, the evaluations will consider to what extent local health workers have become more involved in village work as a result of the Project. The extent to which village demand for the services of these workers has increased will be assessed as an indication that villages have recognized the value of input from these health workers as a resource available to them. It is expected that health workers will increase the amount of time spent on health education provided in the villages, as well as the amount of time spent in village follow-up for identified health problems.

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VII. Covenants and Negotiating Status

The Project Agreement shall contain covenants providing in substance as follows:

1. The Project shall be implemented on behalf of the Cooperating Country by the Office of the Regional Development Director, Arusha Region;

2. The Cooperating Country shall make available one Government employee in each designated Ward to serve as Ward Health Facilitator with the duties described herein;

3. The Cooperating Country will continue to provide the normal salary for the designated Ward Health Facilitator; and

4. The Cooperating Country shall provide housing and office space for the two long term technicians.

This Project Paper Amendment has been developed by a collaborative design team composed of representatives of the Government of Tanzania from the office of the Regional Development Director of the Arusha Region, a consultant provided by Development Alternatives, Inc., a design consultant from REDSO/EA, a representative of the Medical Missionaries of Mary and USAID/Tanzania. The Government of Tanzania through the office of the Regional Development Director of the Arusha Region has reviewed the Project Paper Amendment and provided a specific request for the assistance described herein. The above list of covenants has been discussed and it has been agreed that they will be contained in the Project Agreement. No difficulties are anticipated in negotiating and signing a Project Grant Agreement with the Government of Tanzania shortly after this Project Amendment is approved and authorized by AID/Washington.

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VIII. ANNEXES

A. Logical Framework

B. Detailed Budget Estimate

C. Government of Tanzania Request

D. PID Approval Cable, Issues and Responses

E. 611(a); 611(e)

F. Waiver Justifications

G. Map of Arusha Region

H. Procurement Plan

I. Statutory Checklist

J. Economic Feasibility Worksheet

K. Cost Preparation Worksheets

L. Job Descriptions

M. Motorcycle Loan Agreement Arrangements

ANNEX A

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project 5 years
From FY 81 to FY 86
Total U.S. Funding $6,573,000
Date Prepared June 1981

Project Title and Number Arusha Village Health Project (621-0143)

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Sector Goal: To help Tanzania develop a health services system which can improve the health status of the people sufficiently for them to enjoy life, participate fully in community development activities and contribute to the national goal of self reliance.	Measures of Goal Achievement: 1. Increased demand by villages for health worker assistance 2. More villages undertaking interventions to prevent health problems 3. Less complaints of illnesses resulting from preventable conditions especially connected to ignorance or environmental factors.	1. Regional/District records. 2. Regional records 3. Facilitator, Village Health Representative reports	1. Health problems are present in Region which inhibit the attainment of a full, productive life. 2. Many health problems now present are vulnerable to community oriented and initiated public health interventions. 3. The Village Development Council is the appropriate structure to address village problems.
Project Purpose: To develop in the Arusha Region a replicable process, whereby villagers, through their Development Councils and Health subcommittees, identify, understand and resolve community public health problems, with a minimum of outside financial assistance	End of Project Status: 1. Government and Party officials familiar with Project, its purpose and methods. 2. Regional policy articulated establishing "Village Health Committee." 3. One Ward selected in each of Arusha's 23 Divisions in which Project activities initiated.	1. Survey done during evaluation undertaken following Phase One activities. 2. Regional Development Director records. 3. GOT and Project records 4. GOT and Project reports	1. There are sufficient unutilized resources available for all villages to undertake some action at even a "low" level of activities. 2. There are sufficient numbers of public health workers available to provide the

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Narrative Summary	Objective Verifiable Indicators	Means of Verification	Important Assumptions
	4. 2 ward Health Facilitators chosen from each identified Ward 5. 46 Ward Health Facilitators trained 6. 92 villages in Arusha Region incorporated into Project 7. 80% of Project Villages have active Village Health Committee 8. 92 Village Health Representatives chosen, one from each incorporated village. 9. 80% of active villages have completed at least one public health project 10. Local health personnel spending more time in field doing health education and interacting with Village Health Committees.	5. GOT and Project Reports 6. GOT and Project Reports 7. Facilitator reports 8. Facilitator reports, GOT reports. 9. Facilitator and Project reports 10. Rural health center and Dispensary records.	necessary technical inputs. 3. The Ward Health Facilitators will have sufficient time, energy and interest to begin working in the villages. 4. small Project successes will lead to further interest. 5. Village Development Councils and Village Health Committees will support the work of the Ward Health Facilitators.
Outputs: 1. Government and Party leaders involved in understanding of and support for work of Village Health Committees 2. Official notification delegating health responsibilities to appropriate subcommittee 3. Establishment of selection process for Ward Health Facilitators 4. Establishment of basic and in-service training programs for Ward Health Facilitators. 5. Activation of Village Health Committee in two villages per Ward Health Facilitator. 6. Selection of Village	Magnitude of Outputs: 1. Appropriate officials participating in workshops at Regional,District and Ward levels. 2. Regional Directive issued from RDD's office on health responsibilities in the villages. 3. 46 Ward Health Facilitators (2 per selected ward) 4. 3 week initial training followed by 2 days 6 times per year. 5. 92 villages involved 6. 92 Village Health Representatives selected and trained 7. At least one undertaken by each village 8. Appropriate personnel spending time each month in villages 9. Appropriate personnel spending time each month in villages 10. Village Health Committees identify projects and successfully get Government resources or support projects themselves.	GOT and Project records.	1. That all people identified for project positions will be competent and reliable and be able to perform their jobs. 2. That AID and GOT deliver their inputs in a timely fashion. 3. That the Project is not disrupted by external factors. 4. Health concerns are a high priority of a sufficient number of villagers to create involvement in the Project. 5. Regional personnel support the Project.

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Narrative Summary	Objective Verifiable Indicators	Means of Verification	Important Assumptions
Health Representative in each Project village 7. Initiation of public health interventions at village level. 8. Increased provision of health education to villagers 9. Increased use of local health personnel in village health deliberations. 10. Recognition of value of community initiated and planned public health interventions. 11. Increased ability of villages to identify and take action to solve their own health problems.	11. Village Health Committees identify projects and successfully get Government resources or support projects themselves.		

Inputs*	Implementation Target:	($000)	
AID			
Technical Assistance			AID Project records, PIO/s, PIL, etc.
2 Long-term technicians	120 w/m @ $9166	1100	
Short-term consultants	16 w/m @ $12500	200	
Local Hire	180 w/m @ $333	60	
Training			
Seminars		315	
Ward Health Facilitator		68	
Village Health Representative		12	
Commodities			
Vehicles		386	
Educational Equipment		50	
Sub-Project support		1300	

* See Annex B for Detailed Budget

Narrative Summary	Objective Verifiable Indicators		Means of Verification	Important Assumptions
Inputs	Implementation Target:	($000)		
Other Costs		860		
Contingency		300		
Inflation		1922		
	AID Subtotals	6573		
Tanzania				
Government Salaries		200	Government of Tanzania records	
Sub-project support		433		
Other Costs		244		
Contingency and Inflation		514		
	Tanzania Subtotal	1391		
PROJECT TOTAL		7964		

ANNEX B

DETAILED EXPENDITURES BUDGET

Arusha Village Health Project 621-0143 Project Paper

($000)

AID

Fiscal Year	(82)*	(83)	(84)	(85)	(86)	(87)*	TOTALS	COMMENTS
Technical Assistance								
Long term								
1 Health Administrator	55	110	110	110	110	55	550	) 120 mo @
1 Training Director	55	110	110	110	110	55	550	) $9166 ave**
Short term								
1 Training Specialist	75						75	6 mo @ 12,500
Consultants	12	36	36	17	12	12	125	10 mo @ 12,500
Local Hire								
1 Admin. Asst.	3	6	6	6	6	3	30	
1 Secty	2	4	4	4	4	2	20	
1 Driver	1	2	2	2	2	1	10	
Training								
Seminars								
Regional	2	1	2	2	2	1	10	
District	8	6	11	11	11	6	53	
Division	31	28	55	55	55	28	252	
Facilitator Training								
Initial		12					12	
Continuing		7	14	14	14	7	56	
Village Rep Training		4	2	2	2	2	12	
Commodities								
Vehicles								
5 Land rovers @ 18	90			90			180	Land rover replace-
52 Motorcycles @ 1.5	80						80	ment after 3 yrs.
92 Bicycles @ .2	18						18	

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	(82)*	(83)	(84)	(85)	(86)	(87)*	TOTALS	COMMENTS
Spares								
Land rover @ 1750/yr.	44			44			88	
Motorcycles (20%)	16						16	
Bicycles (20%)	4						4	
Educational Equip.	50						50	
Village Health Proj. Support		150	400	300	300	150	1300	14,000/village
Other Costs								
POL/Maintenance								
Land rover	17	35	35	35	35	17	174	
Motorcycles		43	86	86	86	43	344	
Per Diem		30	55	37	18	6	146	
Honoraria		10	17	12	8	3	50	
Furniture/Appliances	46						46	
Evaluation		20		40		40	100	
AID Subtotal	609	614	945	977	775	431	4351	
Contingency (10%)	41	35	68	73	53	30	300	not applied to salaries
Inflation (5%, 12%)	64	124	343	513	511	367	1922	5% on salaries, otherwise 12% (compounded)
AID TOTAL	714	773	1356	1563	1339	828	6573	

* represents 6 mo Project activities

** includes overhead

($000)

GOVERNMENT OF TANZANIA

Fiscal Year	(82)*	(83)	(84)	(85)	(86)	(87)*	TOTALS	COMMENTS
Salaries	20	40	40	40	40	20	200	
Village + GOT contrib. to sub-projects		51	133	100	99	50	433	
Office Rental	1	2	2	2	2	1	10	
House Rental	3	5	5	5	5	3	26	
Per Diem			6	24	43	25	98	Regional GOT contribution
Honoraria			3	7	12	8	30	Village contribution
POL/Motorcycles		10	20	20	20	10	80	thru loan repayments scheme $375/yr./ motorcycle
GOT Subtotal	24	108	209	198	221	117	877	
Contingency (5%)	1	5	10	10	11	6	43	not applied to salaries
Inflation (5%, 12%)	2	23	78	104	158	106	471	5% on salaries, otherwise 12% (compounded annually)
GOT Totals	27	136	297	312	390	229	1391	(17% of total Project Cost)
Project Total							7964	

* represents 6 mo Project activities

ANNEX C

JAMHURI YA MUUNGANO WA TANZANIA

PROJ: 621-0143

OFISI YA WAZIRI M UU

MAENDELEO YA MKOA—ARUSHA

Anwani ya Simu : REGCOM.
Simu Nambari : 2270-4
Ukijibu Tafadhali Taja:

OFISI YA MKUU WA MKOA.
S L. P 3050,
ARUSHA

Kumbukumbu Na APVDP/H/2

19 May, 1981

The Director,
Agency for International Development,
Mission to Tanzania,
DAR ES SALAAM/TANZANIA.

Dear Sir :

The purpose of this letter is to request assistance from the Government of the United States to permit the Arusha Planning and Village Development Project (AP/VDP-621-0143) to be expanded to include a health component. This will enable the project to more truly reflect the fact that this is an integrated regional development program.

In discussing this project with members of your staff, it was understood that the A.I.D. assistance should be so directed that it is consistent with the Government of Tanzania's policies as stated, for example, in its Five-Year Plan. This health component to the integrated Arusha region development program should to the maximum extent possible :

1. Minimize the recurrent cost burden on the Government of Tanzania by working through the existing regional organizational structure;

2. Focus more on preventive rather than curative methods, techniques and services;

3. Emphasize village self reliance; and

4. Assure that the health component is consistent with the AP/VDP 621-0143.

The Government of Tanzania appreciates the assistance of A.I.D. in the area of health which is high on the Government's priorities, as it is on A.I.D.'s.

D.P. MAZATTA
REGIONAL PLANNING OFFICER
FOR : REGIONAL DEVELOPMENT DIRECTOR

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ANNEX D

PID Approval Issues and PP Responses

The PID approval cable attached to this Annex dated April 21, 1980 expressed three areas of concern as follows:

1. Prior to Project design the Mission should re-evaluate the options for the administrative mechanism through which the Project will be implemented;

2. The Project should carefully examine technical assistance costs; and

3. The Project should take special care in addressing 611 and environmental concerns.

Administrative Mechanism

In the PID the Project was proposed as a separate activity, designated as the Arusha Village Health Project (621-0159). Prior to and following the arrival of the design team, the possibility of incorporating this Project as an amendment to the ongoing Arusha Planning and Village Development Project (APVDP-621-0143) was discussed with Regional government and Mission personnel according to recommendations received from AID/Washington.

The Regional authorities indicated that for administrative and other purposes, they would prefer the Project to be incorporated as an amendment to the APVDP (See Letter of Request, Annex C). Since the objectives of the planning process developed in the Project are similar to that of the APVDP, the Mission also supports this idea.

As discussed in Section I above, the design team has concluded that the Project should be considered as an amendment to the APVDP. This means that the Project number will be the same, and once obligated, the Project will not appear as a separate activity. However, this does not mean that the Project will necessarily be implemented by the same contractor, Development Alternatives, Inc. (DAI), which is involved in the APVDP. The Project will go out for competitive bids according to normal AID contractor selection procedures and a contractor will be selected according to the best proposal as reviewed by representatives of AID/Washington, USAID/Tanzania, and the Government of Tanzania.

Technical Assistance Costs

A detailed review of technical assistance costs associated with long and short term experts presently working in Tanzania under contract with AID was undertaken during Project design. Specifically, one

recently implemented health project and the ongoing APVDP were examined.

It is considered normal AID practice to allow for overhead, which includes the contractor's fee, when costing out the budget for proposed Projects. In the case of the two Projects mentioned above, it was found that when allowances are made for transport, salary, and all support costs for long term technicians, including the contractor's overhead and fee, the resulting figure is now close to $110,000 per year per technician to maintain one person in Tanzania.

The level of technical assistance to be provided was discussed extensively during design, taking into account the high level of costs associated with such assistance. As discussed in Section III A, Economic Feasibility, the proposed level of technical assistance was finally agreed upon. This is partly due to the physical size and diversity of the Arusha Region, and partly due to the technical requirements involved in implementation. In the estimation of the design team, lower levels of technical assistance would lead to a failure to acheive Project objectives.

611(a) and the Environment

The issue of 611(a) is addressed in Annex E and Environmental Concerns are discussed in Section III E of this Project Paper.

ANNEX D

PID Approval Cable and Issues

"True Copy"

TELEGRAM

USAID DISTR. (A/21/80) PROJ. 621-0159 (PID)
ACTION: HNP
INFO: PRM
ACTION: RF CHRON
AID DE RUEHC 4031 1111123
INFO ZNR UUUUU ZZH
CHARGE R 201104Z APR 80
A/DCM M SECSTATE WASHDC
CHRON TO RUEHNS/AMAMBASSY DAR ES SALAAM 2556
INFO RUQMNI/AMEMBASSY NAIROBI 5634
BT
UNCLAS STATE 104031
AIDAC NAIROBI FOR REDSO/EA
E.O. 12065: N/A
TAGS:

SUBJECT: ARUSHA VILLAGE HEALTH PROJECT (621-0159) - PID

1. PROJECT CONCEPT OUTLINDED IN SUBJECT PID IS APPROVED BY AA/AFR.

2. AID/W PROJECT COMMITTEE MET MARCH 17, 1980 TO REVIEW SUBJECT PID.

3. PRIOR TO PROJECT DESIGN. MISSION IS TO RE-EVALUATE ALTERNATIVE APPROACHES TO CARRYING OUT THE OBJECTIVES SET FORTH IN THE PID. SPECIFICALLY, THE MISSION IS TO REVIEW PROJECT OBJECTIVES IN THE CONTEXT OF THE OVERALL OBJECTIVES OF THE ARUSHA REGIONAL PLANNING AND VILLAGE DEVELOPMENT PROJECT (621-0143) TO DETERMINE IF THE HEALTH SECTOR ACTIVITIES PROPOSED IN THIS PID SHOULD BE INCORPORATED BY PP AMENDMENT INTO THE ON-GOING PROJECT. THE MISSION IS TO CABLE AID/W THE RESULTS OF THIS REVIEW AND PRESENT ITS JUSTIFICATION FOR AID/W APPROVAL FOR A) COMBINING THE PROJECT INTO ARPVD THROUGH A PP AMENDMENT OR B) DESIGNING THE PROJECT AS A SEPARATE ACTIVITY AS PROPOSED IN THE PID.

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4. CONCERNS TO BE ADDRESSED DURING PROJECT DESIGN:

   A. THE LONG-TERM TECHNICIAN AND SHORT-TERM CONSULTANT COSTS APPEAR TO BE HIGH. THE MISSION IS TO EXAMINE THESE DURING PROJECT DESIGN TO DETERMINE MORE PRECISE COST ESTIMATES.

   B. SPECIAL CARE IS TO BE TAKEN IN ADDRESSING SEC. 611 AND ENVIRONMENTAL ISSUES.

5. AA/AFR CONCURS IN THE RECOMMENDED NEGATIVE DETERMINATION OF THE IEE FOR THIS PROJECT.

VANCE

BT

4031

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ANNEX E

Certification Pursuant To
Section 611 (e) of the
Foreign Assistance Act.

As Amended

I, Barry Riley, the principal officer for the Agency for International Development in Tanzania, do herewith certify that in my judgement, Tanzania has both the financial capability and human resources to implement this health component addition to an existing A.I.D. - financed project entitled, Arusha Planning and Village Development Project (APVDP No. 621-0143).

This judgement is based on the satisfactory Tanzanian performance to date under APVDP 621-043, the record of implementation of other A.I.D. - financed projects in Tanzania, and the results of the consultations undertaken during the intensive review of this new project amendment.

Barry Riley
Acting Director, USAID/Tanzania

12 June '81
Date

ANNEX E

Discussion of 611(a) Considerations

Because of the difficulties encountered by the APVDP with respect to satisfying the requirements of Section 611(a) (1) of the Foreign Assistance Act, the design team for the present Project has considered these issues very carefully. It is the understanding of the team and the Mission that 611(a) requires that preliminary planning and reasonably firm cost estimates be completed before any agreement or grant is signed obligating the U.S. government to finance implementation of any activities that will have a total value of greater than $100,000. This planning must identify what will be provided under the assistance (goods and services), how it will be provided, and a reasonably firm estimate of the costs.

For the present Project the Detailed Project Description, Section II C, the Detailed Budget, Annex B, and the Budget Worksheets, Annex K provide all the information necessary to satisfy the requirements of 611(a) for all funds to be obligated under this Project with the exception of the line item in the budget that is titled Village Health Project support.

This item has been budgeted at the level of approximately $14,000 per Project village. This is intended to provide a minimum level of support for village identified sub-projects.

As discussed in Section II C (3) and the Economic Feasibility, Section III A, the purpose of this Project is the establishment of a process at the village level which will institutionalize the abilities of villagers to take action in improving their health conditions through the established structure of the Village Health Committee. The sub-projects identified and implemented will not rely solely on the Project fund. It is expected that some sub-projects will be undertaken with no Project financial support.

The Mission and the design team further conclude that since the primary purpose of the Project is not to finance specific sub-projects, but to support a system or establish an ongoing institutional capacity, then the 611(a) requirement can be satisfied by the establishment of solid criteria for sub-project eligibility and approval together with an illustrative list of projects that will in all liklihood be carried out. The Technical Feasibility, Section III C presents in detail the criteria for project proposal preparation, and the project approval criteria, as well as the approval process. In addition, there is presented a list of probable projects.

An upper limit of $25,000 will be placed on sub-project support for any one particular activity. This limit has been set because

of the emphasis that sub-project support should be secondary to the establishment of the process itself. It will insure that projects undertaken will not require excessive support, not available elsewhere in Arusha Region or in Tanzania generally.

According to legal interpretations received by the Mission regarding the "reasonably firm" cost estimates required under 611(a), it has been stated that "as a rule of thumb, when a budget item is over $25,000, it should have a detailed supporting breakdown". In the case of this Project, according to the requirement stated above, no sub-activity greater than $25,000 will be considered for funding, so it has been concluded that the detailed cost estimates for each specific activity are not required for initial obligation. Of course detailed cost estimates for each sub-project will be developed and included in the proposals prepared by the Village Health Committees and reviewed according to the procedures set out in Section III C.

Therefore, it is also concluded that the requirements of 611(a) have been met with respect to the sub-project support fund.

APPENDIX F

I. Motor Vehicles

Problem: A Request for commodity procurement source origin waiver from Geographic Code 000 (U.S. only) to Geographic Code 935 (Special Free World) and a proprietary procurement waiver for the purchase of Landrovers follows:

a)	Cooperating Country	:	United Republic of Tanzania
b)	Authorizing Documents	:	Project Paper
c)	Project	:	Arusha Village Health Project (621-0143)
d)	Nature of Funding	:	Grant
e)	Description of Commodities	:	a) 10 right-hand drive, 4 wheel drive, landrover station wagons b) 52 90-125cc Motorcycles - Yamaha, Honda or Suzuki c) Spares for above

				($000)
f)	Approximate Value	:	a) Landrovers	180
			b) Motorcycles	80
			c) Spares	110
				370

g)	Procurement Origin	:	Code 935 Countries
h)	Probable Procurement Source	:	Australia, Kenya and/or Tanzania, Japan England

Discussion: Section 636(i) of the Foreign Assistance Act of 1961, as amended, provides that none of the funds made available to carry out the Act shall be used to purchase motor vehicles unless such motor vehicles are manufactured in the United States. Section 636(i) provides further that when special circumstances exist, the President is authorized to waive the provisions of this section in order to carry out the provisions of the Act. In the Conference Report on the Foreign Assistance Act of 1967 (which added Section 636(i) to the Act), it was reported that the committee of conference was in agreement that motor vehicles manufactured in the United States should be procured except when there are emergency or special situations, such as a need for right-hand drive or other types of vehicle not manufactured in the United States (House Report No. 892 dated November 7, 1967). The waiver authority provided in Section 636(i) has been delegated to the Assistant Administrator of Executive Order No. 10973 and State Department Delegation of Authority No. 104.

Further, AID Handbook 1, Supplement B, Section 4(b) states that procurement source/origin waivers may be based on unavailability of a commodity from countries included in the authorized geographic codes (section 4(b) (2) and on such other circumstances as are determined to be critical to the success of the project objectives (Section 4(b) (7).

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Justification: The purpose of the project is to provide assistance to the Government of Tanzania through the Arusha Regional Development Office for the development of a replicable "process" at the village level that will activate and then support through training and material assistance the work of Village Health Committees in the identification, understanding and resolution of community public health problems. Project activities will include: 1) holding promotional workshops for Government and Party personnel at all levels in the Region to discuss Project goals and objectives; 2) selection and training of candidates from existing categories of government community agents to work as "Facilitators" with Village Health Committees in their areas; 3) activation of Village Health Committees leading to the planning and implementation of community initiated public health interventions to solve local health problems; 4) increased involvement of existing government health workers in health related discussions and activities at the village level and 5) selection of a Village Health Representative to be the permanent link in the village between the existing health structure and the village.

To effectively carry out this program in the Arusha Region will require appropriate transport for project personnel. This mobility will strengthen individual villages' abilities to participate in and direct the planning and implementation of development activities. With outreach from rural health facilities to the villages being a critical element in providing community public health services, it is necessary that transportation be available and operational.

With regard to the vehicles that will be necessary to implement Project activities, as discussed above, the Government of Tanzania has recently made a decision to standardize their vehicle fleets. This will better enable them to maintain sufficient spare parts availability and maintenance capability to be able to service their vehicles and keep them on the road. The vehicles they have chosen for this purpose are Landrovers for general transport requirements and Isuzu trucks for heavier work requirements. Project vehicles, which are purchased for use by the Government, titled by the government, and will revert to Government control upon completion of the Project, should conform to this Government policy. Even outside of specific government maintenance capabilities through the motor pool, these are the types of vehicles which can be repaired most easily in the rural areas around Arusha because of spare parts availability and mechanics familiar with their operation. This will be very important in this Project because the vehicles will be on the road constantly.

AID/W (COM/ALI) investigated the road conditions, spare parts availability, and repair facilities in remote areas for all kinds of vehicles during an extensive field visit in Tanzania during April and May 1979. The trip report of this visit emphasizes the necessity of right-hand drive vehicles in Tanzania and states that, "The only two U.S. manufactured right-hand drive vehicles are not acceptably represented in Tanzania--in effect, there is no U.S. vehicle representation in Tanzania at all." Regarding spare parts and maintenance, the report observes that there is "no maintenance or spare parts support in country except for limited maintenance in a few projects which are maintaining Jeep Wagoneers (L/H drive)".

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Landrovers will be used to transport the long term technicians and key regional health personnel. The motorcycles are for supervision at the district levels. Since it was considered essential to reach the villages, the least costly way of doing this was to provide them with motorcycles.

The type of motorcycle needed in Arusha is a single cylinder 90-125cc "trail" model. There are no light weight motorcycles in this range made in the U.S. There are no distributors for American or any Code 941 made motorcycles in Tanzania. Motorcycles from Japan (Yamaha, Honda, and Suzuki) are imported in large numbers through distributors in Tanzania, spare parts are available for these bikes and mechanics are familiar with these engines.

In summary, successful implementation of this Project requires right-hand drive vehicles and motorcycles for which spare parts and competent repair facilities are available in remote areas. In addition, the Tanzanian Government has standardized its vehicle fleet to Landrovers. The types of vehicles needed in Tanzania are not available from U.S. manufacturers.

Recommendation: Based upon the above discussion, it has been found that 1) exclusion of procurement of the project vehicles from countries included in AID Geographic Code 935 would seriously impede attainment of United States foreign policy objectives and the objectives of the Foreign Assistance Program, and 2) that special circumstances exist which justify waiver of the requirements of Section 636(i) of the Foreign Assistance Act of 1961, as amended.

This waiver will permit procurement, at an approximate total cost of $370,000, of ten landrover vehicles, fifty-two 90-125cc motorcycles and spare parts as set forth above.

Approved: _____

Disapproved: _____

Date: _____

Drafter: APharr

Clearance: AD: BRiley BR
PRM: ARuiz de Gamboa (in draft)
SMA: SKlaus (in draft)
CON: IPeterson
HNPO: AHenn (in draft)

II. Recipient Country Contribution

Problem: A request for a waiver of the stipulation under Section 110(a) of the Foreign Assistance Act, which requires that the recipient country provide at least 25% of the total Project cost of any assistance provided by the U.S. Government under the Act follows:

a)	Cooperating Country	:	United Republic of Tanzania
b)	Authorizing Document	:	Project Paper
c)	Project	:	Arusha Village Health Project (621-0143)
d)	Nature of Funding	:	Grant
e)	Level of AID Assistance Provided	:	$6,573,000
f)	Level of GOT Contribution	:	$1,391,000
g)	GOT Contribution as % of Total Project Cost	:	17%

Discussion: Section 110(a) of the Foreign Assistance Act requires that a determination of recipient country contributions to total Project cost under U.S. Government assistance be made, and that the recipient country provide at least 25% of this cost. However, it also states that this cost sharing requirement can be waived if the recipient country cannot meet it and is classified among those countries considered to be "relatively least developed". In addition, Section 124(d) of the Foreign Assistance Act states that the Assistant Administrator can waive the requirement under Section 110(a) for "good cause".

Justification: Extensive discussions with Regional officials during the design of this Project led to an agreement on the level of inputs that the Government of Tanzania would be able to provide in support of the Project. These inputs are presented in Annex B, Detailed Budget. The Government is providing personnel, housing, certain operating costs and in kind, self-help contributions for Project initiated village sub-projects. These inputs make up 17% of the total Project cost. It is the assessment of the design team that given present financial constraints in Tanzania, this level of support is reasonable and is a sufficient indication that the Government is committed to the Project. Any higher level of resources would severely strain the financial capacity of the Government at this time. Even at this level, as shown in the Economic Feasibility, Section III A, the recurrent cost burden is nearly covered.

In summary, the successful implementation of the Project requires that the GOT contribution remain at the level described above.

Recommendation: Based on the above discussion, and on the status of Tanzania as a "relatively least developed" country, it is recommended that the circumstances exist which justify waiver of the requirements of Section 110(a) of the Foreign Assistance Act of 1961, as amended, and that such a waiver be approved for the Arusha Village Health Project.

Approved: _____

Disapproved: _____

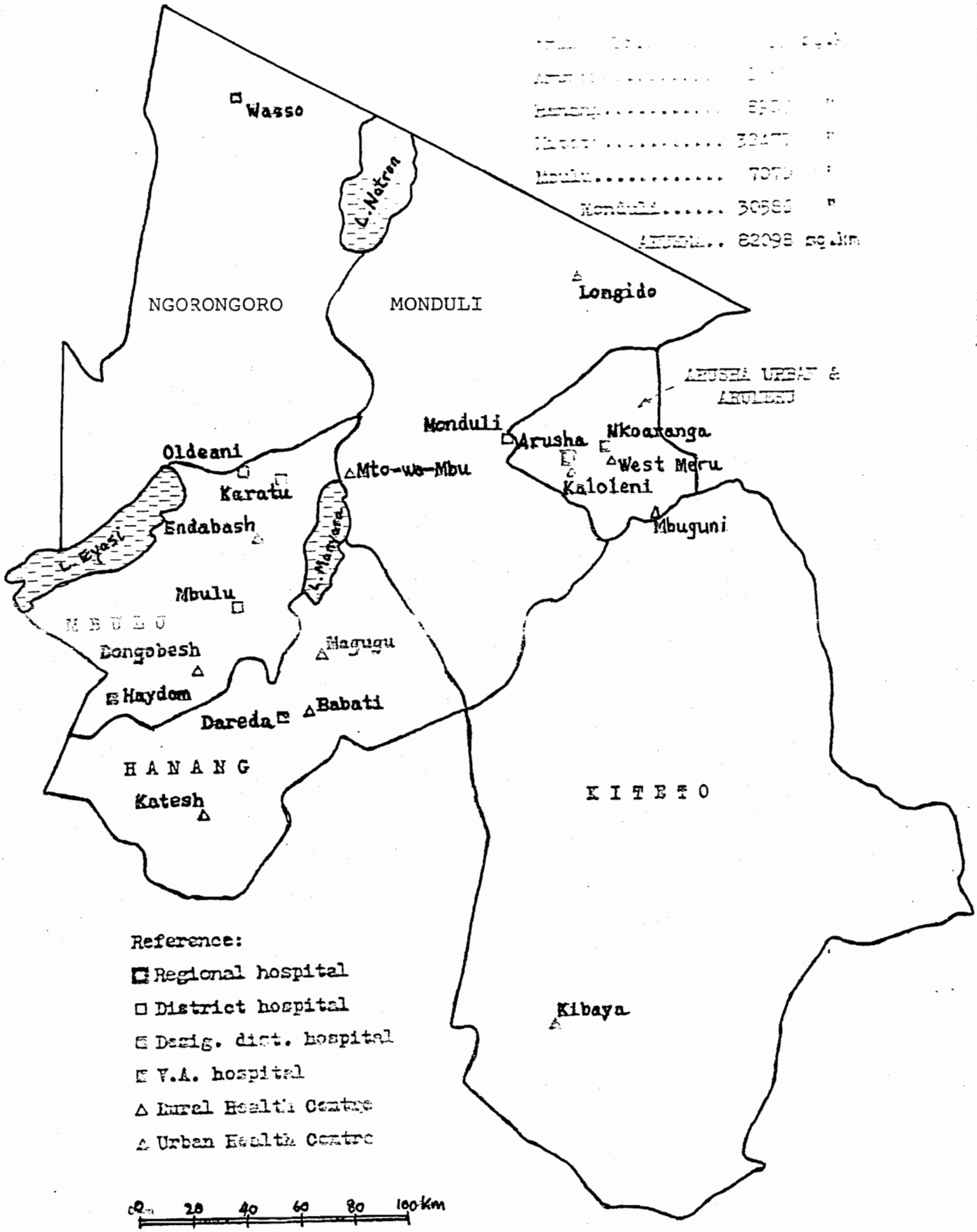
Date: _____

Drafter:HNPO:PGEhmer:6/5/81

Clearances: HRD:AHenn _____
PEM:ARuizdeGamboa _____
EXO:RJohnson _____
CON:IPeterson _____
AD:BRiley _____

ANNEX G

Map of Arusha Region



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Annex H

Procurement Plan

The following procurement schedule sets out a listing of the various commodities that will be purchased with portions of the grant funds under this Project as further delineated in the Detailed Budget (Annex B). As previously stated, this Project will be implemented through the Office of the Regional Development Director, Arusha Region, with technical assistance provided by a Contractor to be chosen following Project Paper approval through normal AID contracting procedures with the collaboration and approval of the Government of Tanzania. The nature of this Project and commodities to be purchased will lead to commodity procurement by a number of different entities.

In accordance with Handbook 1B Chapter 3, the Government of Tanzania will be responsible for purchasing all motor vehicles, motorcycles and bicycles for the Project. To assist in this process and to expedite timely arrival of the vehicles, upon which much of the project implementation depends, it is expected that the Mission will be requested by the Government of Tanzania to issue a direct letter of commitment to the suppliers for the vehicles. A USAID PIO/C may be used to expedite timely arrival of office furniture, household furniture and appliances.

Detailed specifications for the educational equipment will be developed by the Contractor in conjunction with other Project staff after an assessment of the needs has been made following the arrival of the long term technicians. In addition, any procurement of commodities under the sub-project support fund, which will be necessary to assist villages with implementation of their identified health interventions will be undertaken by the Government of Tanzania following development of detailed specifications during the project proposal preparation process.

Handbook 1B further states that a contractor may be selected to procure commodities and services on behalf of the grantee, when the magnitude of purchases, necessity of careful timing of purchases and the non-availability of technical expertise in the Government so indicates. Managerial control is still exercised over this procurement by the administering agency through the contractual relationship. In this Project the Contractor may be expected to procure the educational equipment. The contractor procurement procedures and procurement capability will be reviewed and approved in writing by AID prior to his undertaking any commodity procurement. Contractor procurement is preferred over Mission or AID procurement both for policy reasons, as stated in Handbook 1B and for reasons of a limited number of direct hire staff in the Missions which will continue into the near future.

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Procurement Schedule

Commodity	Cost ($000)	Date Ordered	Expected Arrival	Ordered By	Authorizing Document
A. Motor vehicles					
5 Landrovers (stationwagons)	90	Dec. 81	Apr. 82	TanGov	Direct Letter of Commitment to Supplier
5 Landrovers (stationwagons)	90	Dec. 84	Apr. 85	TanGov	"
52 Motorcycles (90-120 cc)	80	Apr. 82	Nov. 82	TanGov	"
92 Bicycles	18	July 82 Sept 82	-- Apr. 83	USAID/T TanGov	RFP published Direct Letter of Commitment to Supplier
B. Furniture/Appliances (for 2 technicians houses plus offices)					
Appliances (refrigerator, freezer, stove, 4 air conditioners, washer, dryer, de-humidifier-see Mission standard list)	20	Sept 81	Apr. 82	USAID/T	PIO/C
Furnishings	20	Sept 81	Apr. 82	USAID/T	PIO/C
Office Furniture	6	Sept 81	Apr. 82	USAID/T	PIO/C
C. Educational Equipment					
Specifications (to be developed May 82)	50	June 82	Oct. 82 (via air-freight)	Contract-or	Contract

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ANNEX I

Statutory Checklist

Listed below are statutory criteria applicable generally to projects with FAA funds and project criteria applicable to individual fund sources: Development Assistance (with a subcategory for criteria aplicable only to loans); and Economic Support Fund.

CROSS REFERENCES: (a) IS COUNTRY CHECKLIST UP TO DATE?
(b) HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

(a) Yes. Resubmitted with Zanzibar Malaria Control Project (621-0163) in March 1981 and with Training for Rural Development II (621-0161) in June 1981.

(b) Yes

I. Strategy Project Checklist

A. General Criteria for Project

1. FY 79 App. Act Unnumbered; FAA Sec. 653(b); Sec. 634A.

(a) Describe how Committees on Appropriations of Senate and House have been or will be notified concerning the Project; (b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that figure)?

(a) Project is included in FY 81 Congressional Presentation.
(b) Yes.

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?

Yes; see Annex E.

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?

No GOT legislative actions will be required.

4. FAA Sec. 611 (b); FY 79 App. Act Sec. 101. If for water or water-related land resource construction, has project met the standards and criteria as per the Principles and Standards for Planning Water and Related Land Resources dated October 25, 1973?

N/A

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 and Regional Assistant Administrator taken into consideration the country's capability effectively to maintain and utilize the project?

Yes; see Annex E.

6. FAA Sec. 209. 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.

Yes; this Project will be part of a regional integrated development project.

7. FAA Sec. 601 (a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster 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.

N/A

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).

The Project will be undertaken by U.S. contractor for the provision of technical assistance and commodities.

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 GOT will contribute approximately 17% of total project cost. See Annex B.

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

No.

11. FAA Sec. 601 (e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes.

12. FY 79 App. Act Sec. 608. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b); 111; 113; 281a. Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (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; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

(a) The Project will support the self-help efforts of the rural poor to improve their health condition through the application of appropriate technologies. The poor will be the beneficiaries on a sustained basis.

(b) This Project supports rural self-help efforts through the strengthening of local government organizations and the incorporation of community views into the process.

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(c) This Project relies on large self-help component.

(d) Women will participate in the Project and are expected to be beneficiaries, since it is expected that many identified health problems will involve mothers and young children.

(e) N/A

b. FAA Sec. 103,103A, 104, 105, 106, 107. Is assistance being made available for health under Sec. 104(c); if so, extent to which activity emphasizes low-cost integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems and other modes of community research?

104(c): The Project does not address the delivery system per se, but encourages the poor to take action against their own priority health problems, especially those of mothers and children. Existing auxiliary medical personnel will be utilized in a key Project role and their abilities to perform their jobs in the area of preventive health care will be strengthened.

c. (107) Is appropriate effort placed on use of appropriate technology?

Yes.

d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the cost 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)?

GOT will provide approximately 17% of total budget for Project. Waiver of cost sharing requirement presented in Annex F.

e. 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, or is the recipient country "relatively least developed"?

Yes; Tanzania is one of the 25 "relatively least developed" countries.

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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 civil education and training in skills required for effective participation in governmental and political processes essential to self-government.

The Project is supportive of self-help efforts to identify and prioritize health problems and to take action to solve them.

g. FAA Sec. 122(b). 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?

Yes.

II. Standard Item Checklist

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.

2. FAA Sec. 604(a). Will all commodity procurement financed be from the U.S. except as otherwise determined by the President or under the delegation from him?

   Yes; see Waivers, Annex F.

3. 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?

   Yes.

4. FAA 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?

   N/A

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5. FAA Sec. 608(a). Will U.S. Government excess personal property be utilized wherever practicable in lieu of the procurement of new items?

   Yes.

6. FAA Sec. 603(a). Compliance with requirement in Section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percentum 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.

   U.S.-flag commercial vessels shall be used to the extent practicable.

7. 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?

   Yes.

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

   Yes.

8. 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.

9. FY 81 App. Act. Sec. 105. Does the contract for procurement contain a provision authorizing the termination of such contract for the convenience of the United States?

   The PIO/T will specify that such a clause be included in the contract.

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?

   N/A

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?

N/A

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?

N/A

C. Other Restrictions

1. FAA Sec. 122(e). If development loan, is interest rate at least 2% per annum during grace period and at least 3% per annum thereafter?

N/A

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?

N/A

3. FAA Sec. 620(h). Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?

Yes.

4. FAA Sec. 636(i). Is financing not permitted to be used, without waiver, for purchase, sale, long-term lease exchange or guaranty of motor vehicles manufactured outside the U.S.?

Yes.

5. Will arrangement preclude use of financing:

a. FAA Sec. 104(f). To pay for performances of abortions as a method of family planning or to motivate or coerce persons to practice abortion; to pay for performance of involuntary sterilization as a method of family planning, or to coerce or provide financial incentive to any person to undergo sterilization?

Yes.

b. FAA Sec. 620(g). To compensate owners of expropriated nationalized property?

Yes.

c. FAA Sec. 660. To provide training or advice or provide any financial support for police, prisons, or other law enforcement forces, except for narcotics programs?

Yes.

d. FAA Sec. 662. For CIA activities?

Yes.

e. FY 80 App. Act. Sect. [504]. To pay pensions, etc. for military personnel?

Yes.

f. FY 80 App. Act. Sec. [506]. To pay UN assessments?

Yes.

g. FY 80 App. Act. Sec. [507]. To carry out provisions of FAA section 209(d) (Transfer of FAA funds to multi-lateral organizations for lending).

Yes.

h. FY 80 App. Act. Sec. [511]. To finance the export of nuclear equipment, fuel, or technology or to train foreign nationals in nuclear fields?

Yes.

i. FY 80 App. Act. Sec. [515]. To be used for publicity or propaganda purposes within U.S. not authorized by Congress?

Yes.

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ANNEX J

The following worksheet represents the basis of the recurrent cost analysis discussed in Section III A, Economic Feasibility:

Recurrent Cost by Year - Arusha Village Health Project

Fiscal Year	1982*	1983	1984	1985	1986	1987*
Budget Item						
Training						
Seminars	41	35	68	68	68	35
W.H. Facilitators	--	19	14	14	14	7
VH Representatives	--	4	2	2	2	2
Transport						
Land Rovers (2 twice)	3.6	7.2	7.2	7.2	7.2	3.6
Motorcycles (52)	8	16	16	16	16	8
Bicycles (92)	1.8	3.6	3.6	3.6	3.6	1.8
Spares						
Land Rovers	1.7	3.5	3.5	3.5	3.5	1.7
Motorcycles	1.5	3	3	3	3	1.5
Bicycles	.4	.8	.8	.8	.8	.4
POL						
Land Rovers	7	14	14	14	14	7
Motorcycles	--	53	106	106	106	53
Per Diem	--	30	61	61	61	31
Honoraria	--	10	20	20	20	10
Salaries	20	40	40	40	40	20
Sub Totals	85	239	359	359	359	182
Contingency	4	12	18	18	18	9
Inflation	9	57	142	201	267	173
Totals	98	308	519	578	644	364
GOT Totals	27	136	297	313	392	278
GOT %	28	44	57	54	60	76

* represents 6 months of Project activities.

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ANNEX K

Cost Preparation Worksheets

I. Technical Assistance

A. Long Term	60 months Health Administrator 60 months Training Director 120 @ $9,166	$1,100,000
B. Short Term	6 months Facilitator Training Specialist 10 months Other Consultants 16 @ $12,500	$ 200,000
C. Local Hire	180 months Office Staff 180 @ $333	$ 60,000

II. Training

A. Per Diem

1. First Year

- Regional	
2 sessions of 2 days for 20 people @ $21	$ 1,680
- District	
3 sessions of 1 day for 20 people in 6 districts @ $15	$ 5,400
- Division/Ward	
3 sessions of 1 day for 15 people in 23 divisions @ $15	$ 15,525
- Ward Health Facilitators	
1 session of 15 days for 3 groups of 16 people @ $15	$ 10,800

2. Yearly Costs for years 2-5

- Regional	
2 sessions of 2 days for 20 people @ $21	$ 1,680
- District	
4 sessions of 1 day for 20 people in 6 districts @ $15	$ 7,200
- Division/Ward	
4 sessions of 1 day for 20 people in 23 divisions @ $15	$ 27,600
- Ward Health Facilitators	
6 sessions of 2 days for 46 people @ $15	$ 8,280
- Village Health Representatives(year 3-5)	
1 session of 3 days for 92 people @ $5	$ 1,380
- Village Health Representatives (year 2)	
1 session of 5 days for 6 groups of 16 people each @ $5	$ 2,400

B. Transport

1. Year 1

- Regional	
2 sessions with 20 people travelling @ $15	$ 600
- District	
3 sessions with 20 people travelling in 6 districts @ $15	$ 5,400
- Division/Ward	
3 sessions with 20 people travelling in 23 divisions @ $15	$ 20,700
- Ward Health Facilitator	
1 session for 3 groups of 16 people @ $15	$ 720

2. Year 2-5

- Regional	
2 sessions for 10 travellers @ $15	$ 300
- District	
4 sessions for 10 travellers in 6 districts @ $15	$ 3,600
- Division/Ward	
4 sessions for 20 travellers in 23 divisions @ $15	$ 27,600
- Ward Health Facilitator	
6 sessions for 46 travellers @ $15	$ 4,140
- Village Health Representatives	
6 sessions for 16 travellers each @ $15	$ 1,440

Totals	First Year	$ 60,825
	Second Year	$ 84,240
	Third Year	$ 83,220
	Fourth Year	$ 83,220
	Fifth Year	$ 83,220
		$394,725

III. Vehicles

Landrovers :	2 for long term technicians 1 for consultant use 1 for Regional Medical Officer 1 for Regional Health Officer 5 @ 18,000 x 2 (replaced in year 4)	$180,000
Motorcycles	1 for each Ward Health Facilitator 46 total 1 for each district for project supervision 6 total 52 @ $ 1,500	$ 80,000
Bicycles	1 for each Village Health Representative 92 total @ $200	$ 18,000

IV. Spares

Landrovers:	10 @ $1,750/Landrover/year over 5 years	$ 88,000
Motorcycles	@ 20%	$ 16,000
Bicycles	@ 20%	$ 4,000

V. POL

Landrovers:	@ $.35/km with 20,000 km/yr for 5 vehicles	$ 35,000/yr
Motorcycles	@ $ 1,625/yr* for 52	$ 86,000/yr

VI. Per Diem Support (for Ward Health Facilitators)

Government will require 15 days out per month = 180 days/yr
Government allowance is TSh 60/= per night out
TSh 60 x 180 x 46 = $61,000 — $ 61,000/yr

($1=TSh 8.17)

*POL for Motorcycles figured at $2,000/yr; Facilitators will buy motorcycles at $1,500 over 4 years thus paying back $375 per year, which goes to GOT POL fund making AID POL $1,625/yr.

Schedule of Per Diem Support

$ GOT	GOT %	AID %	YR *	$(AID)
0	0	100	2	61,000
12,000	20	80	3	49,000
37,000	60	40	4	24,000
49,000	80	20	5	12,000

VII. Honorarium (for Village Health Representatives)

Government recommends TSh 150/mo x 12 x 92 = $20,000/yr

Schedule of Honorarium Support

$ GOT	GOT %	AID %	YR**	$(AID)
0	0	100	2	20,000
5,000	25	75	3	15,000
10,000	50	50	4	10,000
15,000	75	25	5	5,000

VIII. Village Sub-Project Support

Facilitators will not be trained until beginning of FY 83; It is proposed that they take another six months beginning work in the villages before actual sub-projects will begin coming in.

Expected Expenditures for Sub-Project Support

FY	82***	83	84	85	86	87	Total
Amount		150	400	300	300	150	1300

IX. Contingency; Inflation

for AID

Contingency figured at 10% of Project costs each year, but not applied to salaries.

Inflation figured at 5% per year compounded annually for salaries; 12% per year compounded annually for all other costs.

for GOT

Contingency figured at 5% of Project costs each year according to GOT procedures

Inflation figured as above for AID.

* Ward Health Facilitators won't be going out until year 2.
** Village Health Representatives won't be chosen until year 2.
*** One half year of Project Activities

ANNEX L

SELECTED JOB DESCRIPTIONS

I. Long Term Project Technicians

A. Health Planner/Administrator - Chief of Party

The senior technician will be responsible for the administration of AID provided goods and services for the Project. He or she will serve as an advisor to the Regional Medical Officer of the Arusha Region and will collaborate in the management, technical support and monitoring of all Project activities. The specific responsibilities of this technician will include:

1. Provide administrative and technical supervision of Project long and short term field personnel;

2. Coordinate AID inputs into the Project and into each specific Project activity;

3. Collaborate with the Regional Medical Officer and staff in the preparation of the annual workplans, and annual reports as required by the Project;

4. Collaborate with the Regional Medical Officer and staff in the creation of a supervision and management system that will be utilized by the Project;

5. Collaborate in the preparation of training materials and curricula for all Project training;

6. Collaborate with Regional Medical Officer in developing format and system for sub-project proposal submission and evaluation; and

7. Prepare regular reports as required by AID, the Government of Tanzania and the Contract.

The person selected for the position of Chief of Party must have had previous field experience in health administration and planning in a developing country setting, ideally in Africa. He or she should have either a doctoral level or masters level degree in health planning and administration, public policy, or an equivalent degree in the social sciences with significant work in the health area.

Demonstrable administrative ability based on recent program leadership experience will be necessary. A proven ability to relate well to people of differing background and experience will be essential for this person to be effective from the Regional to the village level. Travel will probably be extensive and the person's family situation must be able to bear the associated strain. Some experience in the planning and implementation of village level development activities

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will be necessary. An ability to speak Kiswahili at the Foreign Service Institute level of S-2 is required to begin the job, and if any training to reach this level is necessary, it must be provided prior to arrival as an authorized contract expense.

B. Training Director

The other long term technician will be responsible to the Chief of Party and, whenever necessary, can act in his behalf. This person is responsible for coordinating all training activities to be undertaken by the Project. He or she will serve as an advisor to and collaborate with the Regional Health Officer and will have the following specific responsibilities:

1. Collaborate with Regional Health Officer, and Regional Adult Education Officer to design the training programs that are to take place under the Project;

2. Help develop curriculum for training programs;

3. Collaborate with appropriate personnel in conducting training sessions;

4. Help develop monitoring system that will be used to record the establishment of the desired process in the villages;

5. Help identify and incorporate effective community development methodologies for Project use; and

6. Prepare reports as required by the Chief of Party.

This person must have had extensive field experience in community development/adult education. He or she should have at least masters level degree training either in a health related field or in another field with health related experience. The person's field experience must have been in rural areas, preferably in Africa or the developing world. Family responsibilities should also allow for extensive travel. An ability to relate to mid and lower level employees in addition to non-literate populations will be useful. An FSI S-2 level in Kiswahili is also required, as for the Chief of Party.

II. Short Term Technicians

A. Facilitator Training Specialist

This person will arrive some months following the arrival of the long term technicians, and will stay for a six month period through the initial training of the Ward Health Facilitators. He or she will collaborate with the Training Director and the Regional Health Officer in the preparation and implementation of the training program for Ward Health Facilitators.

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This person must have had extensive field experience utilizing one of the models of the "facilitator" or "group process" method of initiating community development. This person must have had significant experience in developing teaching materials for training people in these methods, and must have had experience working in a developing country, preferably Africa. Fluency (FSI S-2 level) is also a requirement.

B. Other Short Term Consultants

The Project will have the capacity to bring in additional short term consultants in specific areas of expertise outside the scope of the technicians already described above whenever such a need is defined by the Project staff. Preference will be given to in-country expertise.

ANNEX M

Motorcycle Loan Plan

Completed applications for loans for the purchase of motorcycles will be received from designated Ward Health Facilitators by the District Development Director of each District. A sample loan agreement form is attached at the end of this Annex. The DDD will review and make recommendations on each application, which will then be forwarded to the office of the Regional Planning Officer. The applications will be evaluated by the Regional Planning Officer and the Regional Medical Officer, who will assess the salary level of each applicant and determine whether the loan should be approved. The loan repayment schedule should be no shorter than four years so that those buying the motorcycles will experience no financial hardships. Since this is not a commercial loan, no interest will be charged. In each case the individual must have a valid drivers license, which must be arranged by each person privately and must be in his possession prior to approval of the loan. The Project will provide a course that will cover maintenance, log book requirements, and the prescribed use of the motorcycles, as well as mileage allowance procedures.

The money budgeted for maintenance and fuel expenses will be expended from a mileage allowance account. The monthly receipt of mileage allowances provides an incentive to owners to keep the vehicle well maintained and is preferable to providing free fuel and maintenance. The mileage allowance will be that set by the Government for use of such motorcycles. A log book will be kept by each operator and reimbursements will be made only for official business trips. Log books will be reviewed by Project personnel and the District Health Officers.

Motorcycle Loan Agreement

AGREEMENT Made this .....day of.....one thousand nine hundred and.....between (Name).....

Designation.....(hereinafter called the "Purchaser" of the one part and the Government of Tanzania (hereinafter called the "Government" of the other part, whereby it is agreed as follows:

1. The Purchaser agrees to purchase outright a *motorcycle /refrigerator/ cooker/spectacles of a value not less than the amount to be advanced by Government.

2. The Government agrees to advance to the Purchaser a sum not exceeding

   Shs.....the receipt of which the Purchaser hereby acknowledges.

3. The Purchaser agrees-

   (a) to repay the sum advanced by.....approximately equal monthly installments to be deducted each month from his salary;

   (b) not to sell, transfer or dispose in any way of his property in the said *motorcycle /refrigerator/cooker/spectacles, or (with the exception of the latter), to remove it from East Africa, without the written permission of the Government, until the whole of the sum advanced has been repaid;

   (c) that if he shall die or leave the service of Government before the sum advanced by the Government is repaid in full, then and in that case the whole of the balance of the said sum shall be forthwith payable by the Purchaser or his executors or an administrator, as the case may be.

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WITNESS our hands the day and year above written.

SIGNED by the said.....
in the presence of:-

Signature of Witness.....

Address.....

.....

Occupation.....

PURCHASER to sign here over ONE SHILLING Revenue Stamp

SIGNED BY.....
(on behalf of the Government as aforesaid in the presence of:-

Signature of Witness.....

Address.....

.....

Occupation.....

.....
Signature of Officer signing on behalf of Government

*Delete as necessary.