要請書

CHRISTIAN OUTREACH
Relief and Development

CORD (CHRISTIAN OUTREACH – RELIEF AND DEVELOPMENT)

COMMUNITY DEVELOPMENT PROGRAMME

PROJECT PROPOSAL TO JICA COMMUNITY EMPOWERMENT PROGRAMME

HEALTH INFRASTRUCTURE AND CAPACITY BUILDING IN SOUTH KASULU DISTRICT

KIGOMA REGION
WESTERN TANZANIA

PROJECT DURATION 3 YEARS

PO Box 21, Kasulu, Kigoma Region, Tanzania. Tel/Fax: (+255) 695 3498, Email: cor-tan@maf.org

Project Summary

Submitted by CORD (Christian Outreach Relief and Development)

Health Infrastructure and Capacity Building in South Kasulu District

I. Background Information

1. Project Title

Health Infrastructure and Capacity-Building in South Kasulu District.

2. Project Location

This project proposal concerns nine villages in four wards of Heru Chini Division, Kasulu District. The villages are Kigondo, Kidyama (Kigondo ward), Lalambe, Shunguliba, Titye (Titye ward), Kaguruka, Rungwe Mpya, and Nyumbigwa (Rungwe Mpya ward) and Mwayaya (Muhinda ward).

Kasulu District is one of the 3 districts of Kigoma Region. It is located in the Western part of Tanzania. It borders Kibondo District in the northeast, Kigoma District to the south and the Republic of Burundi to the northwest. The population of Kasulu District was estimated to be 445,360 by August 2000 and has 90 registered villages. The District covers 9324 square kms with a population density of 47 people per square kilometre.

The District also hosts an estimated population of 200,000 refugees in three refugee camps.

3. Number of Beneficiaries

Name of village	Population (beneficiaries)
1. Kigondo	5, 150
2. Kidyama	7, 200
3. Lalambe	5, 465
4. Shunguliba	2, 910
5. Titye	5, 200
6. Kaguruka	530
7. Rungwe Mpya	10, 200
8. Nyumbigwa	10, 002
9. Mwayaya	10, 432
TOTAL	**57, 089**

4. Estimated Project Period

The total project is expected to last three years. It is composed of three parts. Part 1 and 2 involve the construction and rehabilitation of dispensaries and are expected to last two years. Part 3 concerns health education and capacity building and is expected to last three years. With funding for all three parts, construction or rehabilitation and capacity building will accompany each other to ensure that infrastructure establishment can be sustained by the community that is benefiting.

II. Proponent Organisation

1. Name and Address

CORD (Christian Outreach – Relief and Development) – Kasulu
PO Box 21, Kasulu, Kigoma Region, Tanzania
Tel/fax: 00 255 028 280 3498
Email: cor-tan@maf.org

CORD (Christian Outreach – Relief and Development) – UK Head Office
1 New Street, Leamington Spa, CV31 IHP, UK
Tel: 0044 1926 315301
Fax: 0044 1926 885786
Email: CORD_UK@compuserve.com

2. Date of establishment

CORD worldwide was established in 1967. It is an international Non-Governmental Oganisation and a UK registered charity and company. The organisation now has operations in more than 11 countries, including Rwanda, Mozambique, Zambia, Albania, Afghanistan, Cambodia, Vietnam and Thailand. CORD's principal focus is on refugee support and community development activities. Across all of its programmes CORD adopts a participatory community-led approach, with an emphasis on facilitating sustainable solutions to community-identified issues.

CORD has been established in Tanzania since 1996. CORD is currently responsible for Community Services activities in Nyaragusu and Lugufu 1 and 2 refugee camps and also runs Health Services in Nyaragusu camp. In addition CORD has undertaken a planned handover of refugee activities in Muyovosi camp as part of a strategy to build the capacity of local NGOs.

CORD has been established in Kasulu since 1997 when operations were moved down from Ngara to address the growing influx of refugees in the region. The Community Development Programme (CDP) was established to work in the Refugee-Affected Areas (RAAs) of Kasulu District in 1997, particularly in recognition of the problems of inadequate primary education, health facilities and rural poverty in Kasulu District. The overall aim of the Community Development Programme is to improve the quality of life of the rural population in Kasulu District. The programme has adopted an approach in which participation of the community in planning and management are implicit and sustainability is a key criterium.

3. Number of staff (paid/unpaid, full-time/part-time).

CORD Tanzania employs 98 national staff, approximately 700 refugee staff and 8 expatriate staff. CDP has 7 full-time paid staff including one expatriate officer.

4. Type and date of registration (copy of registration).

CORD is a UK-registered charity (No. 1070684) and a UK Company Limited by Guarantee (No. 3566119).
In Tanzania CORD is also registered under Societies Ordinance (SO No. 8202), the Ministry of Home Affairs (see appendices). CORD is also registered by USAID (No. 10026).
See appendix 1 for the organisations' registration documents.

5. Objectives and major programs.

The main objectives of CDP are infrastructure development and capacity-building for sustainable development with the rural population and local government structures of Kasulu District. CDP

projects initially operated discretely in villages widely separated across the region. However since early 2000 CORD has been operating in nine geographically-clustered villages in order to be able to offer a holistic and integrated rural development programme. These villages were selected by the District Council and their geographical proximity allows for the transfer of benefits between villages and more cost-effective working arrangements. The programme forms part of a long-term commitment to the District and funding is currently being sought to expand the range of work in these villages.

Programmes completed between 1997 and 2000 were based in eight villages scattered across Kasulu District. Major programs include:

- Sustainable improvements to the facilities and quality of primary education.
- Sustainable improvements to the physical health infrastructure and quality of healthcare services.
- Building capacity for sustainable income generation with women and vulnerable groups, and for schools maintenance.

Each of these major programme areas involves working at the village and the District level, both improving the physical infrastructure facilities and capacity building individuals and committees to perform their roles and responsibilities.

6. Previous Project experiences/Donors.

Since 1997 the Community Development Programme has achieved the following:

- Three phases of rehabilitation and reconstruction of school buildings (classrooms, staff rooms, latrines and teachers houses), 1998-1999, 1999-2000 and 2000-2001. In total, 32 classrooms and 8 teacher's offices have been rehabilitated or reconstructed with funding from the New Zealand Overseas Development Agency, UNICEF and the community.
- Capacity building of the District Council Education Department (training of the Inspectorate, Ward Education Coordinators and Headteachers on role and responsibilities, teacher training) and village-level mobilisation for educational support (work with Education committees and Headteachers) to improve the quality of teaching, with funding from CORD General Funds and the District support for VSO Education Advisors (1999-2000).
- Dispensary construction, mobilisation of the community, and capacity building of District Council Health Sector for sustainable service delivery (Nyumbigwa completed 2000, now managed by the village and District Council, and Mugera to be completed early 2001), with funding from CORD General Funds, States of Jersey and the community.
- Health education and capacity building of 10 Primary Healthcare Committees at the village and District level to improve health and standards of healthcare (1998- 2001).
- Income generation projects with school groups and vulnerable groups (1999-2001). 42 women's groups have been trained in income generation skills and 18 women's groups supported with loans to run income generation projects, with funding from Irish Aid.
- Capacity building and support to Village Governments and to develop the roles and responsibilities of District officers (1999-2001).

7. Financial status (copy of financial statements of last 3 years)

The financial statements for years ending 1998, 1999 and 2000 for the Community Development Programme are presented in appendix 6.

8. Major sources of funding devoted to development activities in last 3 years.

The major sources of funding since the conception of the Community Development Programme in 1997 have been CORD General Funds, UNICEF, DFID (Department for International Development, British Government), Irish Aid, New Zealand Overseas Development Agency, and the States of Jersey.

9. Membership of and/or affiliation to other organisations concerned with development.

- CORD is affiliated to ZOA, a Dutch development agency, and enjoys operating joint programmes in Albania and Zambia.
- CORD has been an implementing partner for UNHCR 1996.
- CORD is also playing a key role in supporting the development of local partner organisations including SEKO (Samaritan Enterprise Keepers Organisation), a very young organisation based in Kasulu.
- CDP also works to encourage liaison between agencies and local government through health sector and education sector meetings at District level.

III. Project Budget

The total cost of the project will be TS130,319,000 (Amercian $ 164,336.69). This total does not include a number of unvalued items for some parts of the community and NGO contribution (see below and appendices). The contribution requested from CEP is TS 99,548,377 ($125,533.39) over three years.

The full breakdown of budget costs, the contribution of CORD and the community and the time schedule for payments is given below and in the appendices (for email version, see excel file for total project budget and contribution breakdown). The budget requirements for the three different parts to the project are also presented.

Part 1: Construction of new dispensaries, Kigondo, Lalambe and Shunguliba

Budget Item	**Total Project Cost (TSH)**	**Counterpart contribution**				**CEP fund requested**
		In cash		In kind		
		NGO	Community	NGO	Community	
Seminar and training: Dispensary staff Skilled labour	 615,000 1,350,000			Facilitation	District personnel time for facilitation	 615,000 1,350,000
Construction costs: Construction materials Construction tools Skilled labour Unskilled labour Transport Dispensary equipment Dispensary maintenance	 21,000,000 1,800,000 4,500,000 2,025,000 9,858,000 6,000,000		 2,025,000 All costs: 600/person/year		 3,062,415 District supply medical kits (10.8m project period) and 3 core dispensary staff (24m over project period)	 17,937,585 1,800,000 4,500,000 9,858,000 6,000,000
Research, monitoring and evaluation	33,000			33,000		
Other operational costs: Wear on project vehicle Wear on project truck Rental of office space/utilities Property donated Electricity Water Telephone/communication expenses Official handover occasions	 917,000 2,475,000 55,000 90,000	 CORD CORD CORD CORD				 917,000 2,475,000 55,000 90,000
Salaries for project staff % Construction officer % Project Leader % Programme Officer % Health Project Officer % CORD Doctor	 1,320,000 1,600,000 2,400,000 1,760,000 800,000	 1,320,000 1,600,000 2,400,000 1,760,000 800,000				
Administrative costs: Postage Stationery	 167,000 167,000					 167,000 167,000
Total	58,932,000	7,880,000	2,025,000	33,000	3,062,415	45,931,585

Part 1 Financial Schedule

Financial Schedule	Year 1	Year 2	Year 3	TOTAL
CEP fund	37,336,085	8,595,500	-	45,931,585
NGO				
-in cash	3,940,000	3,940,000	-	7,880,000
-in kind	10,000	23,000		33,000
Community				
-in cash	1,525,000	500,000	-	2,025,000
-in kind	3,062,415	-		3,062,415
TOTAL	45,873,500	13,058,500	-	58,932,000

Part 2: Reconstruction of Mwayaya dispensary and rehabilitation of Titye dispensary.

Budget Item	**Total Project Cost (TSH)**	**Counterpart contribution**				**CEP fund requested**
		In cash		In kind		
		NGO	Community	NGO	Community	
Seminar and training: Dispensary staff Skilled labour	 410,000 1,350,000			 Staff time	District personnel time to facilitate	 410,000 1,350,000
Construction costs: Construction materials Construction tools Skilled labour Unskilled labour Transport Dispensary equipment Dispensary maintenance	 12,000,000 1,200,000 2,700,000 1,175,000 8,990,000 4,000,000		 Contribution 1,175,000 All costs: 600/person/year		 1,288,208 District to supply medical kits (7.2m project period) and 3 core dispensary staff (12m over project period)	 10,711,792 1,200,000 2,700,000 8,990,000 4,000,000
Research, monitoring and evaluation	33,000			33,000		
Other operational costs: Wear on project vehicle Wear on project truck Rental of office space/utilities Property donated Electricity Water Telephone/communication expenses Official handover occasions	 916,000 1,650,000 Unvalued 55,000 60,000	 CORD CORD CORD CORD				 916,000 1,650,000 55,000 60,000
Salaries for project staff % Construction officer % Project Leader % Programme Officer % Health Project Officer % CORD Doctor	 1,320,000 1,600,000 2,400,000 1,760,000 800,000	 1,320,000 1,600,000 2,400,000 1,760,000 800,000				
Administrative costs Stationery Postage	 167,000 167,000					 167,000 167,000
Total	42,753,000	7,880,000	1,175,000	33,000	1,288,208	32,376,792

Part 2: Financial Schedule

Financial Schedule	**Year 1**	**Year 2**	**Year 3**	**TOTAL**
CEP fund	26,428, 792	5,948,000	-	32,376,792
NGO				
-in cash	3,940,000	3,940,000	-	7,880,000
-in kind	10,000	23,000	-	33,000
Community				
-in cash	800,000	375,000		1,175,000
-in kind	1,288,208			1,288,208
TOTAL	32,467,000	10,286,000	-	42,753,000

Part 3: Capacity building at village and district level in nine villages, Kigondo, Kidyama, Lalambe, Shunguliba, Kaguruka, Rungwe Mpya, Mwayaya, Nyumbigwa and Titye.

Budget Item	**Total Project Cost (TSH)**	**Counterpart contribution**				**CEP fund requested**
		In cash		In kind		
		NGO	Community	NGO	Community	
Seminar and training:						
Village health workers	4,158,000			Staff time		4,158,000
TBA						
General	7,830,000					7,830,000
population	8,208,000			900,000		7,308,000
PHC						
	540,000					540,000
Construction costs:						
None						
Research, monitoring and evaluation	34,000			34,000		
Other operational costs						
Wear on project vehicle	917,000					917,000
Wear on project truck	-					
Rental of office space/utilities	CORD					
Property donated						
Electricity	CORD					
Water						
Telephone/communication	CORD					
	CORD					
expenses	55,000					55,000
Salaries for project staff						
% Project Leader	1,600,000	1,600,000				
% Programme Officer	2,400,000	2,400,000				
% Health Project Officer	1,760,000	1,760,000				
% CORD Doctor						
	800,000	800,000				
Administrative costs:						
Stationery	166,000					166,000
Postage	166,000					166,000
Total	28,634,000	6,560,000	900,000	34,000		21,140,000

Part 3: Financial Schedule

Financial Schedule	Year 1	Year 2	Year 3	TOTAL
CEP fund	14,435,000	4,435,000	2,270,000	21,140,000
NGO				
-in cash	2,187,000	2187,000	2,186,000	6,560,000
-in kind	5,000	5,000	24,000	34,000
Community	Unvalued	Unvalued		
-in cash	-	-	900,000	900,000
-in kind	-	-	-	-
TOTAL	16,627,000	6,627,000	5,380,000	28,634,000

Total Project Contributions

	TOTAL PROJECT	CEP FUNDS REQUIRED	NGO CONTRIBUTION	COMMUNITY CONTRIBUTION
Part 1	**58,932,000**	**45,931,585**	**7,913,000**	**5,087,415**
Part 2	**42,753,000**	**32,376,792**	**7,913,000**	**2,463,208**
Part 3	**28,634,000**	**21,140,000**	**6,594,000**	**900,000**
TOTAL	**130,319,000**	**99,448,377**	**22,420,000**	**8,450,623**

IV. Project Description

1. Project Goals, Strategies and Impact

1.1 General socio-economic condition of the target community

There is a high degree of poverty in Kasulu District. This is reflected in the average annual income per capita of Tsh. 30,000/= which is below the national average of Tsh 90,000/= per annum. The majority of the population are subsistence farmers with fragile livelihoods based on agricultural production, dependent on seasonal influences and the stability of markets. There are limited alternative opportunities for employment and particularly for women, and by which to supplement or increase the family income. There are no tarmac roads, all roads are in a very bad state of repair due to heavy refugee traffic, lack of investment in their upkeep and local surface material. They are either very muddy or dusty depending on the season. The socio-economic problems of these communities have been largely overlooked by agencies because of the relative isolation of the District, the historical trend for labour to migrate to central and coastal regions, and the more immediate needs of large refugee populations. There are many health issues within the region, with a very high prevalence of malaria, malnutrition (chronic malnutrition is reported to be around 15 to 20% in some parts of the District), anaemia, diarrhoea, bronchitis and other diseases causing high rates of infant and maternal mortality. It is difficult for most of the rural population to access adequate healthcare facilities, and to date, there is a low level of awareness concerning disease prevention and cure. Accurate statistics to describe the situation can only be estimated from hospital attendance records and functioning dispensaries. It is anticipated that HIV/AIDS is an as yet underestimated problem in the District, but likely to affect 10 to 20% of the adult population, comparable to other regions of Tanzania and the Great Lakes region.

1.2 Geographical and cultural peculiarities of the project area.

Kasulu is an isolated District for transport, trade and information. Kigoma Region is the second poorest in mainland Tanzania, and historically has been characterised by an exodus of labour to employment in the coastal and highland regions of Tanzania, leaving behind very little in the way of investment or infrastructural development.

Kasulu District is a Refugee Affected Area

The Kigoma Region hosts refugees from Burundi, the DRC and Rwanda. In January 2001 the total refugee population in Kasulu District is estimated to be 200,000. These are Burundian and Congolese refugees, situated in Lugufu, Nyaragusu, Mtabila and Moyovosi Camps. This number fluctuates

frequently depending on the political instability of these neighbouring countries. In villages on the border, such as Mwayaya, the community has often had to provide emergency shelter to refugees, sharing their buildings and resources as well as living in an area that is tense due to military activity. In those villages closest to the refugee camps, such as Mvugwe, the people have found themselves neighboured by large "instant cities" which bring the associated problems of increased crime, environmental damage and pressure on local resources such as firewood. The existing refugee population and repeated influxes of refugees in this region of north-western Tanzania create demands on the local population and the Tanzanian Government, for which local resources are not available or sufficient.

1.3 Specific problem(s) to be addressed by the project.

Many of the specific health problems to be addressed by the project can be understood by referring to the District Health Plan produced in May 2000 by the Kasulu District Health Management Team. It lists the priority health problems for the District as follows;

Primary:

- A high maternal mortality rate (170/100,000) resulting from malaria, malnutrition, diarrhoea, etc.
- A high morbidity and mortality due to childhood illnesses (7/1000)
- A high morbidity of tuberculosis
- Increased cases of rabies
- High morbidity due to trypanosomiasis

Secondary:

- Inactive primary healthcare committees
- The absence of an emergency/disaster preparedness unit
- Poor environmental sanitation
- A poor health management information system
- Shortage of medical equipment

The root causes of these problems include both developmental factors and those relating to the influx of refugees into the region.

Primary Healthcare Facilities

- There is an insufficient number (49)of primary health facilities (dispensaries) in rural villages of Kasulu District. The average number of patients for 1 dispensary is 8,665. It is recommended that a dispensary serves a population between 5-7,000. With an annual population growth rate of 2.8%, dispensaries are becoming increasingly over-burdened.

- The absence of a dispensary will often mean that those who are sick undertake harmful self - medication or seek medical attention when it is too late.

- As the existing dispensaries are not evenly or uniformly spaced throughout the District often women and their families have to travel/walk to receive medical treatment and care. Walking distances between villages range between 1 and 5 hours. This is a walk that a woman in labour or with a sick child is unable to make. In villages where there is no dispensary women giving birth rely on local support systems, i.e. Traditional Birth Attendants (TBAs) or their neighbours. The majority of TBAs are not fully or recently trained or registered.

  In Kigondo, Lalambe and Shunguliba (villages chosen for the project) there is no dispensary and villagers are forced to travel (often on foot) distances of up to 30km to receive even basic treatment. In these villages, building a dispensary has been identified as a priority by both the Village and District Government.

  Lalambe does not have a dispensary and the community has to walk 2 hours in opposite directions to either Titye or Murufiti Dispensaries. The village has 3 TBAs, none of whom are trained, and 2 Traditional Healers.

Kigondo does not have a dispensary and the community has to walk 3 hours to Kasulu District hospital or 2 hours to Murufiti Dispensary for medical attention. The village does not have any village health workers or registered Traditional Birth Attendants. However it does have 2 registered Traditional Healers. In November Primary Healthcare Committee meetings were reinstigated with CORDs suggestion and support.

- The influx of refugees into the District may have caused changes in disease patterns and has considerably increased pressure on the District hospital services. The District has 3 hospitals, 2 mission hospitals (Kabanga run by the Roman Catholic Church and Heri Mission run by Seventh Day Adventist Church of Tanzania) and 1 government hospital in Kasulu town.

- The refugee population necessarily places an increased burden on existing health services, particularly in referral hospitals (all 3 in Kasulu District), where the number of refugee patients adds considerably to existing case loads.

Maintenance of existing dispensaries

- Many existing dispensaries are in a poor physical condition and lack basic sanitation and clean water facilities. Rural dispensaries have largely deteriorated without sufficient funds channelled from central of local government, or the sufficient mobilisation of the community to sustain and maintain their functions. This has meant an even further reduction in the capacity of dispensary facilities to fulfil their service requirements.

Local Government support

- Funds provided through annual grants to the District Council are currently not adequate to cater for the needs of primary health care at village level such as maintenance of buildings, supply of equipment and medicines and training of staff. Very often monthly supplies of vaccines and medicines from the government are incomplete or occasionally totally absent. This means that the provision of quality health care is not being met in many rural villages of Kasulu District.

  In Mwayaya the existing dispensary is a structure of just one room where patients are seen, medicines distributed, immunisations given and women give birth. Children are weighed outside in the veranda area. The building is in poor condition, there are no latrines or water facilities. Both the Village and District Government have requested a new facility that meets current standards. It is proposed to convert the existing structure into a basic residence for dispensary staff. (Please see photographs – Appendix C) A Clinical Assistant and 1 trained nurse staff the dispensary. The dispensary also serves people from Nyankoronko village (2 hours walk away) which has a population of 2,040. The nearest hospital, Heri Mission is 8km from the village but charges high fees for services (Tsh 8,000 for care during a normal delivery compared to Tsh 2,000 at Kabanga Mission Hospital over 50 km away). In 1998 there were said to be 7 Traditional Birth Attendants (TBAs) in the village but none had been trained and there were no Village Health Workers (VHW).

  In Titye, the dispensary receives a good level of community support. However the building is in poor condition and does not conform to current standards.

- The healthcare problems described above are compounded by the chronic under-funding of the District hospitals where the added demands stretch an already tight budget and staffing numbers.

The Need for Health Education

- There is a low level of awareness in rural areas concerning the prevention and treatment of predominant health problems such as malaria, diarrhoea and malnutrition amongst communities. The main medium by which information reaches the communities is by radio. In the communities in which we are working, there has been no previous effort to deliver health education. In other parts of the District the situation is the same, except for the area in which World Vision have been

operating a Child Survival and Protection Programme. It is therefore difficult for the village communities to know how to take steps independently to improve their environmental and nutritional situation.

1.4 Goals and objectives of the project in response to these needs.

Responding to the issues raised above requires both an effective approach to health education on the prevention, diagnosis and cure of the major diseases and easier access to health facilities and medical services. A way has to be found to improve villagers' understanding of the above and to enable them to take action to improve their access to health facilities, to take measures in disease prevention (such as environmental sanitation) and to increase health awareness and education.

Responsibility for the development of a health infrastructure in Tanzania has traditionally been left to villagers as the local government capacity remains inadequate to provide improved facilities. This form of community mobilisation must be accompanied by building relationships and accountability between the village and local government for work to be sustainable and supported.

The local government health sector continues to be short on funds and under-skilled in mobilising and managing community-based healthcare facilities. Until both these issues are resolved within the government structure, organisations such as CORD have a valuable role to play in strengthening the capacity of both village and government.

1.5 Overall goal(s) of the project.

The overall goal of this project is:

To facilitate sustainable improvements to the health of people in the rural areas of South Kasulu District.

Three distinct overall objectives of the project are:

To improve the provision and quality of primary health facilities in South Kasulu District.

To improve the quality of healthcare service provision by healthcare practitioners in South Kasulu District.

To facilitate sustainable improvements to the capacity of the community and local government to provide quality healthcare services and health education.

This may be achieved in three parts, all of which may be funded by SEP:

Part 1: Construction of three new dispensaries in Kigondo, Lalambe, and Shunguliba.
Part 2: The reconstruction of Mwayaya dispensary and rehabilitation of Titye dispensary.
Part 3: The training of health practitioners and capacity building with Primary Healthcare Committees, Village Governments and the District Council Health sector to provide quality healthcare services and health education in nine villages, Kigondo, Lalambe, Shunguliba, Mwayaya, Titye, Kaguruka, Rungwe Mpya, Kidyama and Nyumbigwa.

In all three parts the involvement of the community and the District Council is intrinsic to the project design.

1.6 Quantitative or qualitative targets of the project.

The specific outputs of the project are as follows:

Part 1:

- The provision of improved dispensary access to the population of Kigondo, Lalambe and Shunguliba by constructing and equipping a new dispensary in each village.

- The provision of an improved quality of healthcare from the dispensary with full staffing and continued maintenance managed by the community and the District Council.

Part 2:

- The reconstruction and full equipment of Mwayaya dispensary, and rehabilitation and full equipment of Titye dispensary to current standards.
- The provision of an improved quality of healthcare from the dispensaries with full staffing and continued maintenance managed by the community and the District Council.

Part 3:

- All health practitioners (TBAs, Traditional Healers) are trained and offer an improved standard of service in all nine villages.
- Health education and awareness in the community is improved by the training and facilitation of community health workers in each village.
- The capacity of the Primary Healthcare Committee, the Village Government and the District Council to plan and manage development of its own healthcare services is increased.

1.7 Activities to be implemented by the project.

The following logical framework outlines the activities to be undertaken and the indicators that will be used to monitor progress during the project period.

PROJECT GOAL	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
To make sustainable improvements to the health of people in the rural areas of South Kasulu District.	Reduction in maternal and child mortality and incidence of common diseases (malaria, diarrhoea).	Village and district-level health statistics. Hospital and dispensary records.	Health of population of focus area not adversely affected by epidemic, change in environmental conditions or other.
OVERALL OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
To improve the provision and quality of primary health facilities in South Kasulu District.	Number of functioning dispensaries increases.	District annual reports and project monitoring system.	No change in regional situation prevents full work and functioning.
To improve the quality of healthcare service provision by healthcare practitioners in South Kasulu District.	Improved quality and access to health services for primary healthcare needs.	District annual reports and project monitoring system (baseline information collection and survey).	Training and monitoring leads to a direct increase in the quality of service provision by healthcare practitioners.
To make sustainable improvements to the capacity of the community and local government to provide quality healthcare services and health education.	PHC in place and functioning involved in providing quality healthcare services and heath education.	District annual reports. PHC reporting minutes. \Knowledge of new initiatives from District and CDP reporting.	Trained personnel do not leave the project area. External factors do not reduce the impact of capacity building training with the community and local government.
TARGETS/OUTPUTS	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS/RISKS
Part 1: Construction of 3 new dispensaries – Kigondo, Lalambe, and Shunguliba. Improved healthcare service with full staffing and maintenance managed by the community and the District Council.	Construction and full equipment of dispensary buildings, latrines and rainwater tanks to required standard completed. Reporting on quality of service.	Observation against schedule of work agreed with each village committee. Reporting through PHC.	Infrastructure and training provided lead to direct improvement of healthcare. Full staffing quota available from District. Maintenance skills remain in the community.
Part 2: Reconstruction of Mwayaya dispensary and rehabilitation of Titye dispensary. Improved healthcare service with full staffing and maintenance managed by the community and District Council.	Reconstruction and full equipment of dispensary buildings, latrines and rainwater tanks to required standard completed. Reporting on quality of service.	Observation and monitoring visits as above.	District Council continues to support health provision at the end of 2005.
Part 3: Training of health practitioners (TBAs, TH, and VHW). Health education and	Completion of training all TBAs, TH and at least 2	Participation and recording of activities, CORD team and PHC, and dispensary staff. CHW indicators of health	TBAs, TH and CHW put training into practice. Suitable mechanisms ensure health education of community by health

awareness of community increased by VHWs. Capacity of Primary Healthcare Committees, Village Governments and the District Council Health sector to plan and manage development of its own healthcare services increased. In nine villages, Kigondo, Lalambe, Shunguliba, Mwayaya, Titye, Kaguruka, Rungwe Mpya, Kidyama and Nyumbigwa.	CHW in each village. Health awareness increased – VHWs increase activity in health education. Active and strong primary healthcare committee in each village – gauged by CDP committee monitoring system. Contributions collected from community towards future projects and maintenance of dispensaries.	awareness and reporting. CDP Committee capacity building indicators. Bookkeeping and accounts of PHC and minutes.	practitioners. Those individuals who receive capacity building training do not leave the district. Culture of District conducive to support community initiatives.
ACTIVITIES Part 1: Construction of 3 dispensaries. Training of dispensary staff. Work with PHCs and District Council to increase capacity to maintain improved quality of services.	INPUTS Construction training, materials, tools, transport, supervision and monitoring. 1 week training on-site each village, CORD Officer and facilitator, VG , PHC, VHW, TBA, & TH. Attend monthly meetings PHC and VG, monitor and facilitate programme of development, meet with and transport District officials to villages, involve in training programmes and other activities.	MEANS OF VERIFICATION Record-keeping against project schedule of work. Recording of activities and evaluation. Monthly reporting of CDP and reporting against time schedule.	ASSUMPTIONS/RISKS All components are possible to resource, i.e. materials available, transport does not break down. Training will be translated into action. Committees accept and work with CORD on their programme of development. Time delay due to slow mobilisation by the community. Lack of consistent support from community and District representatives due to other time pressures.
Part 2: Reconstruction/rehabilitation of 2 dispensaries. Training of dispensary staff. Work with PHCs and District Council to increase capacity to maintain improved quality of services.	Same as for Part 1.	Same as above.	As above.
Part 3: Train village health practitioners. Facilitate health education and awareness of community through VHWs. Build capacity of PHC, VG and District Council to plan and manage health service improvements.	Recruitment and training of VHW (six weeks). Visit, observe and facilitate training, CORD officer and District health staff facilitator, aid development of materials, etc. Attend PHC, VG and District Council meetings, transport District Officers to meetings, train/facilitate to required needs. Liaison with District Health Management Team.	Recording of activities and evaluation. CHW indicators reporting through PHC and CDP minutes of meetings and CDP indicators in meeting reports.	

1.8 Strategies and outline of the project.

The 'tripartite' community development approach that CORD employs in Kasulu District involves working with *individuals, village-level institutions and local government structures,* managing the relationships between each of these dimensions. Working in this way enables CORD to ensure that projects will be successful as it allows the most appropriate actors or group of actors to be supported for specific actions to take place.

All three parts of the program will operate in a similar way to previous CORD programs, staging the sequence of activities in each village carefully to ensure that the community has sufficient input and resources to invest in the project. Each village is at a different level of capacity and demonstrates a different skill and resource base. The community development team will apply a range of capacity-

building techniques to facilitate the program and its ownership by the community with sufficient input from local government.

1.9 Major potential risks to the project and how will they be coped with.

The logical framework also highlights the major potential risks to the project. These can be dealt with in the following ways:

At present there is no anticipation that the health of the population of the focus area should be adversely affected by epidemic, a change in environmental conditions or otherwise, or that the security situation will change significantly in the next three years. However, it is possible that local pockets of disease may develop which will affect the overall impact of the programme. These would need to be anticipated and attended to. A programme of baseline data collection will be carried out by CORD in the next three months in each of the focus villages. From this information it will be possible to check this risk.

Training and monitoring experience has been gained extensively in previous community development programmes and from sharing learning with other NGOs in the District. The approach to training that will be offered to the communities will be designed with maximum practical impact as its target. Much of the training will be carried out in real-life situations in the villages with lively, experienced and participatory facilitators. A variety of techniques and presentational forms will be used in each training course.

To reduce the possibility that trained personnel will leave the project area careful consideration will have to be given to the financial and non-financial incentives that they are offered by CORD, the community and the District. This will be a vital part of our discussions in PHC meetings.

External factors, such as a change in government, or change in healthcare management from central to local government, may reduce the impact of CORD's capacity-building training with the community and local government. If for example there is a change in PHC constitution or exchange of manpower between Districts. At present there is no indication that the new Local Government Reform Agenda will be replaced, so CORD's action in this area can be to ensure that as new staff filter into the area they are managed and skilled appropriately.

The assumption that providing a dispensary and training will lead to a direct improvement in healthcare is not accepted by CORD. This is why it has been necessary to include in this proposal an emphasis on training and capacity-building. Both of these areas must include the introduction of effective systems for maintaining quality standards, monitoring, reporting and improving the services offered.

There is a risk that the manpower commitment from Local Government to resource the dispensaries may not be fully adequate, however this is already being addressed as meetings regarding this matter have been held with the District Medical Officer (DMO), the District Executive Director (DED) and the District Manpower Services Officer. Both the DMO and the DED raised the issue early in January on separate occasions in Dar-es-Salaam with the relevant authorities in the Ministry of Health. A letter is included in the appendices which details the District Medical Officer's commitment to this matter. They are seeking permission to employ new personnel in the health sector, and reassurance has been given that the matter is receiving full attention. This project would provide an extremely strong incentive to increase the skill-base in the District health team.

Maintenance skills of the trained skilled labourers could become redundant after the project is completed. Efforts will be made by CORD to facilitate the finding of further construction work, it may be appropriate for the individuals to group together in an enterprise which would be eligible for CORD's support to income generation.

Again, to ensure that effective health education is reaching the general population, and significant improvements are being made in the health environment, the activities of VHWs will be closely monitored by PHCs and CORD.

CORD will continue to work with as many individuals in the District as possible, on an individual level and in coordinating groups to ensure that the culture of the District remains supportive and does not depend on the action of a few effective individuals.

CORD has adequate experience of resourcing construction programmes to be able to anticipate wherever possible, problems that may arise. However, in unforseeable situations some flexibility on the schedule of implementation as agreed with the community will be required.

Each community is different, and CORD does not like to push from above for change. However, in many situations it is possible to encourage community mobilisation and support that reduces unnecessary time delay due to the individual working pace of each village-level committee and its leadership. To some extent this issue can be accommodated at the planning stage but inevitably involves a high level of judgement as to what is community-managed and what is CORD-managed.

It is important to be aware of the lack of consistent support from village communities and local government representatives due to other pressures on time and resources at the planning stage of the project, when realistic timeframes can be agreed with each community.

2. Community Participation

2.1 Relationship between the proponent and the beneficiaries of this project.

CORD has been working in each of the proposed villages for a varying length of time, ranging from six months to three years. Much of the contact with village members has been on formal occasions when attending Village Government (VG) meetings and Primary Healthcare Committees (PHC). CORD works in a way it believes can create the most beneficial relationship with the community, with communication in both directions and a clear understanding of expectations of the community and their expectations of CORD. The team recognises that formal meetings provide a limited opportunity to establish good relationships both with groups and individuals, and staff endeavour to spend time in less formal discussion wherever possible. The working relationship between CORD and its beneficiary community has an excellent record, with visits to each village once every two to four weeks, and two-way communication by letter between times. This has proved to be an effective way of working.

It is anticipated that during this project period the team will attend all VG and PHC meetings, as often as possible with a district official. The role that is performed by members of the team will however change over the project period as individuals within the committees become more able and group working becomes stronger. The Construction Officer will also spend time with each construction team, visiting once every two weeks and staying with the team for periods of one or two days duration where necessary.

CORD has never received any hostility to its activities in the villages where it has worked and generally enjoys a spirit of partnership.

2.2 In what way(s) have the target beneficiaries participated in the identification of the problem(s) to be addressed, settling of objectives, and planning of project activities?

A Participatory Rural Appraisal was conducted by CORD in 1998 (with funding from the Department for International Development, UK Government) to study the rural health needs of Kasulu District. This involved spending a week in eight villages. Many of the conclusions drawn from this study have informed our work in the new focus villages including the prioritising in health of the need for more adequate health services and in particular, dispensary construction.

Consultation in Village Government meetings and Primary Healthcare Committee meetings has taken place regularly in all of the new focus villages. A fully represented PHC has 24 members. Views have also been heard in other forums. For example in Lalambe and Kigondo, at recent village public meetings, construction of a dispensary was listed by the community as their 'number 1' development priority for the village.

Consultation with members of the District Health Management Team has taken place on numerous occasions, both informally and with other agencies in the District Health Sector Meetings. Similarly, weekly briefings are held with the District Executive Director of the District Council concerning plans and activities.

Sharing of understanding and experience has also taken place in meetings held every two months with World Vision, the only other NGO working in the health sector in Kasulu District.

2.3 If the project is implemented, how will the beneficiaries participate in project management and contribute to other project costs?

For the construction, rehabilitation and reconstruction of dispensaries, villagers will be/have already been encouraged to contribute locally available construction materials and pay for casual labour. They will also be mobilised to raise funds to support the ongoing operation and maintenance of the dispensary. In Lalambe, Mwayaya and Kigondo, villagers have either begun digging the foundations for a new dispensary, collected stones and sand or made bricks to start the construction work.

The District will be required to support the project with core dispensary staffing and the provision of 'medical kits' (including drugs). District officials will be expected to accompany CORD to project villages to perform their roles and responsibilities for the village committees, for inspection of progress and encouragement.

2.4 In what way(s) will the project affect (whether positively or negatively) women's participation to decision making process of development activities?

Women will form the majority of the community members using the dispensaries for ante-natal and post-natal care, and it is therefore important to listen to their needs in the management of the project.

Women are present in both the VG and PHC meetings, and often contribute in discussion. However, they are not equally represented on these committees. For the purposes of the project efforts will be made to ensure that information is communicated to women, that they are aware of the opportunities, and that the opportunities offered by the programme do not exclude women for reasons of practicality or conflicts with existing gender roles and expectations. In previous project experience it has been noted that many of the activities for the construction projects have been carried out by men, whether as trained skilled labour, casual labour or in village government roles. With the aid of focus group work and discussion, a gender analysis will be carried out to aid the design of training, recruitment of Community Health Workers, management by the Primary Healthcare Committee and provision of health facilities. Gender awareness forms a part of the capacity building programme with which CORD works with VG and PHC committees. Attendance and participation of women at VG and PHC meetings is monitored by CORD.

3. Technical Aspects

3.1 What skills and techniques will the beneficiaries acquire through the project?

Building construction and maintenance: as part of CORD's overall holistic approach to the development of its focus villages, a team of skilled labourers should be established in each village. In all villages except for one, Mwayaya, a team has been employed on previous school construction projects and requires refreshment and extension of their skills to dispensary construction. In Mwayaya it will be necessary to provide a two-week training course in basic construction skills. Following these courses the skills of the labourers will continue to be developed by coaching from the Construction Officer and Projects Leader. One to one support and coaching will also be given to the village chairman and their deputy in team leadership and project management skills.

Dispensary staff (usually a team of one Clinical Officer, one Nurse and one Assistant) will receive training to boost their existing medical knowledge with a particular emphasis on providing a good

quality service, working closely with the community and enabling the community to find solutions to problems encountered. A one-week course will cover:

- Refreshing their knowledge of laboratory and diagnostic equipment,
- Procedures for the management of supplies, stocks, patient flow and correspondence,
- Necessary skills for book-keeping and financial accountability,
- Working productively with TBAs, THs, VHWs, the VG and PHC.

In addition, evidence of a comprehensive understanding of the treatment of common conditions, reproductive health, preventative health, the Integrated Management of Childhood Illnesses, and nutrition will be checked and encouraged.

The capacity building programme that CORD has developed for work with village level committees will be completed during the project period. It will ensure that members of the Primary Healthcare Committee will be trained in the following:

- Their roles and responsibilities in communicating and coordinating action on the health needs of the villages.
- Monitoring activities of the dispensary/health facilities that exist, VHWs, TBAs, and TH.
- Skills in book-keeping and managing for financial accountability.
- Mobilisation of the community to contribute and participate in activities to improve the health services in the village.
- Listening to the needs and encouraging the participation of all members of the village community.
- The roles and responsibilities of the District Council for the provision of health services.
- Supporting the work of health practitioners and developing educational health materials.

Community health workers would be recruited by the PHC to provide health education to members of the village, to enable them to take practical action both in preventative and curative (recognition of symptoms) healthcare and nutrition. They will be trained over a period of months in the following:

- Their roles and responsibilities in health education for the village community.
- Basic knowledge in preventative and curative healthcare, and nutrition, covering the major illnesses and HIV/AIDS in the community.
- Techniques for communicating information about health to (different groups) in the community.
- Developing materials for effective health education.
- Planning and monitoring activities for health education and practical change to improve healthcare with village members.
- Working with other health practitioners and the District Council.
- Reporting to the Primary Healthcare Committee.

Traditional Birth Attendants (TBA) will be given formal training (the first for many) in ante-natal, peri-natal and post-natal care, and working with the dispensary staff and its service provision.

Traditional Healers (TH) will be given formal awareness training in curative and preventative healthcare and involved in discussions with dispensary staff concerning early diagnosis, safe healing remedies and working cooperation.

The village population will benefit from health education facilitated through the activities of community health workers (one to one advice, focus groups, theatre, information materials, schools work, youth work, etc.), dispensary staff (one to one advice and suppliers of information materials) and the Primary Healthcare Committees (coordinating action on health). This will cover a comprehensive range of health matters including improved nutrition, preventative and curative healthcare for malaria, diarrhoea, anaemia, bronchitis, and AIDS.

3.2 What specific technical inputs from Japanese experts will be necessary for the project when and how long?

No specific technical inputs are anticipated to be required, whilst CORD has the local capability to manage the project effectively, with additional expertise sought through the local government structure and NGO network. However, additional guidance from JICA would be most welcome.

4. Financial/Economic Aspect

4.1 Expected financial and other benefits of the project on the present conditions of the beneficiaries.

It is naturally difficult to justify health projects on financial grounds as most of the benefits require social appraisal and are not possible to quantify. Expected benefits to the project beneficiaries involve reducing the household income spent on healthcare, reducing the time spent sick, caring for the sick or walking to use health facilities and therefore will result in increased household income, increased household production, and improved all-round well-being. Specific benefits include:

- Direct benefits in terms of reduced mortality and morbidity.
- Improved healthcare at a cheaper cost (closer in distance, demanding less time, less effort and preventing further illness or exacerbation of condition due to travel).
- Health problems for the villagers will be less compounded as the number of days spent sick should decrease, leading to an overall increase in productivity, income and standard of living.
- Referrals can be made faster and more effectively reducing unnecessary stress on district hospital facilities.
- Health education can be disseminated from the dispensary to Community Health Workers and the PHC.
- The village members will be mobilised to collect for and maintain the health services within the villages.
- Increased effectiveness of local government resources allocation at the village level.

4.2 Expected benefits from the cost-effectiveness point of view.

- In the villages where CORD has chosen to construct three dispensaries, the costs of construction can be justified for the following reasons:
  - no suitable building exists in the village that could be renovated or rehabilitated as a dispensary.
  - Providing good quality workmanship but with relatively inexpensive materials and contributions from the community will create a building that will stand for fifteen to twenty years at relatively low cost.
- In Mwayaya the reconstruction of the building is necessary because the present structure is unsafe and not fit for rehabilitation. The soft (staff, community use and management) infrastructure to support the dispensary is already existing and requires only to be strengthened with capacity building. Similarly, in Titye, the dispensary building requires rehabilitation as it is presently unsafe.

- The cost of capacity building village-level committees and working with local government to support those is highly cost-effective. CORD has already witnessed the benefits of time spent capacity building for example in Nyumbigwa where the VG and PHC are managing the dispensary in liaison with the District Council. Since opening the dispensary the committees have managed it effectively and introduced new initiatives, such as the registration of TBAs and employment of a Technical Assistant in the dispensary. The dispensary has proved to be cost-effective to run and financially sustainable by the community and District. CORD staff time and fuel to attend meetings are the greatest costs following the completion of the structure and capacity building of the committee.
- CORD is one of the lowest cost implementers of development work in this area, maximising the use of project resources and minimising administration and overhead costs.

4.3 Sustainability of the benefit of the project.

The sustainability of the project will be inherent in:

- The quality of the infrastructure created and the transfer of building and maintenance skills to a team of skilled labour.
- The strength of the Primary Healthcare Committees established, working relationships between dispensary staff, PHCs, Community Health Workers and members of the community, and their ability to mobilise and increase the participation of the community.

- The understanding and management of relationships between the District Council and the village committees.

The approach CORD applies to community development focuses on creating a relationship between CORD and the community which facilitates the transfer of skills and learning, but most of all, increasing the ability of the village to act on its own initiative. The team aims to nurture committees as people accept responsibility for their own development, by listening, advising and encouraging people at an appropriate pace.

5. Capacity Building

5.1 What training inputs will be provided to the beneficiary organisation's leaders and members to improve the managerial capability of their organisation or community?

At the village level, the Village Chairperson and deputy, Primary Healthcare Committee Chairperson and dispensary staff will receive one to one coaching on leadership, management, group facilitation and accountability skills.
District Council officials will be encouraged to fulfil their responsibilities to the village communities, and to take steps to strengthen the structure of accountability that will enable better service provision.

5.2 What organisation structures will sustain the project after CEP assistance?

The District Health Management Team will be ultimately responsible for the Health Reform Programme (implemented in July 2000) under which responsibility for the improved management of health facilities will fall. At District level this programme will direct funding towards improvements of health services in the following key areas;

- Reproductive and child health services (obstetric care, family planning and child health)
- Communicable disease control (malaria and STD/HIV/AIDS)
- Community health promotion/disease prevention (water, hygiene and sanitation)
- Improved organisational structures and institutional arrangements for better health service management at all levels.
- Procurement of drugs, medical supplies, diagnostic reagents and laboratory supplies.

At the end of the three-year project period, Village Government and Primary Healthcare Committee structures will be institutional at village level. The committees will have gained significant training and experience in managing healthcare facilities, the improvement of healthcare services and activities to reduce the incidence of disease. The PHC should be supporting the continued activity of Community Health Workers both financially and managerially with contributions and participation from the community.

The village committees should have greater confidence in approaching the District Council for advice or material provision, and be fully aware of their rights to improved healthcare provision. This in turn will help to stimulate improved accountability on behalf of the District Health team.

6. Innovative Features

6.1 What are the innovative features of this project?

There are three highly innovative features of this project:

- The well-established approach of CORD CDP team that has produced genuine community ownership of improved physical infrastructural facilities in past projects.

- Using a strong team that focuses time increasingly on techniques for the capacity building of individuals, organisations and institutions to bring about long-term change, instead of infrastructural improvements in its programmes.

- The 'tripartite' approach to capacity building, that addresses the need to build the capacity of individuals, village-level institutions and local government structures. CORD has excellent relationships with the District Departments and constantly strives to support their work, not to create parallel structures.

6.2 Under what conditions can the project be replicated in other communities?

If/when funding from the Health Reform Programme reaches Kasulu District, the Council will have an established and effective model of developing the capacity for local service delivery with which to work. If the funding received is inadequate for the construction of dispensaries, Parts 2 and 3 of the proposal concerning capacity building are replicable at all levels of funding. District Council officers involved in the CORD programme will have developed an understanding of the approach sufficient to support the transfer of its principal elements to other geographical areas of the District.

7. Consistency to the Government Policy

7.1 How the project goals, objectives and approaches are consistent with the government's policy and programs?

As mentioned in the above section the District plan highlights the priority for the District. The government's policy and programmes for primary healthcare have focused on the UNDP-supported programme of Child Survival, Protection and Development (CSPD). This addresses preventative and curative healthcare of the most prevalent diseases and causes of maternal and infant mortality in the rural areas. The UNDP has more recently begun funding the third phase of the AIDS Control Programme. While both of these programmes have been acknowledged by the District Health Management Team, they have not received adequate funds with which to introduce a programme of care in any Wards of Kasulu District. The objectives of the District Health Department remain broad: to upgrade the health status of the population and increase the life expectancy of the people of Kasulu. This will be indicated by a reduction in mortality and morbidity rates and the percentage delivery of health services to the population.

There is only one other NGO, World Vision, operating a CSPD programme in the District. This is in a different geographical area to CORD. It is difficult to predict when adequate funding would be received for the District to begin to implement either programme. The 2001-2005 District Plan highlights the low capacity of both Central Government and the District health department for health service delivery, and the need to reach village level communities. However, under the Local Government Reform Programme, control over hospital and health resources has been devolved to the District Council level. This now offers the potential for a more efficient allocation of resources and the flexibility for to employ and discharge staff. It will therefore be much easier to transfer excess hospital staff, and employ staff from outside the region, to rural health facilities.

This programme would enable CORD to address each of the challenges to improve health in the CSPD and AIDS Control Programme in an integrated way. Strong support for CORD's work in this area has been expressed at the District level, and applications are under way for the transfer of staff into the region to increase the pool of dispensary staff available (see letter attached).

7.2 Local government or other line agencies be involved in project implementation.

As mentioned in previous sections the District Health Management Team and Health Department will be involved in project implementation. This will take the form of officials accompanying CORD staff to PHC meetings, to check the operations of a dispensary, or to provide information, the provision of dispensary staff and the provision of medical staff as facilitators on training programmes.

8. Project implementation.

8.1 Describe the structure, composition and functions of the project implementing team that shall be responsible for the day-to-day operations of the project.

One Construction Officer responsible for infrastructural aspects of the programme:
- technical drawing/design of building structures
- communication of project plans to District engineer
- purchase and delivery of materials to project sites, overseeing their safe storage
- training and on-site coaching of skilled labour during regular visit (technical advice)
- on-site coaching of manager of skilled and casual labour during regular visits (usually the village chairman)
- communication, correspondence and problem-solving with construction teams in each village
- monitoring and evaluation of progress

One Health Project Officer responsible for capacity-building aspects of the programme:
- attending and facilitating PHC meetings in all focus villages, working to a village-specific capacity-building schedule (standard CORD practice)
- arranging and facilitating training programme for dispensary staff, village health workers and TBAs
- monitoring book-keeping, financial accountability and savings of each PHC
- communicating activities and liaising with District staff concerning staffing or other issues
- monitoring and evaluating progress in capacity-building

One Projects Leader responsible for:
- overseeing the activities of the Construction Officer and Health Projects Officer
- arranging transport to the villages
- monthly reporting on project activities

One Programme Officer responsible for:
- communicating and reporting progress to JICA
- training of above officers where necessary to improve quality of the work of the community development programme.

8.2 Describe the financial management system to be employed in the monitoring of project funds.

At village-level, simple book-keeping and monitoring. Financial accountability to maintained by allocating responsibility and check systems.
At project-level, standard CORD procedures involve spending against present budget lines, recorded through an order, requisition and delivery note system.
CORD accounts are reported monthly to CORD UK and audited annually by.
CORD accounts are reported monthly to CORD UK and audited annually by D.A. Owen, a UK-registered firm or Chartered Accountants. CORD CDP programme operates to the same stringent financial reporting standards as required by UNHCR for its refugee programme.

8.3 What inputs of human resources and facilities will be made by the proponent organisation and the beneficiaries to the project?

All inputs will be cash specifically appropriated as CORD's regular budget and disbursed for project related costs. This will include:

A. Salaries:

Construction officer x 50% for two years.
Projects Leader x 33% for 3 years.
Programme Officer x 20% for 3 years.
Health Project Officer x 66% for 3 years.
Doctor x 10% for 2 years.

Plus in-kind contributions:

B. Rental of equipment and furniture (actual cost of rental payment)
C. Office space and utility expenses incurred in the building and used for the project (actual monthly rental payment x % allocable to the project)
D. Electricity (total cost of light and power consumption x % allocable to the project based on approximate square metre area)
E. Water (total water consumption x % allocable to the project cost based on number of personnel)

Rental of office space/utility expenses/CORD-owned office space (unvalued).
Rental and staffing of store and storekeeper.
Property donated (unvalued).
Electricity and water expenses (unvalued).

Other miscellaneous donations:

1 LandRover double cabin pick-up from CORD, for transport of team to and from health project village sites for meetings, delivery of small construction materials, mobilisation of community, provision of technical support and capacity building
Truck for transport of materials, depreciation cost.

9. Activity schedule

Major activities	1st year	2nd year	3rd year
Part 1: Construction Kigondo Lalambe Shunguliba	Engage District	District staff to be facilitated into place	Monitoring of District support maintained.
	Community mobilisation for contributions to construction	Community mobilisation for contributions to maintenance of service	Monitoring and support to community mobilisation continues through PHC.
	Refresher training for skilled labourers		
	Construction work to commence.	Construction work to be completed.	Facilitate maintenance of structure by community.
	Capacity-building PHC to manage project.	Facilitation of PHC to manage project.	Continuing support to PHC for further health activities.
Part 2: Rehabilitation/ Reconstruction Tityc and Mwayaya	Engage District	District staff to be facilitated into place	Monitoring of District support maintained.
	Community mobilisation for contributions to construction	Community mobilisation for contributions to maintenance of service	Monitoring and support to community mobilisation continues through PHC.
	Refresher training for skilled labourers		
	Construction work to commence.	Construction work to be completed.	Facilitate maintenance of structure by community.
	Capacity-building PHC to manage project.	Facilitation of PHC to manage project.	Continuing support to PHC for further health activities.
Part 3: Health Education	Training: Dispensary staff following completion of dispensary. Recruitment and training of VHWs. VHWs commence activities for health education to general population.	Training of TBAs. TH and other health practitioners following completion of dispensary and start of service. VHWs receive ongoing training and support as they develop a programme of activities for the health education of the general population.	
	Capacity Building: PHC receives monthly support at meetings and programme of capacity building to enable management of health projects. Facilitation of PHC to supervise construction. Facilitation of community mobilisation by PHC. District officials encouraged and transported to attend PHC meetings. District support sought on issues of local government responsibility to communit.y	Prrogramme of activity with PHC extended to suit requirements. Facilitation of community's management of dispensary and health education work by VHWs, particularly monitoring systems and advocacy approaches to working with District.	Programme continues. PHC also mobilised to begin full community support for incentives to VHWs. Monitoring of systems continues.

APPENDICES

1. Copy of CORD's Tanzania registration document.
2. Map of the project location:
   a) Tanzania
   b) Western Tanzania
   c) Kasulu District
3. Detailed calculation of project costs and counterpart contributions for dispensary materials.
4. Letter of support from the District Medical Officer concerning staffing of the dispensary and local authority support for the project.
5. Annual report – copy to follow at end January 2001.
6. Copy of financial accumulative statements for the Community Development Programme for the years 1998, 1999 and 2000.

References:

Kasulu District Council Five Year District Development Plan 2001-2005