برنامج الأغذية العالمي | Programme Alimentaire Mondial | World Food Programme | Programa Mundial de Alimentos

**Executive Board**
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# DRAFT COUNTRY PROGRAMMES

## Agenda item 8

*For consideration*

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# DRAFT COUNTRY PROGRAMME – UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010)

# NOTE TO THE EXECUTIVE BOARD

**This document is submitted to the Executive Board for consideration.**

The Secretariat invites members of the Board who may have questions of a technical nature with regard to this document to contact the WFP staff focal points indicated below, preferably well in advance of the Board's meeting.


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# EXECUTIVE SUMMARY

In the last two decades, the United Republic of Tanzania has registered significant socio-economic development. Building on its achievements, and through its National Strategy for Growth and Reduction of Poverty,[1] the country is committed to meeting the Millennium Development Goals by 2015, but significant efforts need to be made to achieve this. Despite its rich resource endowment, United Republic of Tanzania is one of the poorest countries in sub-Saharan Africa, ranking 164th of 177 countries.[2] It is classified as a least-developed, low-income and food-deficit country and has an estimated population of 36.9 million people, 51.1 percent of whom are women.[3] An estimated 36 percent of the population live below the basic needs poverty line, and 20 percent live on less than US$1 a day.

This intervention is WFP Tanzania's second country programme. It builds on the achievements of the current country programme for 2002 to 2006, drawing on the recommendations of evaluations and the preliminary results of a comprehensive food security and vulnerability analysis. It has been designed with guidance from the Country Programme Steering Committee, chaired by the Director of the Disaster Management Department in the Prime Minister's Office, in collaboration with the rest of the United Nations Country Team.

This country programme will contribute towards the Millennium Development Goals related to eradicating extreme hunger and poverty, achieving universal primary education, promoting gender equality, reducing child mortality, improving maternal health, and combating HIV/AIDS. It was designed under the framework of Tanzania's National Strategy for Growth and Reduction of Poverty, responds to the United Nations Development Assistance Framework and is in line with WFP's Strategic Plan for 2006 to 2009. The country programme has four components: (i) support to primary education; (ii) support to HIV/AIDS-affected households; (iii) food for asset creation; and (iv) supplementary feeding to vulnerable children and lactating and pregnant women.

The country programme will assist a total of 874,000 beneficiaries over four years. The total food requirement is 69,732 mt, at a food cost of US$21.2 million and a total cost of US$40.0 million.

[1] United Republic of Tanzania. *National Strategy for Growth and Reduction of Poverty, 2007–2010*.

[2] United Nations Development Programme (UNDP). 2005. Human Development Report.

[3] United Republic of Tanzania. 2002. *Population and Housing Census Results.*

# DECISION

The Board endorsed draft country programme United Republic of Tanzania 10437.0 (2007–2010) (WFP/EB.A/2006/8/6/Rev.1), for which the food requirement was 69,732 mt at a total cost of US$32.2 million covering all basic direct operational costs, and authorized the Secretariat to formulate a country programme, taking account of the comments of the Board.

## SITUATION ANALYSIS

1. In the last two decades, United Republic of Tanzania has registered significant socio-economic development. Building on its achievements, the country is committed to meeting the Millennium Development Goals (MDGs) by 2015, but significant efforts still need to be made to achieve this. Despite its rich resource endowments, Tanzania is one of the poorest countries in sub-Saharan Africa, ranking 164th out of 177 worldwide. It is classified as a least-developed, low-income and food-deficit country and has an estimated population of 36.9 million people, 51.1 percent of whom are women. An estimated 36 percent of the population live below the basic needs poverty line, and 20 percent live on less than US$1 a day.[4] Per capita gross domestic product (GDP) was US$287 in 2003, and food accounted for 65 percent of households' consumption expenditure in 2002.[5] Poverty is greater in households whose heads are economically inactive or illiterate or have a large number of dependants.[6]

2. Although agriculture is the mainstay of the economy, poverty is extremely high in rural areas, where 77 percent of the poor population lives; poverty is highest among households that depend on subsistence agriculture.[7] Tanzania's agricultural system is rain-dependent and highly susceptible to climatic shocks, particularly in semi-arid and arid areas of central and northern Tanzania where chronic and transitory food insecurity hamper households' ability to meet their food needs at all times. This is exacerbated by widespread environmental degradation, notably through tree felling and poor farming practices, which accelerate soil erosion.

3. Economic reform programmes in the 1990s have not reduced existing inequalities. On the contrary, indicators of income poverty, human capacity, survival and nutrition show growing rural–urban disparities and disproportions in poverty status across and within regions and districts. The trends are similar for distributions of population, natural resources and infrastructure such as transport, schools and health facilities; for example, more than 70 percent of households in Dar es Salaam, Kilimanjaro and Mbeya regions use improved water sources, compared with less than 40 percent in Coast, Tabora and Kagera regions, with a nationwide low of 20 percent in Lindi region. Dar es Salaam, Kilimanjaro and Mbeya also have the lowest average distances to secondary school, ranging from 2.5 to 8.7 km, compared with more than 20 km in Shinyanga and Rukwa regions; again Lindi has the worst average, of more than 25 km. WFP statistics indicate that girls represent only 32 percent[8] of primary schools enrolments in pastoral areas.

4. Tanzania is normally self-sufficient in its staple crop – maize – and other non-cereal production, but poor infrastructure in rural areas, high transportation costs and malfunctioning markets limit the internal distribution of food from surplus to deficit areas. A significant portion of the surplus is concentrated in southern highland regions and does not reach food-deficit areas of Tanzania; most of it is traded with neighbouring food-deficit countries. The government purchases maize surpluses from remote districts as a buyer of

[4] UNDP. 2005. *Human Development Report*.

[5] United Republic of Tanzania. 2002. *Household Budget Survey Report.*

[6] Ibid.

[7] United Republic of Tanzania. 2002. *Population and Housing Census Results.*

[8] WFP. 2004. *Analysis of enrolment data from schools targeted by the WFP-supported school feeding programme.*

last resort, but inadequate budget allocation to the strategic grain reserve (SGR) has limited this capacity and its impact. At the household level, poor food handling, storage and processing often result in post-harvest losses up to an estimated 40 percent of production,[9] further deteriorating the food security status.

5. Central and northern Tanzania – notably the regions of Dodoma, Singida, Arusha, Manyara, Shinyanga, Mwanza and Tabora – has suffered repeated drought over the last decade, affecting poor households' coping capacities for both chronic and transitory food insecurity. Many vulnerable households lost their productive assets in the recent succession of poor harvests. Declining per capita staple food production, droughts, high post-harvest losses, a lack of income-generating activities and the prevalence of HIV/AIDS are among the causes of food insecurity and increased vulnerability to economic and climatic shocks.

6. Female-headed households are among the most vulnerable because their coping strategies are already limited under normal conditions. Women are overburdened by child care, cooking, planting, harvesting, collecting wood and other responsibilities. In periods of food insecurity, women are forced to adopt extreme coping mechanisms to secure food for their families.

7. For the past three decades, despite the efforts of several actors, chronic malnutrition (stunting) among children has been very prevalent in Tanzania, particularly in central and southern zones; the latest survey reports a national prevalence of 38 percent[10] (< -2 SD). More than half the regions have medium to high chronic malnutrition rates, which reach 53 percent. At the national level, 22 percent of children have low weight for height (underweight; -2 SD), with 4 percent being severely underweight (-3 SD).[11] The national rate for low birth weight is 16 percent.[12] The prevalence of anaemia among women is a concerning 43 percent.[13] Vitamin A deficiency (< 20 mg/dl) affected 24 percent of children under 5 years of age[14] in 1997; the prevalence of goitre was 7 percent in 2003.[15]

8. Socio-cultural factors and caring practices are leading causes of malnutrition in Tanzania. The rate of exclusive breastfeeding up to 6 months of age is 41 percent; the median duration of exclusive breastfeeding is two months.[16] Complementary foods are often introduced incorrectly, exposing children to early malnutrition, which is compounded by generally poor availability and quality of food. Cultural habits and limited knowledge are leading causes of a lack of dietary diversity. The staple diet is a carbohydrate-based bulky porridge with very low energy density. Animal protein is not easily affordable for most households. Vegetables form a marginal part of most diets, but are generally cooked for so long that micronutrients are lost. Other causes of malnutrition are poor child care

[9] SACCAR/GTZ. 1994. *Strengthening Postgraduate Training in Agriculture Regional Programme in Land and Water Management*. Proceedings of a Subject Matter Workshop, SACCAR/GTZ-Sponsored Regional M. Sc. Programme Land and Water Management, Morogoro, Tanzania, 12 to 15 September 1994. 67 pp.

[10] NBS. Demographic and Health Survey (DHS) 2004.

[11] Ibid.

[12] Tanzania Food and Nutrition Centre (TFNC). *Nutrition Situation in Tanzania*.

[13] DHS 2004. The indicator refers to all women, not just pregnant and lactating, as the survey made no distinction.

[14] TFNC. 2004.1997. *Micronutrient Survey*.

[15] TFNC. 2004. *National IDD Control Programme Survey, 2003–2004.* Report no. 2002. Dar-es-Salaam.

[16] DHS. 2004.

owing to mothers' workloads, maternal malnutrition and high prevalence of malaria, intestinal parasites and diarrhoea.[17]

9. HIV prevalence among people aged 15 to 49 years is 7 percent nationally, with a high of more than 10 percent in Mbeya, Iringa and Dar-Es-Salaam, and a low of 2 percent in Manyara and Kigoma.[18] National prevalence is higher among women, at 8 percent, than men, at 6 percent.[19] In 2003, there were an estimated 1.8 million people living with HIV/AIDS (PLWHA), and the number of orphans rose from 810,000 in 2001 to 2 million in 2003.[20] HIV/AIDS has worsened the health status of Tanzanians, reducing life expectancy to 46 years.[21] In 1999, the government declared HIV/AIDS a national disaster, and efforts have been made to mitigate its impact. Tuberculosis (TB) is another major public health problem in Tanzania, which is among the top 22 countries in the world for TB incidence, ranking sixth in Africa, with 472 cases per 100,000 people.[22] The association between TB and HIV infection is one of the most serious public health, social and economic threats in developing countries. About 50 percent of Tanzania's HIV-positive people suffer from tuberculosis (TB).

10. The government's strategic framework to combat HIV/AIDS focuses on prevention, care, support and the mitigation of socio-economic impacts. Anti-retroviral drugs (ARVs) are provided to AIDS patients nationwide, but access to ARVs alone does not prolong the life span of AIDS patients. Appropriate and adequate dietary intake is crucial to the success of these programmes, particularly in food-insecure areas.

11. Since the 1990s, efforts have been made to improve access to education. From early 1990 to 2004, the enrolment rate increased from less than 50 to 90.5 percent, primary school completion rates increased from 7 percent to 27 percent[23] and drop-out rates decreased from 3.8 percent to 3.4 percent. [24]

12. In chronically food-insecure areas, however, general educational indicators lag far behind the nationwide averages. These areas are characterized by low attendance, high drop-out rates and low transition rates between primary and secondary school. Chronic food insecurity has a clear impact on access to education, especially among the most vulnerable, food-insecure and poverty stricken households. During the lean season, children are often forced to drop out of school to look for food. Girls tend to be more affected, because they are withdrawn from school to look after their siblings while parents search for food.

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[17] Research for Poverty Alleviation (REPOA). Undated. *Trends and Determinants of Malnutrition in Tanzania*. Document presented by W. Lindeboo and Klama Blandina at the 10th annual REPOA Research Workshop.

[18] Tanzania Commission for AIDS (TACAIDS), National Bureau of Statistics (NBS) and Opinion Research Corporation (ORC) Macro. 2005. *Tanzania HIV/AIDS Indicator Survey* 2003–2004. Calverton, Maryland, USA.

[19] Ibid.

[20] United Republic of Tanzania. 2003. *National Guide on Nutrition Care and Support for People living with HIV/AIDS*. Ministry of Health. December; Mhamba, R. and Ndyetabula, J. 2004. *Rapid Analysis and Action Planning for Scaled Up Responses to Support Orphans and Vulnerable Children (MVC/OVC)*. Conducted on behalf of the Department of Social Welfare, Ministry of Labour, Youth Development and Sports. UNAIDS, UNICEF, USAID and WFP. August.

[21] UNDP. 2005. *Human Development Report*.

[22] UNDP. 2003. *Human Development Report*.

[23] Basic Education Statistics in Tanzania 1995 to 2005.

[24] Ibid.

13. Large numbers of school-age children in drought-prone pastoral areas do not attend school at all, and many drop out before acquiring basic literacy and numeric skills. For example, for the years 2000 to 2004, the primary completion rates were 56, 67, 73, 68 and 75 percent in Monduli district and 53, 56, 51, 56 and 61 percent in Kiteto district, compared with a national average of 77 percent. In 2004, transition rates to secondary school were 18 percent and 21 percent in Kiteto and Kondoa districts, compared with a national average of 36 percent. There are regional and gender disparities in net enrolment rates (NERs), which are generally low in pastoral and drought-prone districts.[25] In 2004, 71 percent of school-age children in Monduli were enrolled, 71.1 percent in Ngorongoro, 72 percent in Simanjiro, 66 percent in Dodoma, 76 percent in Kiteto and 85 percent in Singida rural.

14. The government is implementing the second phase of its poverty reduction strategy through the National Strategy for Growth and Reduction of Poverty (NSGRP). The Tanzania Joint Assistance Strategy of the government and development partners provides an avenue for the United Nations Country Management Team to support government strategies and NSGRP policies and for ensuring that the new phase of the United Nations Development Assistance Framework (UNDAF) is aligned with government priorities.[26] The focus is on joint programming to ensure maximum impact in addressing poverty and food insecurity.

15. Government efforts to fight poverty and food insecurity have concentrated on revamping the agriculture sector, which is the economy's lead sector, accounting for 45 percent of GDP and about 60 percent of export earnings. The Agricultural Sector Development Programme (ASDP) addresses such challenges as low productivity of land, labour and input, underdeveloped irrigation potential, limited access to financial services, poor rural infrastructure, crop pests and livestock diseases, and high post-harvest losses.[27]

16. To counter recurring food deficits in drought-prone areas, the government maintains an SGR, mainly to provide safety nets through price stabilization and subsidized general food distribution. Budgetary constraints have prevented this from attaining its annual capacity of 150,000 mt, however, and for the last ten years SGR stocks have been less than 100,000 mt in all but a few years, when they reached a peak of 130,000 mt.

17. This country programme (CP) will contribute towards the MDGs related to eradicating extreme hunger and poverty (MDG 1), achieving universal primary education (MDG 2), promoting gender equality (MDG 3), reducing child mortality (MDG 4), improving maternal health (MDG 5) and combating HIV/AIDS (MDG 6).

## PAST COOPERATION AND LESSONS LEARNED

18. WFP has provided assistance to Tanzania since 1963, through development programmes and relief to refugees and drought and flood victims. WFP's current portfolio of activities consists of regional protracted relief and recovery operation (PRRO) 10062.2, assisting approximately 400,000 refugees in western Tanzania, and CP 10065.0, which ends in December 2006 and assists 730,000 beneficiaries.

[25] Ministry of Education and Culture. 2004. *Basic Statistics in Education. Regional Data.* Dar-es-Salaam.

[26] The UNDAF matrix for 2007 to 2010 was being prepared while this document was drafted. Its preliminary outcomes are outlined in paragraph 25.

[27] ASDP. 2004.

19. The CP for 2002–2006 originally consisted of three activities: school feeding, food for asset creation, and a supplementary activity related to HIV/AIDS. Following recommendations from the CP mid-term review (MTR) of October/November 2004, a budget revision was approved by the Executive Board in 2005, significantly expanding the HIV/AIDS activity by transforming it into a core activity in response to government priorities.

20. Under the current CP, more than 190,000 children received meals at 330 schools in the food-insecure areas of Dodoma, Singida, Arusha and Manyara. The school feeding programme has had impressive results, with average absolute enrolments between 2001 and 2005 increasing by 40 percent for boys and 36 percent for girls. Average absolute enrolments for both boys and girls at assisted boarding schools more than doubled over the same period. Average school attendance rates, which were usually less than 40 percent before the programme, were 81 percent in 2004 and 80 percent in 2005. Programme implementation also led to improved school infrastructure through the construction of classrooms, teachers' offices, boarding facilities and water and sanitation facilities at the most needy schools. Food for more than 12,000 food-insecure, HIV/AIDS-affected households has enabled PLWHA to participate in care and treatment programmes and orphans and vulnerable children (OVC) to continue attending school. Internal counterpart reports indicate that the number of PLWHA attending counselling and health care programmes has increased by 40 percent since 2003. Food-for-work activities have benefited 9,000 households, enabling them to create and preserve livelihood enhancing assets, improve their access to potable water for domestic and livestock uses, diversify their crop production, and increase available arable land through irrigation works. The construction of irrigation canals in Mwungwe area, same district, for example, increased the area of agricultural land from 40 acres in 2003 to more than 1 800 acres in 2005.

21. Efforts have been made to foster government ownership of the CP. Following the MTR recommendations, a national steering committee was established, chaired by the Prime Minister's Office (PMO) and including all the line ministries that coordinate CP implementation. The committee has set up an accountability structure.

22. Monitoring and evaluation (M&E) has been enhanced on the recommendation of the MTR. Dodoma sub-office has additional staff, and a sub-office has been opened at Arusha, northern Tanzania, to improve the coordination of CP activities. M&E tools have been revised, and databases for school feeding and HIV/AIDS information have been improved.

23. M&E of the food-for-asset-creation activity will be tackled in the coming CP. The wide variety of activities implemented under this component pose a particular challenge to M&E by making it difficult to standardize tools and formats. The country office will strive to design appropriate M&E tools and methods for this component.

24. In response to Tanzania's changing environment, the targeting criteria have been modified according to MTR recommendations. Although food availability remains an important consideration, other food security and vulnerability criteria are included to target households that need food assistance. The Vulnerability Analysis and Mapping (VAM) Unit has defined vulnerability factors with which to prioritize activities and areas. Targeting for the CP 2007–2010 uses findings from the VAM Unit's comprehensive food security and vulnerability analysis (CFSVA) of January 2006. At the community level, community-managed targeting and distribution (CMTD) will be the targeting tool; this promotes community participation at all stages.

25. In July 2005, the country office assessed the 330 schools in the school feeding activity through visits. The assessment found that food storage capacity, documentation and

schools' adherence to ration quantities needed to be improved. Recommendations for improving the school feeding activity were drafted, including making similar assessments at least once a year, training district officials and teachers and providing materials to improve schools' storage capacity. These recommendations have been taken into consideration in the CP's school feeding component.

26. An internal review of the cost-efficiency of the CP shows that it has an alpha value[28] of 1.085, meaning that the cost of the ration bought and delivered by WFP and its donors is 8 percent less than the market price.

27. This intervention is WFP Tanzania's second CP. It builds on the current CP's achievements by responding better to government priorities within the UNDAF. The CP's success will depend on the maintenance and strengthening of partnerships. The country office will support the UNDAF process by capitalizing on joint programming opportunities when they arise.

28. Other challenges for the country office include strengthening its M&E system so that decisions related to the CP are better informed; enhancing the capacity of implementing partners; and developing a resource mobilization strategy to support part of the education component through non-traditional funding sources.

## STRATEGIC FOCUS OF THE COUNTRY PROGRAMME

29. This CP contributes towards MDGs 1 to 6; it has been designed under the framework of Tanzania's NSGRP and responds to UNDAF. Building on achievements of the current CP 2002–2006 and in line with WFP's Strategic Plan (2006–2009), it will have four core components: (i) support to primary education (Strategic Objective 4); (ii) support to HIV/AIDS-affected households (SO 3); (iii) food for asset creation (SO 2); and (iv) supplementary feeding for vulnerable children and pregnant and lactating women (SO 3).

30. Tanzania's NSGRP for 2007–2010 will be implemented according to the first Poverty Reduction Strategy of 2000 and focuses on three main clusters of action: (i) economic growth and income poverty alleviation; (ii) improved quality of life and social well-being; and (iii) governance and accountability. The four components of the CP will contribute towards the first two clusters of action, focusing on government goals: improving food availability and accessibility at the household level in urban and rural areas; ensuring equitable access to primary and secondary education for boys and girls; and improving the survival, health and well-being of all children and women and of vulnerable groups. With regard to nutrition, government goals are to reduce the prevalence of stunting in children under 5 and the prevalence of wasting.

31. This CP has been designed to contribute to the following UNDAF outcomes:

- increased food availability and access for the most vulnerable populations, including those infected and affected by HIV/AIDS and their carers;
- effective mechanisms – including social protection – to address institutional and socio-cultural barriers in order to promote and protect the rights of the poor and most vulnerable;

[28] The alpha value is the ratio of the local market price to the cost to WFP and its donors of delivering commodities from an external source to the locality.

- increased and equitable access to formal and non-formal education;
- improved community access to safe, clean water and environmental sanitation in rural areas;
- increased and equitable access to comprehensive reproductive and child health interventions;
- increased access to comprehensive services for the prevention, care, treatment and impact mitigation of HIV/AIDS and other major diseases.

32. The four components will target and assist vulnerable groups at critical stages of their lives. Food aid will promote development by reducing vulnerable groups' exposure to socio-economic and environmental shocks and food insecurity. Following WFP's Enabling Development Policy, the four interventions of this CP are designed to: (i) enable young children and pregnant and lactating women to meet their special nutrition-related health needs; (ii) enable poor households to invest in human capital through education and training; (iii) enable poor families to gain and preserve assets; and (iv) mitigate the effects of natural disasters in areas vulnerable to recurring crises.

33. Given Tanzania's high incidence of malnutrition and the important role of WFP and development partners, especially the United Nations Children's Fund (UNICEF), in the nutrition arena, the country office is committed to supporting the government in attaining the nutrition-related goals of the NSGRP.

34. In accordance with recent nutrition-related policy, WFP Tanzania views nutrition in its broader context; food-related interventions are relevant, but efforts in advocacy, capacity building and enhancing the nutrition impact of other CP components are equally important.

35. With UNICEF and the World Bank, the country office promoted creation of the National Nutrition Working Group, chaired by the Tanzania Food and Nutrition Centre and responsible for designing and implementing the country's first Nutrition Strategic Plan and the National Nutrition Surveillance System (NNSS).

36. Using a vulnerability analysis framework, the regions for intervention have been selected according to their food security status, incidence of poverty and HIV/AIDS, prevalence of malnutrition, other health indicators, school enrolment rates and incidence of natural disasters, mainly drought. Following CFSVA recommendations, the CP will operate in Dodoma, Manyara, Singida, Arusha, Kilimanjaro, Tabora, Mwanza, Shinyanga and Iringa regions.

37. A strong M&E system will be the backbone of the new CP; combined with an MTR and ad hoc yearly evaluations for each component, M&E will inform decision-making, promote a learning approach and enhance programming flexibility. Other cross-cutting issues in the CP include government ownership, protection of the environment, community participation, gender equality and empowerment, and capacity building.

38. Communities will be the centre of the development process, and will be involved in all stages, including design, implementation, M&E and selection of beneficiaries. Following WFP's Enhanced Commitments to Women, women's full benefit from activities, their participation and their empowerment will be emphasized at all stages of every component.

39. The relationship between WFP and UNICEF in Tanzania is being strengthened. Guided by the WFP/UNICEF Memorandum of Understanding (MOU) and its matrices on nutrition, education and HIV/AIDS, collaboration in nutrition and HIV/AIDS has been established and joint programming opportunities in education are being explored as both agencies prepare the CP action plan.

40. The donor environment in Tanzania is evolving towards direct budget support or basket funding through the Tanzania Joint Assistance Strategy. The United Nations system will have to respond to this development. WFP Tanzania has proposed to the government that CP interventions be included in the targeted districts' overall budget plans. The CP would thus be considered as direct budget support, paving the way for an eventual exit strategy.

41. The following are the expected outcomes of the CP:

- increased enrolment and attendance, reduced drop-out rates and reduced disparity between boys and girls in WFP-assisted schools (SO 4);
- improved concentration and learning capacity of boys and girls at assisted day and boarding schools (SO 4);
- improved compliance of patients on ARV/TB treatment and of women on prevention of mother-to-child transmission (PMTCT) programmes (SO 3);
- improved access to education for orphans and other children in vulnerable households affected by HIV/AIDS (SO 4);
- improved health and nutritional status of women and children participating in PMTCT programmes (SO 3);
- improved coping capacity of vulnerable food-insecure households affected by HIV/AIDS;
- increased crop yields, reduced post-harvest losses, increased household access to water and reduced cost of crop transportation from farms to markets (SO 2); and
- reduced prevalence of low birthweight (2.5 kg) and underweight, and improved child feeding and care practices among vulnerable children and pregnant and lactating women (SO 3).

## Basic Component 1 – Support to Primary Education in Drought-Prone and Pastoral Districts

42. Schoolchildren in Dodoma, Singida, Arusha and Manyara regions will receive food as an incentive for parents to send them to school, to stabilize attendance and to reduce absenteeism. WFP will provide a daily individual ration of a morning drink made from blended food, such as corn-soya blend (CSB), and a cooked meal of cereal, pulses and vegetable oil. Other activities will be related to improving school infrastructure – storage, water supply, latrines and fuel-efficient stoves – and training teachers and school committees on the environment, sanitation, water management, food management and reporting. A total of 282,000 beneficiaries will be assisted under this component.

43. The component will be implemented under the overall responsibility of the PMO through the CP steering committee. The Ministry of Education and Vocational Training will appoint a full-time project focal point to support the steering committee and the districts during implementation. WFP and UNICEF will explore possible collaboration in activities related to school feeding, particularly those that are in the WFP/UNICEF essential package of interventions.

44. Following the positive impact of the current school feeding activity, the government recognizes school feeding as an important support to education. As part of the phase-out strategy, the government will be required to allocate resources and food to support school feeding operations. As the school feeding component has been operational for only five years, however, the country office will not consider a phase-out strategy before the

next programme cycle, to allow sufficient time for significant and lasting impacts on the targeted school feeding population.

## Basic Component 2 – Integrated Support to Food-insecure Households Affected by HIV/AIDS

45. Supporting national efforts to mitigate the effects of HIV/AIDS and enhance the survival of PLWHA, this component will provide food support to 40,000 beneficiaries: home-based care recipients, orphans and other children in vulnerable households, orphans attending boarding vocational training centres, patients on ARV/TB therapy, and women enrolled in PMTCT treatment. Beneficiaries will receive a ration of maize, pulses, vegetable oil and CSB. Family take-home rations will be provided every three months to orphans in the care of households and to patients receiving home-based care. Patients on ARV/TB/PMTCT treatment will receive a family take-home ration every month to ensure adherence to the treatment. Beneficiaries under ARV/TB treatment will receive food for six months; beneficiaries under PMTCT will receive food from the time they enrol in the programme until 18 months after delivery. Orphans attending boarding vocational training centres will receive two cooked meals a day – breakfast and lunch – for two years.

46. Orphans and vulnerable children attending vocational courses will receive training in carpentry, tailoring, masonry, batik tie-and-dye making, business management and life skills.

47. The component will support and strengthen the activities of local NGOs: vocational training, counselling services, testing, health care services and socio-economic support, among others. It will be implemented in partnership among WFP, local councils, health facilities and NGOs under the direct supervision of the Ministry of Health, its Social Welfare Department and the PMO. The Ministry of Health and Social Welfare will appoint a full-time project focal point to provide support during implementation. The component will be implemented in coordination with UNICEF and the World Health Organization (WHO), both of which support PMTCT programmes.

48. Geographic targeting will be based on the following criteria: (1) food-insecure areas; and (2) food-secure areas with high HIV/AIDS prevalence. WFP will implement this activity in Arusha, Manyara, Kilimanjaro, Dodoma, Tanga and Iringa regions. Cooperating partners, in collaboration with local government and communities, will target beneficiaries through a community-based participatory approach.

49. Under United Nations joint programming, the UNDAF HIV/AIDS group has developed a four-year work plan for Zanzibar in which WFP will participate with food support. Other joint programming opportunities include working with the Joint United Nations Programme on HIV/AIDS (UNAIDS) to provide food support to HIV/AIDS-infected and-families in Dar es Salaam.

50. The exit strategy for this component will be discussed with the government later, as the government's capacity to tackle the epidemic increases.

## Basic Component 3 – Support to Food Security and Disaster Mitigation in Drought-Prone and Poverty-Ridden Areas

51. To mitigate the effects of natural and socio-economic shocks and improve the coping mechanisms of vulnerable households, this component includes activities aimed at improving the management of farming and post-harvest practices, increasing agricultural productivity through greater access to irrigated and reclaimed land, and diversifying the

crop production resources of weak rural farmers to reduce their dependency on one crop. The component also aims to enhance access to water supplies for domestic use and livestock, improve capacity to manage natural resources, and improve access to markets through rehabilitation/construction of rural roads. The component will aim to reduce communities' vulnerability to natural disasters, mainly drought, through asset creation. It will operate in drought-prone areas in Dodoma, Kilimanjaro, Singida, Shinyanga, Arusha, Tabora, Manyara and Mwanza regions.

52. The component will have approximately 440,000 beneficiaries, 50 percent of whom will be women. At least 60 percent of the members of project committees will be women.

53. Beneficiaries will receive food rations as an incentive to participate in asset creation activities during the lean period when food access is poor and commodity prices are high. Food aid will also encourage beneficiaries to participate in training modules. Family take-home rations of maize, pulses and vegetable oil will be provided according to the number of workdays completed by each beneficiary and the nature of activities performed.

54. The component will be implemented under the overall responsibility of the PMO through the CP steering committee. The Ministry of Agriculture and Food Security will appoint a full-time project focal point to support the steering committee and the districts during implementation. An exit strategy for this component will be discussed with the government through the steering committee at the appropriate stage of the CP. Cooperating partners – the Food and Agriculture Organization of the United Nations (FAO), local NGOs, etc. – will contribute to related to community irrigation activities.

55. Extensive consultation and revision with government, donors, NGOs and United Nations partners preceded this component's formulation. WFP is a member of the steering committee set up by the government for the International Fund for Agricultural Development (IFAD)-supported Participatory Irrigation Development Programme. Implementation of this component will involve all partners, including the United Nations Inter-Agency Technical Committee to create linkages with other food security programmes, as described in the UNDAF.

56. Beneficiary targeting and activity selection will be carried out using the CMTD mechanism, enabling communities to design projects and participate in every step stage. The field-level implementing partners will facilitate this process. The country office will enhance the capacity of communities to implement and manage M&E tools to help increase community participation and strengthen M&E of the component.

## Basic component 4 – Targeted Supplementary Feeding for Vulnerable Groups

57. This component is part of a set of nutrition-related interventions to support the government and other development partners in reducing malnutrition in Tanzania. WFP will provide supplementary feeding to moderately malnourished children - of between -2 SD and – 3 SD underweight – and to pregnant and lactating women. The intervention will cover food-insecure areas of Dodoma and Singida. The component is designed to prevent the deterioration of children's nutritional status, reduce the prevalence of low birth weight and underweight in the targeted areas, and increase parents', especially mothers', knowledge of child care and feeding practices.

58. A monthly take-home ration will be provided at health facilities to 72,000 moderately malnourished children and 40,000 pregnant and lactating women, as part of regular mother-and-child health (MCH) services. The total number of beneficiaries during the

CP will be 112,000. Food aid will be provided to pregnant and lactating women for six months before and six months after delivery. Moderately malnourished children will be monitored and supported until one month after they reach the ideal weight. The component will include behaviour change communication (BCC), demonstration feeding and education to mothers on caring and feeding practices. Beneficiaries' participation in the implementation and management of the component will be crucial to success by changing behaviour and habits. Different approaches to community participation will be piloted. Collaboration with UNICEF on supplementary feeding will take advantage of UNICEF's experience in BCC, counselling and community nutrition packages.

59. The CSB ration will provide 30 percent of pregnant and lactating women's daily requirement – assuming that the remaining 70 percent will be obtained through regular home diet and that roughly 50 percent of the take-home ration will be shared with other household members. It will provide 40 percent of children's daily requirement – assuming that the remaining 60 percent will be obtained through regular home diet and that roughly 50 percent of the take-home ration will be shared with other household members.

60. The component will be implemented under the overall responsibility of the PMO through the CP steering committee. The Ministry of Health and Social Welfare will appoint a full-time project focal point to support the steering committee and the districts during implementation.

## Implementation Strategies

61. A central-level CP steering committee will be responsible for strategic coordination of the CP. The committee will be composed of senior government officials and will meet once a year to discuss policy matters and review implementation reports. A technical committee composed of the focal points from each of the relevant line ministries will meet twice a year to review the implementation of the CP. The PMO will be the focal point for day-to-day coordination and implementation matters related to the CP.

62. WFP will cover 100 percent of landside transport, storage and handling (LTSH) throughout the CP. On arrival at Dar es Salaam port, food commodities will be transported by road to extended delivery points of Arusha and Dodoma and to schools in districts or villages; transport and delivery costs will be paid from LTSH funds.

63. Since 1994, WFP Tanzania has procured maize grain, maize meal, beans and salt locally for its own projects and for neighbouring countries such as the Democratic Republic of the Congo, Rwanda and Burundi. Experience over the past five years has shown that WFP Tanzania has the capacity to purchase up to at least 40,000 mt of commodities per year, depending on availability and timely cash contributions. The country office expects to buy approximately 70 percent of this CP's requirements locally. The country office has worked mostly with established large traders, but is fostering relationships with medium-and small-sized traders. To reduce transport costs, purchases closer to the beneficiaries will be emphasized.

64. Timely availability of resources for the CP will be important; in the past, unpredictable release of food and non-food resources has affected CP implementation and co-funding arrangements with donors. Effective implementation of the CP also depends on having a strong government counterpart structure at the central and local levels.

65. A major natural disaster could disrupt CP implementation by straining the administrative and logistical capacity of WFP and its partners.

## PROGRAMME MANAGEMENT, MONITORING AND EVALUATION

66. CP design was based on internal and external consultations. In mid-September 2005, the national steering committee, chaired by the Director of the Disaster Management Department in the PMO, met WFP senior management and officials from relevant ministries to discuss the elaboration of the new WFP CP. The committee decided to form working groups to design the CP's four components.

67. Four appraisal missions were convened, composed of government officials, WFP officers, officials from United Nations agencies and consultants. Meetings were held at the national, district and village levels to assess each of the components and elaborate recommendations for the new CP. Consultations with beneficiaries and implementing partners provided insight into the impact of the CP. Findings of the appraisal missions were presented at debriefing meetings with the country office, United Nations agencies in the UNDAF process and government ministries.

68. The CP components were based on the MTR recommendations, appraisal mission reports, an internal assessment of the CP and the preliminary results of the CFSVA. A country office workshop in December 2005 decided the main characteristics of each component. Final drafts of CP components were discussed and approved at a steering committee meeting in January 2006.

69. In line with the policy directive approved by the Board in 2002 on results-based M&E, WFP Tanzania will improve and harmonize existing M&E arrangements, formats and tools.

70. The country office, in consultation with its partners and the regional bureau, has designed appropriate logical frameworks for each of the CP components. Logical frameworks will be used to define institutional arrangements, set-up M&E systems, redesign existing data collection formats and prepare annual M&E plans for monitoring, data collection, analysis and reporting activities. The country office will emphasize the improvement/development of databases for storage and analysis of M&E data, seeking support from headquarters and the regional bureau in improving existing M&E systems for the CP components and adopting the corporate M&E tools as they evolve from the Common Monitoring and Evaluation Approach project.

71. Linkages will be strengthened with local government authorities in M&E and reporting systems and arrangements. To avoid duplication of efforts and resources, the country office will use the existing reporting systems of the government and partners to collect performance indicators for the CP.

72. In order to track the CP's performance, appropriate baseline information will be collected and compared at different stages of programme implementation. The findings of M&E studies will provide a tool for corrective measures to achieve the intended outcomes. The country office will engage its partners in periodic assessments of the effectiveness and efficiency of food aid to the beneficiaries and of output and outcome indicators.

73. As part of the M&E for each component, regular monitoring visits will include the collection of beneficiaries' perceptions of food aid using standard information sheets. For follow-up, the sub-offices in Dodoma and Arusha will coordinate the summaries of findings and proposed actions.

| ANNEX I-A: BENEFICIARY COVERAGE BY COMPONENT AND FOOD ALLOCATION | | | | |
|---|---|---|---|---|
| **CP component** | **Quantity of commodities (mt)** | **Distribution by component (%) [1]** | **Number of beneficiaries male/female/total (CP period)** | **% of female beneficiaries (CP period)** |
| Component 1 – Support to primary education in drought-prone and pastoral districts | 30 030 | 43 | Male: 148 000<br>Female: 134 000<br>**Total: 282 000** | 47.5 |
| Component 2 – Integrated support to food-insecure households affected by HIV/AIDS | 18 414 | 26 | Male: 19 600<br>Female: 20 400<br>**Total: 40 000** | 51 |
| Component 3 – Support to food security and disaster mitigation in drought-prone and poverty-ridden areas | 12 936 | 19 | Male: 215 600<br>Female: 224 400<br>**Total: 440 000** | 51 |
| Component 4 – Targeted supplementary feeding for vulnerable groups | 8 352 | 12 | Male: 36 000<br>Female: 76 000<br>**Total: 112 000** | 67.8 |
| **Total CP** | 69 732 | 100 | Male: 419 200<br>Female: 454 800<br>**Total: 874 000** | 52.0 |

| ANNEX I-B: COMMODITY TYPE AND RATION SIZE | | | |
|---|---|---|---|
| **CP component** | **Type of food commodities (name)** | **Individual ration size (per person per day)** | **Nutritional content (kcal, % kcal from protein) (overall ration)`** |
| Component 1 – Support to primary education in drought-prone and pastoral districts | Maize, pulses, vegetable oil, corn-soya blend (CSB) | Maize 120 g<br>Pulses 30 g<br>Vegetable oil 5 g<br>CSB 40 g | 718 kcal<br>14.37% kcal from protein |
| Component 2 – Integrated support to food-insecure households affected by HIV/AIDS | Maize, pulses, vegetable oil, CSB | **OVC**<br>Maize 300 g<br>Pulses 50 g<br>Vegetable oil 20 g<br>CSB 80 g<br>**ARV/TB/PMTCT**<br>Maize 450 g<br>Pulses 60 g<br>Vegetable oil 25g<br>CSB 120 g | <br>1 742 kcal<br>12.7% kcal from protein<br><br><br><br>2 518 kcal<br>12.7% kcal from protein |
| Component 3 – Support to food security and disaster mitigation in drought-prone and poverty-ridden areas | Maize, pulses, vegetable oil | Maize 200 g<br>Pulses 30 g<br>Vegetable oil 15 g | 962 kcal<br>11.06% kcal from protein |
| Component 4 – Targeted supplementary feeding for vulnerable groups | CSB | Women: CSB 400 g<br>Children: CSB 300 g | 1 520 kcal<br>18% kcal from protein<br>1 140 kcal<br>18% kcal from protein |

[1] Commodities allocated to each component as percentage of total commodities.

## ANNEX II: RESULTS AND RESOURCES MATRIX—DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010)

| Results chain (logic model) | Performance indicators | Risks, assumptions | Resources required |
|---|---|---|---|
| **UNDAF outcomes:**<br>➢ Increased food availability and access for the most vulnerable population, including those infected and affected by HIV/AIDS and their carers, through the food-for-asset-creation component<br>➢ Effective mechanisms, including social protection, in place to address institutional and socio-cultural barriers in order to promote and protect the rights of the poor and most vulnerable, through the HIV/AIDS component<br>➢ Increased and equitable access to quality formal and non-formal education, through the school feeding component<br>➢ Improved community access to safe, clean water and environmental sanitation in rural areas, through the food-for-asset-creation component<br>➢ Increased and equitable access to comprehensive reproductive and child health services, through the supplementary feeding component<br>➢ Increased access to comprehensive services for the prevention, care, treatment and impact mitigation of HIV/AIDS and other major diseases, through the HIV/AIDS component | **UNDAF outcome indicators**<br>To be added after finalization of the UNDAF results matrix in May 2006 | | |
| **WFP CP outcomes:**<br>**Component 1: Food for education**<br>1. Increased enrolment and attendance, reduced drop-out rates and reduced disparity between boys and girls (WFP SO 4) | **WFP CP/development project outcome indicators (to be achieved in targeted groups by 2010)**<br>1.1 Enrolment of boys and girls increased from 90% to 95%<br>1.2 Attendance rates for boys and girls increased from 80% to 85%<br>1.3 Drop-out rate of boys and girls reduced from 3.4% to 1%<br>1.4 Ratio of girls to boys stabilized at 1:1 | The Government of Tanzania is committed to achieving universal primary education and education for all goals by designing and advocating for appropriate support policies | Expected government contribution: US$2 716 011<br>Cost to WFP: US$16 851 551<br>Total component cost: US$19 562 264 |

| ANNEX II: RESULTS AND RESOURCES MATRIX—DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010) | | | |
|---|---|---|---|
| **Results chain (logic model)** | **Performance indicators** | **Risks, assumptions** | **Resources required** |
| 2. Improved concentration and learning capacities of boys and girls at assisted schools (WFP SO 4) | 2.1 Pass rate for grade IV exams increased from 80% to 95%<br>2.2 Pass rate for grade VII final exams increased from 26% to 60% | The government and the private sector provide additional resources | |
| **Component 2: HIV/AIDS**<br>3. Improved compliance of patients on ART/TB treatment and women on PMTCT programmes (SO 3)<br>4. Improved access to education for orphans and other children in vulnerable households affected by HIV/AIDS (SO 4)<br>5. Improved health and nutritional status of mothers and children participating in PMTCT programmes (SO 3)<br>6. Improved coping capacity of vulnerable food-insecure households affected by HIV/AIDS | **Outcome indicators** [1]<br>3.1 Proportion of ART/TB patients with at least 95% adherence rate increased from the current level by 20%<br>3.2 Proportion of mothers returning with their children at 18 months for HIV testing increased from the current level by 50%<br>4.1 Proportion[2] of school-age orphans enrolled in schools of 100%<br>5.1 Proportion of children born with HIV+ mothers who test HIV- at 18 months increased from the current level by 40%<br>5.2 Proportion of deliveries with low birth weight (< 2.5kg) decreased from 16% to 10%<br>5.3 Proportion of PMTCT-participating mothers with body mass index less than 18.5 at 6 and 8 months after delivery decreased from the current levels by 5%<br>5.4 Proportion of patients attaining 10% gain in body weight at 6 and 12 months after initiation of ART increased from the current levels by 20% | The Government of Tanzania is committed to responding to the HIV/AIDS epidemic<br>WFP's partners are capable of providing complementary care and support services | Expected government contribution: US$465 136<br>Cost to WFP: US$10 579 100<br>Total component cost: US$11 040 048 |

[1] Baseline data for this component will be collected during the first quarter of 2007.

[2] Proportion (%) = number of school-age children enrolled in school/number of school-age children. Reference population is all school-age children receiving WFP assistance.

| ANNEX II: RESULTS AND RESOURCES MATRIX—DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010) | | | |
|---|---|---|---|
| **Results chain (logic model)** | **Performance indicators** | **Risks, assumptions** | **Resources required** |
| | 6.1 Percentage of people/households discharged from food aid and self-supporting increased by 10% annually[3]<br>6.2 1 400 orphans and other vulnerable children graduated from vocational training programmes<br>6.3. Proportion of PLWHA joining partners' support groups increased from the current level by 25% | | |
| **Component 3: Food for asset creation**<br>7. Increased crop yields, reduced post-harvest losses, increased household access to water and reduced cost of crop transportation from farms to markets (WFP SO 2) | **Outcome indicators**<br>7.1 Targeted farmers' crop yields increased by 33%<br>7.2 Post-harvest losses reduced from 40% to 20%<br>7.3 Proportion of households with access to adequate water for domestic and livestock uses increased from 20% to 50%<br>7.4 Cost of crop transportation reduced by 50% | Proper food management and handling by targeted farmers<br>Effective marketing system is enhanced | Expected government contribution: US$2 010 756<br>Cost to WFP: US$7 691 506<br>Total component cost: US$9 698 682 |

[3] Determined by cooperating partners' annual assessments of the coping strategies and eligibility of all assisted beneficiaries.

| ANNEX II: RESULTS AND RESOURCES MATRIX—DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010) | | | |
|---|---|---|---|
| **Results chain (logic model)** | **Performance indicators** | **Risks, assumptions** | **Resources required** |
| **Component 4: Nutrition**<br>8. Reduced prevalence of low birth weight (< 2.5 kg) and underweight (<- 2 SD of reference median weight/age) and appropriate child feeding and care practices promoted among vulnerable pregnant and lactating mothers and vulnerable children | **Outcome indicators**<br>8.1 Low birth weight (< 2.5 kg) reduced from 16% to 8%<br>8.2 Underweight (<- 2 SD) reduced from 28% to 8%<br>8.3 Exclusive breastfeeding at 6 months increased from 41% to 60%<br>8.4 Complementary feeding among children breastfed at 6 months increased from 30% to 50% | Pregnant and lactating women attend MCH sessions regularly and receive counselling<br>Intervention receives support from district health management teams | Expected government contribution: US$152 848<br>Cost to WFP: US$4 922 735<br>Total component cost: US$5 075 581 |
| **CP outputs:**<br>**Component 1**<br>1.1 Early-morning drink and midday lunch provided on 195 school days/year to day students and 270 school days/year to boarding students<br>1.2 Basic and complementary inputs and resources are provided to the schools | **Output indicators:**<br>1.1.1 282 779 schoolchildren receiving school meals, broken down by gender<br>1.1.2 Average number of days snack and lunch are provided<br>1.1.3 30 030 mt of food distributed – 7 506 mt a year<br>1.2.1 Proportion of schools with necessary inputs and resources (targets in brackets): water supply facilities (165 schools), student–classroom ratio (45), student–latrine ration (40)<br>1.2.2 660 school-level people trained in school feeding management at least once every two years<br>1.2.3 20 district-level people trained in school feeding management at least once every two years | The Government of Tanzania continues to implement relevant nationwide school health programmes, including a deworming component<br>Adequate funds for training, monitoring, capacity building and inputs available<br>Communities and schools are committed to fulfilling their obligations | |

| ANNEX II: RESULTS AND RESOURCES MATRIX—DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010) | | | |
|---|---|---|---|
| **Results chain (logic model)** | **Performance indicators** | **Risks, assumptions** | **Resources required** |
| **Component 2** | | | |
| 1.3 ART/TB patients, HBC clients, pregnant and lactating women and vulnerable orphans provided with family take-home rations and/or on-site meals | 1.3.1 40 482 beneficiaries provided with family food rations | Existence of competent partners | |
| 1.4 Community volunteers trained on prevention, care and support for HIV/AIDS | 1.3.2 Proportion of PLWHA joining partners' support groups increased by 10% annually | Existence of an effective and non- stigmatizing referral system for vulnerable women, orphans and PLWHA | |
| 1.5 Prophylaxis administered to infants on PMTCT programmes within 72 hours of birth | 1.3.3 18 414 mt of food distributed – 4 603 mt a year | | |
| 1.6 Children on PMTCT programmes brought back for testing at 18 months of age | 1.4.1 60 community volunteers trained and participating in community care and support activities | | |
| | 1.5.1 734 infants administered with prophylaxis within 72 hours of birth | | |
| | 1.6.1 Percentage of children brought back for testing at 18 months | | |

| ANNEX II: RESULTS AND RESOURCES MATRIX—DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010) | | | |
|---|---|---|---|
| **Results chain (logic model)** | **Performance indicators** | **Risks, assumptions** | **Resources required** |
| **Component 3** | | | |
| 1.7 Increased area under irrigated land | 1.7.1 Irrigated area increased by 30% | Cooperating partners are able to secure and provide non-food items<br>Farmers have access to extension services | |
| 1.8 Good post-harvest practices promoted | 1.8.1 1 500 farmers trained on post-harvest management | | |
| 1.9 Contour terraces rehabilitated or constructed | 1.8.2 100 improved storage facilities constructed | | |
| 1.10 Access road infrastructure constructed or rehabilitated | 1.9.1 2 000 contour terraces constructed and/or rehabilitated | | |
| 1.11 Water supply facilities/schemes constructed or rehabilitated | 1.10.1 300 km of market access roads constructed or rehabilitated | | |
| 1.12 Family food rations distributed to participating people | 1.11.1 400 km of water distribution network constructed/rehabilitated | | |
| | 1.11.2 20 water storage tanks constructed | | |
| | 1.12.1 110 000 people a year provided with family food rations | | |
| | 1.12.2 12 936 mt of food distributed – 3 234 mt a year | | |
| **Component 4** | | | |
| 1.13 Pregnant and lactating women trained on proper child care and feeding practices | 1.13.1 40 000 pregnant and lactating women trained or counselled in proper child care and feeding practices | Health personnel are motivated and have time to provide adequate counselling sessions during MCH attendance | |
| 1.14 Pregnant and lactating women provided with take-home supplementary food | 1.14.1 112 000 beneficiaries – 40 000 women and 72 000 malnourished children – provided with take-home rations | | |
| 1.15 All children <- 2 SD of the reference median weight/age provided with supplementary food | 1.15.1 8 352 mt of food distributed to beneficiaries – 2 088 mt a year | | |

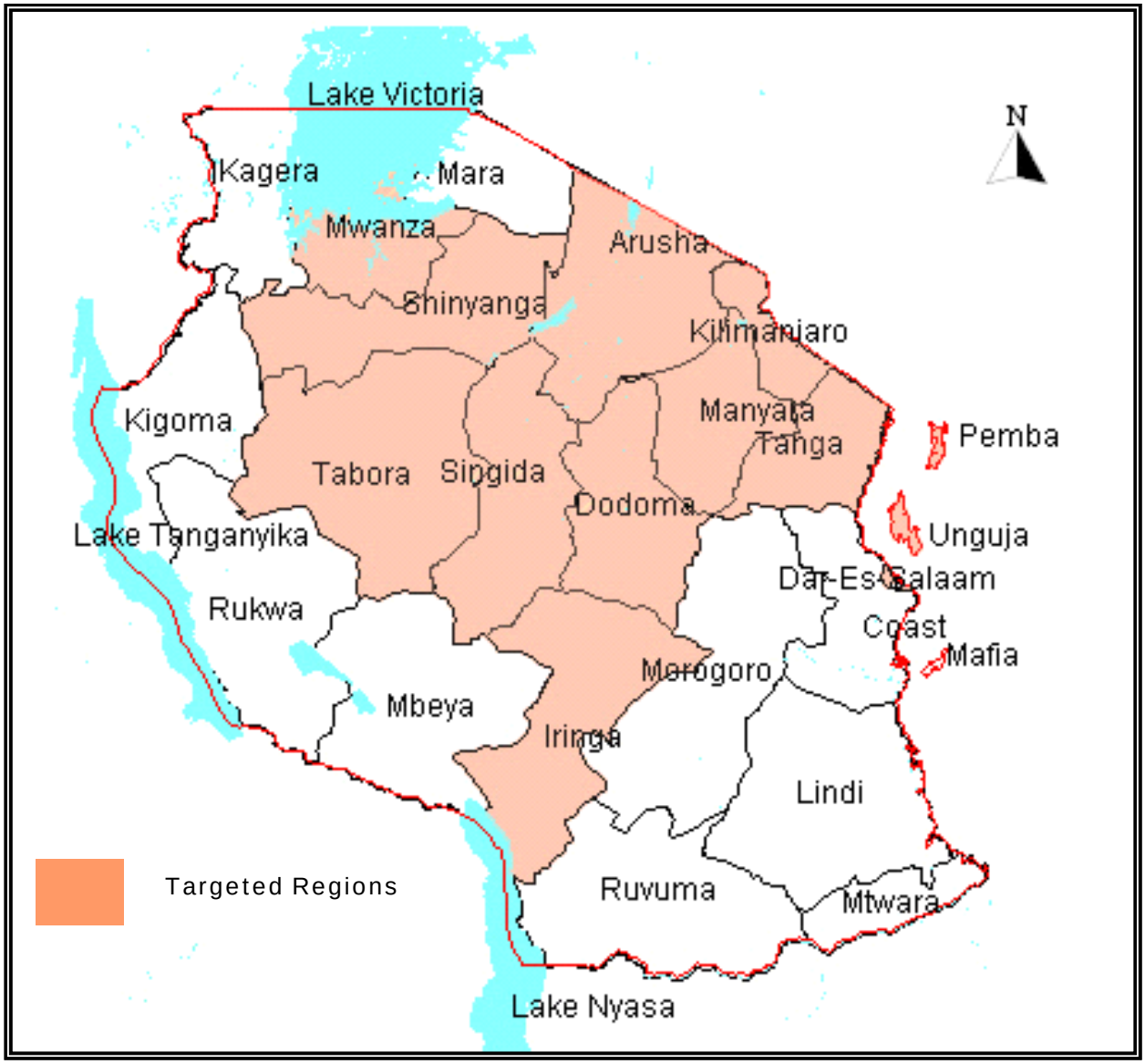
# ANNEX III

| BUDGET PLAN FOR DRAFT COUNTRY PROGRAMME UNITED REPUBLIC OF TANZANIA 10437.0 (2007–2010) BASIC COMPONENTS (US$) | | | | | |
|---|---|---|---|---|---|
| | **Component 1** | **Component 2** | **Component 3** | **Component 4** | **Total** |
| Food commodities (mt) | 30 030 | 18 414 | 12 936 | 8 352 | **69 732** |
| Food commodities (value) | 9 041 340 | 5 631 264 | 4 038 672 | 2 505 600 | **21 216 876** |
| External transport | 1 558 565 | 955 692 | 671 382 | 433 471 | **3 619 110** |
| LTSH (total) | 2 290 968 | 1 568 094 | 1 240 309 | 777 616 | **5 876 987** |
| LTSH (cost per mt) | 76 29 | 85 16 | 95 88 | 93 11 | **84 28** |
| ODOC | 612 000 | 376 000 | 278 000 | 262 000 | **1 528 000** |
| **Total DOC** | **13 502 873** | **8 531 050** | **6 228 363** | **3 978 687** | **32 240 973** |
| DSC[1] | 2 246 240 | 1 355 960 | 959 960 | 622 000 | **5 184 160** |
| ISC[2] | 1 102 438 | 692 091 | 503 183 | 322 048 | **2 619 759** |
| **Total WFP costs** | **16 851 551** | **10 579 100** | **7 691 506** | **4 922 735** | **40 044 892** |
| Government contribution | 2 716 011 | 465 136 | 2 010 756 | 152 848 | **5 344 751** |

[1] The DSC amount is an indicative figure for information purposes. The annual DSC allotment for a CP is reviewed and set annually following an assessment of DSC requirements and resource availability.

[2] The ISC rate may be amended by the Board during the period covered by the CP.

**United Republic of Tanzania Country Programme 10437.0 (2007-2010)**

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## ACRONYMS USED IN THE DOCUMENT

| | |
|---|---|
| ARV | anti-retroviral (therapy) |
| ASDP | Agricultural Sector Development Policy |
| BCC | behaviour change communication |
| CFSVA | comprehensive food security and vulnerability analysis |
| CMTD | community-managed targeting and distribution |
| CSB | corn-soya blend |
| FAO | Food and Agriculture Organization of the United Nations |
| GDP | gross domestic product |
| HIV/AIDS | human immunodeficiency virus/acquired immune deficiency syndrome |
| IFAD | International Fund for Agricultural Development |
| ILO | International Labour Organization |
| LTSH | landside transport, storage and handling |
| M&E | monitoring and evaluation |
| MCH | mother-and-child health |
| MDG | Millennium Development Goal |
| MOU | memorandum of understanding |
| MTR | mid-term review |
| NBS | National Bureau of Statistics |
| NER | net enrolment rate |
| NSGRP | National Strategy for Growth and Reduction of Poverty |
| NNSS | National Nutrition Surveillance System |
| ODK | Regional Bureau Kampala (East and Central Africa) |
| ORC | Opinion Research Corporation |
| OVC | Orphans and vulnerable children |
| PLWHA | person living with HIV/AIDS |
| PMO | Prime Minister's Office |
| PMTCT | prevention of mother-to-child transmission |
| PRRO | protracted relief and recovery operation |
| REPOA | Research for Poverty Alleviation |
| SGR | strategic grain reserve |
| SO | Strategic Objective |
| TB | tuberculosis |
| TACAIDS | Tanzania Commission for AIDS |

| | |
|---|---|
| TFNC | Tanzania Food and Nutrition Centre |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDAF | United Nations Development Assistance Framework |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| VAM | vulnerability assessment and mapping |
| WFP | World Food Programme |
| WHO | World Health Organization |