

INTERNATIONAL EYE FOUNDATION
CS XI
Primary Health Care/Child Survival Project
Northern Red Sea Zone, ERITREA
FIRST ANNUAL REPORT
Cooperative Agreement #FAO-0500-A-00-5018-00

Duration of Project:
SEPTEMBER 30, 1995 - SEPTEMBER 29, 1999

Submitted by:

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October 1996

the
International
Eye Foundation

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ACRONYMS

| | |
|--------|---|
| CA | Cooperative Agreement |
| CSSP | Child Survival Support Program |
| DIP | Detailed Implementation Plan |
| EPI | Expanded Program on Immunization |
| ERRA | Eritrean Rehabilitation and Relief Agency |
| ERREC | Eritrean Rehabilitation, Relief and Emergency Committee |
| KPC | Knowledge, Practices and Coverage |
| MOH | Ministry of Health |
| OMNI | Opportunities for Micronutrient Interventions |
| PHC | Primary Health Care |
| PHN | Center for Population, Health and Nutrition, Bureau for Global Programs, USAID |
| SCF/UK | Save the Children Fund, United Kingdom |
| TBA | Traditional Birth Attendant |
| UNICEF | United Nations Children's Fund |

I. EXECUTIVE SUMMARY

The IEF has been present in Eritrea (under C.A.# FAO-0500-A-00-5018-00) for almost one calendar year. Efforts to negotiate a country agreement began prior to the IEF's establishment in Massawa on the Red Sea Coast of Eritrea. Despite the MOH's assurances that they are in full support of the IEF's Child Survival Project for the Northern Red Sea Zone, a country agreement has still not been signed at the time of this report. Signing of the country agreement is required by the Government of Eritrea to begin implementation of the child survival interventions. The fact that the agreement has not been signed is central to IEF's lack of project activities during the past year.

IEF was able to obtain approval to conduct a baseline KPC survey. At the time the survey approval was granted it was thought that the MOH would approve the project based on successful execution of the survey with supporting data to substantiate the need for IEF's involvement in the region. The MOH recognized IEF's effort in conducting a successful survey and was appreciative of the KPC training received from the CSSP consultant. The agreement, however, was not signed apparently due to on-going concerns over budget requirements set by the Eritrean Rehabilitation, Relief and Emergency Committee (ERREC).

Although the MOH is supportive, as stated, the IEF agreement with Eritrea must be signed by ERREC which coordinates all PVO programming for the government. Over the past year, ERREC has requested changes to the project budget. The IEF in turn did its best to comply with the changing requirements. Recently, ERREC announced a 10% cap on all administrative and management costs (all headquarters and expatriate related expenditures) and a 38% tax (see Annex 6) to be levied on expatriate salaries.

This recent development with ERREC has caused concern amongst PVO's (refer to Annex 7) and caused the IEF to reevaluate its position in Eritrea (see section II.b. for IEF's Options), including closing the project in Eritrea.

II. OVERVIEW OF PROJECT ACTIVITIES

A. Activities Prior to Year 1

Prior to Year 1, IEF was actively communicating with the MOH on a number of project related issues and had standing ties with Eritrea's ophthalmology community. IEF was also attempting to implement its ChildSight project, part of a Matching Grant Cooperative Agreement without a country agreement. While a draft agreement for the Matching Grant was submitted more than three years ago, the MOH never accepted the agreement. In an early discussion with the MOH, IEF was informed that one agreement would be made to include both the ChildSight and Child Survival projects. Later the MOH indicated that two agreements should be negotiated.

IEF was also in close communication with ERRA (precursor to ERREC) to register as an official PVO in Eritrea. IEF applied but was informed that we did not meet the criteria to be registered independently because our budget did not meet the one million dollar per year minimum.

IEF kept the MOH Project Office continuously informed of negotiations for the Child Survival Cooperative Agreement. After, the MOH was informed that the proposal had been accepted by USAID, IEF received, by fax, a new Agreement drafted by the MOH. The new agreement was substantially different than the IEF draft, on which all negotiations had been based.

It was also during this time that IEF was informed of personnel changes in the MOH; the Vice-Minister was replaced and the head of the Projects Office was replaced without explanation. Complicating matters further, the Director of ERRA was also replaced. Within the MOH, the SCF\UK funded position of Advisor was also ended at this time. From December, henceforth, all negotiations were with these new staff.

B. Overview of Year 1

The Project Advisor, Rita Malkki, arrived in Eritrea with the Director of Programs, John Barrows, in mid-December, 1995. An office and residence were located, and office operations began in early January. Because the country agreement between the Government of Eritrea and the IEF had not been signed, no local staff were hired as planned.

Discussions with the Ministry of Health (MOH) during this visit of the Director of Programs yielded some changes in the original project proposal. These changes consisted primarily of a) removing any MOH staff from the project payroll (this criteria was accepted by the MOH in the writing of the proposal); and b) using funds freed by the decrease in salaries to provide material support for health facilities in the project area, specifically for equipment, furniture and supplies. The MOH and IEF agreed to these changes and they were formalized in a subsequent draft country agreement and later in the DIP.

A subsequent visit was made in February by the Child Survival Coordinator, Liliana Clement. She was scheduled to organize the KPC survey, however, immediately prior to her visit the MOH withheld permission for the survey. Therefore, the majority of her trip was spent in negotiations with the MOH to obtain a country agreement. The MOH did grant approval for the KPC survey only, in lieu of a country agreement (Annex 4, Letter of Agreement).

The KPC was conducted in March of 1996. Dr. Muireann Brennan, from the PVO Child Survival Support Program (CSSP) gave technical support for the survey, training a team of MOH personnel in survey techniques. Those trained include, Rezene Araia, PHC Coordinator, Northeastern Red Sea Zone; Teclai Estifanos, Head, Maternal and Child Health

Services, and Tesfayohannes Sebhatu, Training Coordinator. Upon completion of the KPC, results were discussed with the MOH at both the local and national level, USAID, UNICEF, and other PVO's.

Completion of the KPC lead to development of the DIP which was reviewed and accepted by USAID. (Refer to Annex 8 for DIP Review Comments.)

The DIP objectives for the first year of the project included: a) hiring of the Project Advisor, an Administrative Assistant, and a Driver; b) design, preparation, implementation and community feedback of the baseline KPC survey; c) project area population census; d) technical assistance with the design and testing of the project area Health Information System (HIS); e) training assessment survey; f) design of training plans and materials; g) baseline evaluation of knowledge and skills of MOH personnel; h) procurement of equipment and supplies; i) design and implementation of a nutritional survey leading to an IEC; j) initiation of delivery of EPI, Nutrition, and Vitamin A services; and k) four technical assistance visits from headquarters staff.

The actual accomplishments of this project according to DIP objectives for FY 1995 were as follows:

- a) Project advisor was hired; other staff could not be hired due to lack of country agreement.
- b) KPC baseline survey was designed, prepared, and implemented with technical assistance from CSSP. Feedback to the zonal and national MOH staff was completed. Feedback to the communities was not possible due to the lack of a country agreement.
- c) Project area population census, was designed and planned for execution the months of October-November 1996. It was not conducted due to lack of a country agreement.
- d) Design of a project area HIS was begun, but not completed or tested due to 1) desire to coordinate this activity with BASICS, which did not have an HIS expert on staff until close to the end of the fiscal year, and 2) lack of a country agreement.
- e) Training assessment survey was not conducted, due to the lack of a country agreement.
- f) Training plans were begun, and design of training materials has been researched during the project year. This was not completed, however, due to changes in MOH strategy and to the inability of the project advisor to work closely with the MOH in the absence of a country agreement.
- g) An assessment of MOH knowledge and skills would have been linked to the training assessment, serving as a baseline or pre-test of personnel. However, given that the country agreement was not approved, neither activity was permitted.

h) One computer, one fax machine and 50,000 units of vitamin A were acquired through in-kind donation for the Eritrea project. The computer and fax are in the Massawa office. The vitamin A capsules have been stored in IEF Headquarters in Bethesda, awaiting a country agreement to enable them to be shipped to Eritrea and distributed to the project area or as the MOH sees fit. No other items have been procured.

i) A focus group activity was planned for September 1996 to initiate the nutritional survey activity. The survey planned a preliminary assessment of local customs and foods/nutrients available, however, this could not be conducted due to the lack of a country agreement.

j) Initiation of delivery of any child survival intervention was not possible given the lack of a signed country agreement.

i) Visits from headquarters staff included: 1) an initial visit by the Director of Programs, Mr. John Barrows, to discuss changes to the project proposal with the MOH, in December 1995; 2) visit by the Child Survival Coordinator to prepare for the baseline KPC survey and obtain survey approval, in February 1996; and 3) visit by the IEF Executive Director at the request of the Project Advisor and USAID as they felt that the MOH was ready to sign the country agreement. A visit by the IEF's Director of Finance was postponed, as his visit was planned to coincide with the signing of a country agreement to put in place mechanisms for transferring and accounting of funds through the MOH (implementing organization for the Child Survival Project).

In planning for proposed activities, particularly those training activities for health facility staff and for Traditional Birth Attendants (TBAs) in the region, IEF collaborated with the Africare/Massawa office. The Africare Child Survival project was designed very similarly to the IEF project, and in discussions with the Africare Project Advisor, it was decided that sharing materials and possibly training resources (i.e., conducting joint training sessions) would be an effective method for training the health facility staff. Because TBAs would require on-site training, joint training sessions would not be feasible for this activity. However, no training activities were conducted, as noted above.

For further details of the year's activities, in a chronological time line, please refer to Annex 1.

III. CONSTRAINTS, UNEXPECTED BENEFITS AND LESSONS LEARNED

A. Constraints

The primary constraint to implementation of the Child Survival Project was the lack of a country agreement between IEF and the MOH of Eritrea, as noted in Section I. The Zonal Ministry of Health was unable to allow any manpower to be used for IEF project activities

before the country agreement was signed, and therefore the vast majority of activities could not be carried out. A special exemption was made by the Vice Minister of Health to allow MOH personnel to participate in executing the baseline KPC survey.

The country agreement for this project has been fraught with difficulties from the outset. The initial draft agreement was developed, in conjunction with IEF headquarters, by an officer of the MOH who was transferred out of the Ministry shortly before the arrival of the Project Advisor. This resulted in the MOH's need to re-negotiate the agreement with a new officer in charge of the IEF project, the Director of Planning for the MOH. Although the technical plan for the agreement was agreed upon as early as January 1996, the budget for activities became the subject of continued discussion with ERREC and has continued as such.

Ultimately, the IEF Executive Director visited Eritrea in July 1996 in an attempt to finalize remaining budget issues and sign the final version of the country agreement, only to find that the Eritrean Relief and Rehabilitation Commission (ERREC) had developed new guidelines for project activities and budgets that were not in line with the initial revisions. It is possible that even the MOH was not fully cognizant of these new guidelines, as they had never been presented to the IEF by the MOH officer in charge of the project.

The IEF Executive Director, the IEF project advisor, and officers of the MOH together revised the project design and budget according to the new 10% cap on administrative costs. No adjustments were made to reflect the new 38% tax on expatriate salaries. The next step to be taken was for the MOH to submit the revised project along with formal application materials, to ERREC for approval. Because IEF does not have the official status as a registered NGO (budget less than \$1 million per year), the Ministry must request approval, on behalf of the IEF, from ERREC to sign any agreements for projects.

As of the end of September 1996, the MOH had not made any progress in submitting their application to ERREC, and therefore there is still no signed country agreement.

During the Executive Director's visit, it was learned by IEF and USAID that the United States Department of Defense was planning health related activities in the Northern Red Sea Zone. In addition to rehabilitating and building health facilities, the DOD planned to conduct EPI campaigns in the zone. In a meeting with Major Gregory L. Vrentas, DOD, Judith Robb-McCord, Child Survival Fellow representing USAID, suggested that within the zone, IEF should remain in assistance to the health centers as originally proposed in their DIP. Ms. McCord is keeping IEF informed of the DOD's and other parties' interests in the area.

B. Potential Options to Remedy Constraints

The following options are currently being weighed by IEF in consultation with their USAID Project Officer.

1. Maintain project DIP as presented to USAID and MOH, only making a change to remove expatriate Project Advisor.

The presence of an expatriate advisor as head of the project has been a concern to both ERREC and the MOH. Therefore, this is an option they may agree to. However, in discussions with USAID, it was agreed by the IEF that this would not be a suitable option. Although costs would be decreased, the level of activities would also need to be greatly reduced. Given that manpower shortages are already hampering the MOH's ability to deliver health care, it is thought that placing further burden on the Eritrean MOH with full responsibility for this project would be unrealistic. In addition, the lack of technical skills within the MOH at this time would likely leave the project devoid of essential expertise. It has always been the hope of the IEF that the MOH skill and manpower levels would improve over the life of the project in order to negate the need for an expatriate advisor. However, to begin the project with a local hire in the MOH's current state would be imprudent.

2. Scale down project activities from what is currently proposed in the DIP leaving the project as a series of technical assistance activities to the MOH.

In this scenario, the project would serve as a technical committee or group of consultants to the MOH. Assistance would be provided via a series of visits to the project area rather than through the long term presence of a Project Advisor. This option is currently favored by the USAID Mission in Asmara. ERREC and the MOH are also thought to be in agreement with this option.

3. Remove funding of the Child Survival Project from Eritrea.

This would obviously be the most drastic of the options presented. The IEF did propose this idea to USAID/Washington and recently received word that the Office of Procurement would allow the IEF to withdraw funds from Eritrea and reestablish the project in another country (given a formal proposal is submitted for approval). IEF is in the process of evaluating this and all other options with USAID.

C. Lessons Learned

USAID's support to the IEF, both from the Mission and from the PVC Office in Washington has been crucial to IEF's progress to date. If a country agreement is ever signed, it would be because of this involvement and because of USAID's patronage to the IEF.

As the DOD of the United States moves into humanitarian aid, health care infrastructure development and child survival interventions, they should keep USAID informed of their activities to avoid duplication of effort and to enable the two groups to find means of complementing each other's objectives, in order to maximize efficiency and output.

Groups which are working with the MOH on a national level and have established strong relationships with the government (ie. UNICEF, BASICS) should take a lead role in organizing all governmental and non-governmental organizations to meet as appropriate. In

the case of Eritrea, it seems that many groups did meet to share their experiences but that no coordinated national effort was being made which would have brought together the entire range of organizations working on health care in the country.

IV. CHANGES TO PROJECT DESIGN

The original proposal called for the execution of child survival activities in the entire Sahel Province, population approximately 300,000. Since submitting the proposal the project scope and population have decreased significantly, as noted in the DIP. The new project area encompasses the southern area of the Northern Red Sea Zone (as the Sahel Province was renamed), in the Shieb, Emberemi, Dogali and Wokiro subzones with a total population of about 30,000.

Reasons for the reduction include a) areas north of these subzones remain mined; there remains a lack of MOH personnel to handle the larger population effort; and there exists a lack of infrastructure for the larger project. See IEF/Eritrea CS XI-DIP for details.

A new budget has not, however, been drafted to reflect the reduction in effort. This is because the IEF is waiting for a country agreement to be signed and for the DIP to be approved by the MOH before finalizing the budget. Finalization of a budget with submission to USAID would be premature at this time. It is possible that with the evolving needs of the Ministry and with the tenuous nature of IEF involvement in Eritrea, that the project could change in scope yet again, before finding a final form that all parties can agree to.

V. BUDGET

The major change to the project has been the reduction in beneficiary population from 300,000 to 30,000. Budget revisions to reflect this change will be made and submitted as soon as a final decision is made by the MOH to approve the DIP. If the DIP is not approved and a country agreement is not signed the IEF together with USAID will need to reevaluate the nature of the project and a new budget will be drawn to reflect all changes, or other options will be explored.

Minimal costs have been incurred to date. The financial pipeline analysis is attached as Annex 10 for review. The current monthly burn rate is \$13,917 (combined AID/IEF). This is far less than the estimated burn rate (\$25,991 combined AID/IEF) calculated for the original budget. The lack of a country agreement limiting project activities was the main factor contributing towards the under-expenditure.

The major expenses were establishing the office and the KPC survey. Costs related to establishing the field office; purchase of office equipment and supplies, and relocation costs for the Project Advisor totaled about \$18,600. The KPC survey totaled another \$13,000 including costs for a consultant from the CSSP to train MOH and IEF personnel.

VI. ANNEXES

- 1: Time Line of Activities**
- 2: Letter of Support from MOH**
- 3: Letter of Support from ERRA**
- 4: Approval Letter from MOH for KPC Survey**
- 5: Letter to Ambassador Amdemicail Dahsai from IEF**
- 6: Eritrean Income Tax Regulations**
- 7: Letter from Interaction Regarding Tax Issue**
- 8: Reviews of Detailed Implementation Plan**
- 9: Draft Country Agreement**
- 10: Budget Pipeline Analysis**

ANNEX 1: TIME LINE OF ACTIVITIES

TIMELINE

Date

December
1995

9-19 Dec Rita Malkki, Project Advisor arrived in Eritrea with John Barrows, Director of Programs. Multiple meetings were held with the MOH, USAID, other PVO's and other organizations. For details of meetings with MOH, see John Barrows Trip Report.

January
1996 Project Advisor continued negotiations with the central MOH.

Project advisor held initial meetings with the zonal MOH - Zonal MOH officers met included Dr. Zemui, the Zonal Medical Director, and Rezene Araia, the Zonal PHC Coordinator.

Project Advisor redrafted the Country Agreement.

Project Advisor attended a USAID-MOH joint planning meeting for health sector activities.

February
1996 Project Advisor held multiple meetings regarding the Country Agreement with the MOH.

The MOH requested full budget information for the project, rather than the in-country breakdown.

The MOH decided that the percentage of the total budget spent outside of Eritrea was too large, and added that ERREC (then ERRA) would not approve such a budget.

Project Advisor began discussions with the central MOH Chief of Medical Services, Dr. Afeworki, and the Zonal MOH regarding the timing and personnel needs for the IEF/MOH CS Baseline KPC Survey.

29 Feb.- Liliana Riva Clement, IEF Child Survival Coordinator
16 March arrived to assist with the baseline survey and MOH negotiations regarding the Country Agreement.

IEF was given permission to conduct the baseline survey.

March
1996

18 March- Dr. Muriann Brennan, training consultant from JHU/CSSP
5 April began training the trainers for the survey. All survey activities, including initial data analysis and drafting of the survey report were completed.

April
1996 The survey results were presented to the MOH, USAID, UNICEF, BASICS, and CRS representatives.

IEF requested assistance from the Zonal MOH to conduct focus group sessions related to questions raised from the baseline survey results. The MOH declared that it could not provide any further assistance to IEF until the country agreement was in place.

Meetings were held with the zonal MOH officers to discuss components of the Detailed Implementation Plan (DIP) during the remainder of April.

16 April John Barrows, Liliana Riva Clement, and Victoria Sheffield, IEF Executive Director visited the Ambassador Amdemicael Kahsai for an update on the status of the Country Agreement.

May 1996 Several meetings were held during the first two weeks of March to discuss information needed for the DIP. The Project Advisor met with the Zonal Medical Officer, Dr. Zemui, the Zonal PHC Coordinator, Rezene Araia, and the zonal EPI Coordinator, Ato Giniam.

Meetings were also held throughout the month with Ms. Ann Hirschey of Africare to discuss information needed for the DIP and potential activities that IEF and Africare could work together to accomplish.

17 May Project Advisor met with Dr. Tekeste and Dr. Iob to discuss what remaining issues required clarification prior to signing the Country Agreement. The Vice Minister requested that the Project Advisor submit a revised budget based on the same format used for submission to USAID in the project proposal and DIP.

28 May Project advisor was scheduled to meet with Dr. Tekeste and Dr. Iob. (Cancelled)

June
1996 The revised budget, prepared according to the MOH request, was submitted.

The Project Advisor held meetings with Steve W., the

new Child Survival Fellow at USAID and with the USAID Director to discuss these issues and request assistance.

- 3 June Project Advisor was to meet with Dr. Tekeste and Dr. Iob, MOH. (Cancelled)
- 6 June Project Advisor met with Peace Corps Director, Martin Shapiro to discuss Potential Collaboration.
- 11 June Project Advisor met with Dr. Zemui at the Zonal MOH to discuss the Country Agreement/Budget.
- 12 June Project Advisor met with Rezene Araia, Zonal UNICEF PHC Coordinator to discuss Workplan Design.
- 17 June Project Advisor met with Glenn Anders, and Judith Robb-McCord of USAID to discuss General C/S Activities.
- 18 June Project Advisor met with Dr. Iob, MOH and Glenn Anders and Judith Robb-McCord of USAID to discuss General C/S Activities.
- 18-19 June Project Advisor was to meet with the MOH Chief of Administration. (Cancelled)
- 19 June Project Advisor Presented the KPC survey to the MOH Chief of Statistics.
- 21 June Project Advisor presented the KPC survey to the UNICEF PHC and EPI Coordinators.
- 21 June Project Advisor presented the KPC survey to the BASICS Administrator.
- 22 June Project Advisor met with Robert Van Buskirk concerning the project computer.
- 22 June Project Advisor met with Dr. Tekeste and Dr. Iob (MOH) to discuss General C/S activities.
- Later that week Project Advisor met with Dr. Tekeste and Dr. Iob (MOH), and Glenn Anders and Judith R. McCord (USAID), to discuss the Country Agreement/Budget.
- July 1996
- 7-15 July Victoria Sheffield, IEF Executive Director visited project.
- 8 July Project Advisor and IEF Executive Director Victoria Sheffield met with Judith R.-M. (USAID), to discuss the Country Agreement/Budget.

- 9 July Project Advisor and Executive Director met with Judith R.-M. (USAID), Dr. Iob and Mr. Eyasu (MOH), and Mr. Rosso (ERREC), to discuss the Country Agreement/Budget and Tax Issue.
- 9 July Project Advisor and Executive Director met with Dr. Kopano Mukelabai and Dr. Isiyie Ndombi of UNICEF to discuss potential for collaboration.
- 9 July Project Advisor and Executive Director met with Judith R.-M. (USAID) and Dr. Tekeste and Dr. Iob (MOH) to discuss the Country Agreement/Budget.
- 9 July Project Advisor and Executive Director met with Ambassador Houdek and his wife for social purposes.
- 10 July Project Advisor and Executive Director met with Dr. Iob and Dr. Afeworki (MOH) to discuss the Country Agreement/Budget.
- 11 July Project Advisor and Executive Director were to meet with Dr. Iob (MOH) to discuss the Country Agreement/Budget. (Cancelled)
- 11 July Project Advisor and Executive Director met with Judith R.-M. (USAID) to discuss the Country Agreement/Budget.
- 11 July Project Advisor and Executive Director met with Dr. Carl Forsberg of the World Bank to discuss the Country Agreement/Budget.
- 12 July Project Advisor and Executive Director met with Dr. Ghennet of the Behran Eye Hospital to discuss general C/S activities.
- 12 July Project Advisor and Executive Director met with Dr. Iob (MOH) and Mr. Rosso (ERREC) to discuss the Country Agreement/Budget.
- 12 July Project Advisor, Executive Director, and Judith R.-M. (USAID) attended a meeting between the Major G. Vrentas of the US DoD and Dr. IOB (MOH).
- 12 July Project Advisor and Executive Director met with Ambassador Houdek to discuss the Administrative Issue (tax issue).
- 12 July Project Advisor was to meet with Dr. Zemui (MOH) and Dr. Rezene Araia (UNICEF PHC Coordinator). (Cancelled)
- 22 July Project Advisor submitted to Dr. Iob (MOH) all information necessary for the MOH to submit its formal

application for approval of the country agreement to ERREC.

August
1996

- 7 Aug Victoria Graham and Martha Holly Newsome of World Vision, Allan Alemian of Africare, and John Barrows and Victoria Sheffield of IEF met at Interaction to discuss the ERREC tax issue. (see Annex 4) for letter from Interaction to Ambassador Amdemicael Kahsai.
- 30 Aug Project Advisor met with Dr. Iob (MOH) to discuss the Country Agreement/Budget.

September
1996

- 3 Sept Project Advisor met with Judith R.-M. (USAID) to discuss the Country Agreement.
- 5 Sept Project Advisor met with Ann Hirschey of Africare to discuss Administrative Issues(tax issue).
- 6 Sept Project Advisor met with Dr. Rezene Araia (UNICEF PHC Coordinator) to discuss the Country Agreement/Budget.
- 12 Sept Project Advisor met with Steve Siersma of USAID to discuss the Country Agreement/Budget.
- 13 Sept Project Advisor met with Dr. Rezene Araia (UNICEF PHC Coordinator), Ato Biniam (UNICEF EPI Coordinator), and Dr. Paul Fife of UNICEF to discuss EPI activities for the Zone.
- 20 Sept Project Advisor met with Dr. Tekeste (MOH) to discuss General C/S Activities.
- Victoria Sheffield, Executive Director of IEF, Julia Taft, CEO of Interaction and James Goering, Director of Programs of World Vision met with Ambassador Amdemicael Kahsai regarding the ERREC tax issue.
- 23 Sept Project Advisor met with Judith R.-M. and Glenn Anders (USAID) to discuss the possibility of pulling out of Eritrea.

ANNEX 2: LETTER OF SUPPORT FROM MOH

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دولة ارتريا
وزارة الصحة

The State of Eritrea
MINISTRY OF HEALTH

3 November 1994

Mr John Barrows
Director of Programmes
International Eye Foundation
7801 Norfolk Avenue
Bethesda, Maryland, 20814
United States of America

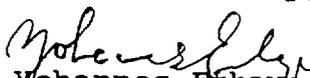
Dear Mr Barrows,

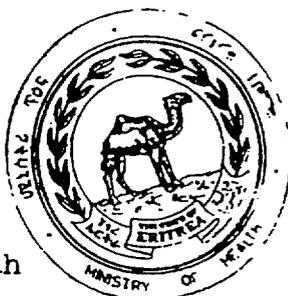
The Ministry of Health would like to thank the International Eye Foundation (IEF) for its appreciation of our problems pertaining to health and its willingness to cooperate with us in finding solutions.

We have had several meetings with you and we have agreed that there is an urgent need to support primary health care activities in Sahel Province - the Province which the Ministry of Health believes would most benefit from IEF's. We have directed you to work in Sahel partly because it is an area severely affected by war, drought and famine and partly because it is a remote area currently under-served. Needless to say, other areas of Eritrea have also suffered because of the war and famine, but through the good will of other donors, these areas are receiving some assistance. To date, there is limited donor support for health care in Sahel, especially for primary health care activities.

IEF's proposal to support child survival activities is in harmony with the Ministry of Health's national policy of Primary Health Care. The Ministry of Health wishes to convey to you its interest and broad agreement to the activities proposed by you during your visit and in writing dated 21 October. We very much hope to reach an agreement with IEF regarding a joint programme of cooperation for child survival/vitamin A supplementation in the new year.

Yours sincerely,


Johannes Embaye
Projects Office



cc. Vice Minister for Health

ANNEX 3: LETTER OF SUPPORT FROM ERRA



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وكالة الاغاثة والتعمير الارترية

Eritrean Relief & Rehabilitation Agency (ERRA)

LEONARDO DAVINCI P.O. Box 1098 Asmara - Eritrea

Tel: 291-1-118300

Fax: 291-1-122861

Date: 26 NOV 1994

Ref:

Fax No : (301) 986-1876

To : VICTORIA SHEFFIELD
EXECUTIVE DIRECTOR
INTERNATIONAL FOUNDATION

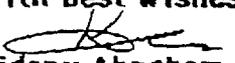
Dear Ms. Sheffield

Re: CHILD SURVIVAL PROPOSAL - LETTER OF SUPPORT

I am pleased to acknowledge the receipt of your fax of 16th November 1994. ERRA appreciates Internal Eye Foundation's interest and willingness to support primary health care activities in Sahel province. As your proposal to support child survival activities is in harmony with Ministry of Health's national policy and supported by the Ministry of health, I advice you to proceed and raise funds for the programmes that are mentioned.

Thanking you for your cooperation

With best wishes


Kidanu Abraham

In charge of NGO affairs



ANNEX 4: APPROVAL LETTER FROM MOH FOR KPC SURVEY

Ministry of Health
Eritrea
AFRICA

13 March 1996

Victoria Sheffield
Executive Director
International Eye Foundation
Bethesda, Maryland USA

Dear Ms. Sheffield:

The Ministry of Health of Eritrea has reviewed the proposal submitted by International Eye Foundation to conduct a Child Survival Program in the Northeastern Red Sea Zone, North of Massawa. We are in agreement ~~with the program and its objectives, and we are in support of~~ *with* the upcoming survey, to begin on the 18th of March. We anticipate signing the Country Agreement ~~by Friday the 15th of March.~~ *soon.*

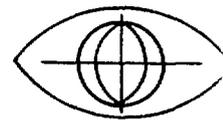
Sincerely,



Vice Minister of Health, Dr. Tekeste

cc: Glenn Anders, Representative, USAID/Eritrea
John Barrows, Director of Programs, IEF

ANNEX 5: LETTER TO AMBASSADOR AMDEMICAIL KAHSAI FROM IEF



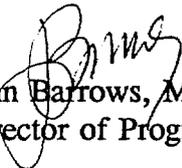
April 23, 1996

Amdemicael Kahsai
Ambassador
Embassy of Eritrea
1708 New Hampshire Avenue, NW
Washington, DC 20009

Dear Ambassador Amdemicael:

On behalf of the Program Department, we thank you for your time last week to discuss IEF projects in Eritrea. As you suggested, we have prepared the following to provide you with a summary of our activities. The information includes a brief review of IEF's involvement with Eritrea, discussions with the MOH and ERRA concerning a country agreement, and descriptions of two projects we are attempting to undertake.

With sincerest appreciation,


John Barrows, M.P.H.
Director of Programs

ATTACHMENTS

- Chronology of IEF approvals for Projects
- Letter of support from Ministry of Health
- Letter from ERRA
- Letter of Agreement to KPC survey from MOH
- Project description of Child Survival
- Project description of ChildSight
- Draft country agreement
- Survey report

the
International
Eye Foundation

Chronology of IEF Approvals for Programs

IEF first met Dr. Desbele Gebregiorgis in 1991 when Victoria Sheffield, Executive Director of IEF, travelled to Asmara to meet with him, UNICEF and Dr. Nerayo Teklemichael at ERRA. From this contact, IEF included Eritrea in a proposal called ChildSight to the U.S. Agency for International Development in late-1992 which was funded in mid-1993. (See attached description.)

In December 1994, IEF wrote a proposal entitled Vitamin A for Child Survival, Sahel Province which was funded in late-1995. This proposal was written in consultation with the Office of Projects of the MOH, Asmara. There were four visits made by IEF staff during the period of 1993 to 1996. These visits were to discuss implementation, gain clarification on a country agreement for activities, information gathering for new proposals, and to attend a national meeting organized by the MOH. (See attached project descriptions for ChildSight and Child Survival projects.)

IEF first raised the issue of a country agreement in 1993 after IEF received funding for the ChildSight project. It was during this time period that the government was formulating its policies on registering non-governmental organizations (NGO's). Later, after IEF received funding for the Vitamin A for Child Survival project, the outstanding issue of a country agreement was again raised. IEF left copies of its own draft country agreement with the MOH for comments and submitted an application to ERRA for registration as a PVO in Eritrea. IEF received a response from ERRA stating IEF did not meet the requirements for registering through ERRA (funding levels below one million USD per year), and instructed us to proceed through the MOH for a country agreement. (See attached, letter from ERRA.) IEF did not receive any response or comments from the MOH regarding the draft agreement.

In 1995, IEF received a draft country agreement from the MOH, based on the draft agreement prepared by Victoria Sheffield of IEF, and Yohannes Embaye and Dr. Nancy Godfrey of the MOH which has been the basis for all subsequent discussions. During a meeting in Asmara in December 1995, John Barrows of IEF stated concurrence in principal to the conditions of the agreement and requested only minor modifications. During this same visit, the ERRA office was visited.

In March 1996, the country agreement was not signed, yet IEF was attempting to implement a baseline health survey, a requirement by USAID child survival programming. At this time a visit was made by Liliana Clement of IEF to discuss the survey and the country agreement. The MOH requested several pieces of information and clarification of the project which IEF did its best comply with. Although the MOH would not sign the country agreement, they compromised, and graciously provided an agreement to conduct **only the survey**. The survey was completed successfully, but the country agreement is still pending. During Ms. Clement's visit the MOH informed her that final approval would need to be obtained through ERRA although the MOH was in principal in agreement with the program and expected it to proceed.

IEF reiterates its commitment to assisting Eritrea and asks for advice on how we should proceed with the MOH to bring discussion of the country agreement to a decision. Your advice and comments are greatly appreciated. IEF strongly believes the work proposed is beneficial to Eritrea and is in line with the objectives of the Ministry of Health.

Relevant Staff:

Victoria Sheffield, Executive Director, IEF/Bethesda
John Barrows, Director of Programs, IEF/Bethesda
Liliana Clement, Program Coordinator, IEF/Bethesda
Rita Malkki, Project Advisor, IEF/Massawa

PROJECT DESCRIPTION: IEF CHILD SURVIVAL

Title: Child Survival/Primary Health Care Project for Northeastern Red Sea Zone, North of Massawa.

Proposed Duration of Project: September 30, 1995 - September 29, 1999.

The Child Survival Program for Eritrea is a four year program aimed at decreasing child mortality in the region. The program is funded through the U.S. Agency for International Development and is designed as a sustainable partnership with the Ministry of Health, concentrating on improving the services provided by the MOH and on community education to enable the population to better their health conditions.

The project hopes to assist in the following interventions:

- *Immunization: by strengthening existing systems and training of Ministry personnel;
 - *Diarrhea case management: through training, community education and distribution of ORS;
 - *Control of vitamin A and micronutrient deficiencies: with provision of vitamin A capsules and other vitamins;
 - *Nutritional improvement: through community education and communication strategies;
 - *Malaria Control: via training and education;
 - *Pneumonia case management: also through training and education (phased-in in year 3 of project).
-

ACTIVITIES REALIZED BY THE CHILD SURVIVAL PROGRAM

The first activity of the program was a Knowledge, Practice and Coverage (KPC) Survey which was conducted in March of 1996. The key survey findings revealed:

- * 5% full immunization coverage rate.
- * 73% of women reported breast-feeding within one hour of delivery, although introduction of complementary foods was delayed.
- *37% of mothers reported their child had diarrhea in the past two weeks, and feeding during the episodes was not increased.
- *31% of mothers reported malaria during pregnancy

During the survey Rezene Araia, PHC Coordinator; Teclai Estifanos and Tesfayohannes Sebhatu were trained in survey techniques and in EpiInfo (a computer program for tabulating data). The results were presented at the local and National Ministry levels.

FUTURE ACTIVITIES ANTICIPATED BY THE CHILD SURVIVAL PROGRAM

In addition to the interventions, IEF would like to work with the Ministry to conduct a facilities survey, similar to the one conducted by Basics but specific to Zone 2 (Note: the Basics survey did not include Zone 2). Further, in accordance with the information revealed in the KPC survey, IEF would like the Ministry to consider an in depth nutritional survey of the area with a qualitative component to more fully address the nutritional concerns such as late introduction of complementary foods to infants.

The implementation plan (DIP) for the program is in the process of being written. This document will be written in concurrence with the local and National Ministries and will serve as the final work plan for all activities. Any changes to the original proposal which are needed to make the program fit the needs of the Ministry can be input into this final DIP document. This process has been explained to Dr. Tekeste, Acting Vice Minister of Health. The new document will also include changes suggested in the MOH letter from 10 November 1995 to comply with Ministry needs.

PROJECT DESCRIPTION: IEF CHILDSIGHT

Title: ChildSight, an Eye Care Program for the under-served
Proposed Duration of Project: August 31, 1993 - August 30th 1996

This project is part of a larger IEF program entitled SightReach in six countries. The funding for the six ChildSight country projects is a special U.S. Congress initiative with very precise goals of targeting blind and visually impaired children. The Eritrea part of the program is based at the Ministry of Health's Birhan Eye Hospital in the capital city of Asmara. The primary contact will be Dr. Desbele Gebregiorgis.

The project targets blind and visually impaired children in Eritrea. Most of these children reside in the rural areas and have never been seen or examined by a health worker due to both the lack of services and health workers and the lack of health workers trained to perform a basic eye examination. To identify children who may benefit from surgery, health workers need to be sensitized to the importance of eye health and blindness in children and learn new skills in basic preventive eye care, screening, treatment and referral. Referral centers need to have their services supported in order to perform pediatric surgery.

The achieve these goals, the project will:

- 1) Conduct a survey: An assessment in the blind school was completed in 1995 to determine major causes of childhood blindness and visual impairment.
- 2) Provide training: Four training workshops need to be completed for health workers, MCH personnel, nurses, and physicians. The content of the training will be in primary eye care, screening techniques, basic treatment, and referral. This training has not been completed. The MOH expressed interest in conducting the training themselves and IEF left copies of eye care training manuals for adaptation by the MOH.
- 3) Upgrade services: The services at Birhan Eye Hospital in Asmara, will be supported to perform pediatric surgery. Visiting volunteers specializing in pediatric ophthalmology will be identified who are willing to provide 1-2 weeks per year to work with Dr. Desbele Gebregiorgis and staff. To date only one visit has been made by Dr. John O'Neal in 1996.

As the project end date is approaching with little implementation to date, IEF has requested a no-cost extension from USAID to continue the activities for one additional years time. IEF is waiting for an official notice from USAID that this request is granted. There is no official agreement with the MOH concerning this project. There has been discussion to either have a separate agreement for this ChildSight project, or to add this project into the Child Survival project agreement.

ANNEX 6: ERITREAN INCOME TAX REGULATIONS

LEGAL NOTICE No. 20 / 1995
Income Tax Regulations

SECTION ONE

General

Article 1.

These Regulations have been issued by the Minister of Finance pursuant to the authority vested in him by Article 68 of the Income Tax Proclamation No. 62 /1994 (Hereinafter referred to as the "Proclamation").

Article 2.

These Regulations may be cited as the "Income Tax Regulations No. 20 of 1995".

Article 3.

Pursuant to Article 3 of the Proclamation, all previous Legal Notices in particular, Income Tax Legal Notice No. 258/62, are hereby repealed and replaced by these Regulations.

SECTION TWO

Payment in Cash or Benefits in Kind :

Article 4.

1. The following payments in cash or benefits in kind shall be excluded from computation of salary and wage income taxable under Schedule 'A':
- a. amounts paid under contracts of employment by employers to cover the actual cost of medical treatment and compensation for physical injury;
 - b. allowances made in lieu of means of transportation granted to employees in accordance with governmental regulations or under contracts of employment;
 - c. amounts paid according to provisions of contracts of employment to employees for on-duty travelling and transportation expenses;

d. amounts of travelling expenses paid to employees recruited from elsewhere other than the place of employment on joining and completion of employment or in connection with their leave, provided, that the expenses covered by such payments are made pursuant to specific provisions of contracts of employment and actually incurred ;

e. cash and store allowance paid to cashiers and store men;

f. entertainment allowances directly attributable to the actual conduct of business;

2 The allowances and payments mentioned in sub-article 1, b, c, d, e, and f of this Article shall only be exempted from tax if they are deemed to be reasonable by the Inland Revenue Department which is empowered to reduce or reject such expenses.

Article 5.

Where an employee is retired for various reasons before he reaches pension age and the amount paid by him as pension contribution while working is refunded back, he shall be exempted from payment of income tax from employment.

Article 6.

If the tax on income from employment instead of being deducted from the salary or wage of the employee is paid by the employer in whole or in part out of his own expense for the employee the amount so paid shall be added to the taxable income and shall be assessed as part thereof.

Article 7.

Unskilled workers referred to in Article 31(2) of the Proclamation, shall be considered as employed regularly by one (1) employer if they work for the same employer for more than fifteen (15) days in the aggregate in a single month and shall pay tax on income from employment.

Article 8.

Persons referred to in Article 31(3) of the Proclamation who remain in Eritrea for more than one hundred and eighty three (183) days in the aggregate in any twelve month period, shall be liable to pay the tax on income from employment received by them for the entire period during which they are in Eritrea.

2. The tax on income from commercial farming of persons or bodies who fail to keep books of account and records shall be charged, levied and collected by the Inland Revenue Office or any other body designated by it. Taxable income shall be calculated in accordance with regulations issued by the Minister.

SECTION SEVEN

GENERAL PROVISIONS

ARTICLE 31 TAX EXEMPTION

The following categories of income shall be exempted from payment of income tax.

- 1) Income from their own employment of self employed workers, such as weavers, pottery workers, blacksmiths, tanners and the like, who are not resident in the municipal or township areas and who do not employ other full-time workers.
- 2) Income from employment of unskilled workers, employed by the day, who are not employed regularly by a single employer.
- 3) Income from employment received from abroad by persons present in Eritrea representing foreign business or other persons not employed or retained by any employer in Eritrea; provided, however, that if any such person remains in Eritrea less than one hundred eighty three (183) days in the aggregate in any one (1) year, shall be exempted.
- 4) Income from interest received by persons on bank accounts.
- 5) Dividends received by share-holders from incorporated or corporated bodies in Eritrea
- 6) Subject to reciprocity, income from employment received for services rendered in the exercise of their duties by:
 - a) Diplomatic and Consular representatives, and
 - b) Other persons employed in any Embassy, Legation, Consulate or Mission of a foreign state, who are nationals of that state and bearers of diplomatic passports, or who are in accordance with international usage or custom, normally and usually exempted from the payment of income tax.
- 7) Income specifically exempted from income tax by the law in force in Eritrea, by international treaty or by an agreement made or approved by the Minister.

SECTION SIX

TAX ON INCOME FROM COMMERCIAL FARMING

ARTICLE 27

Any person or body deriving income from commercial farming shall pay income tax thereon.

ARTICLE 28

Income from commercial farming shall be declared and tax thereon paid annually within four (4) months from the end of the Eritrean fiscal year and tax shall be imposed on the income of the preceding fiscal year; provided, however, that the Inland Revenue Office may, at its discretion, allow the use of a different accounting year.

ARTICLE 29

Any person or body having income from commercial farming shall pay income tax in accordance with Schedule "D" below :

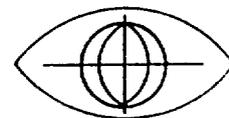
SCHEDULE "D"

| Serial N ^o | Taxable income - Birr | Tax rate on every additional one Birr (%) |
|-----------------------|-----------------------|---|
| 1. | up to 1000 Birr | 2% |
| 2. | From 1001 up to 10000 | 5% |
| 3. | From 10001 - 20000 | 10% |
| 4. | From 20001 - 35000 | 15% |
| 5. | Above 35000 | 20% |

ARTICLE 30

1. The tax on income from commercial farming shall be levied, charged and collected the same as any other trade, business, vocational and professional activities; and its maintenance of books of account and records shall be applied as per sub-article 1 and 2 of Article 26 hereof.

ANNEX 7: LETTER REGARDING TAX ISSUE BY INTERACTION



9 September, 1996

Julia Taft
President and CEO
InterAction
1717 Massachusetts Avenue, NW
8th Floor
Washington, DC 20036

Dear Julia,

Thank you for your letter to Ambassador Amdemicael Kahsai of Eritrea. The points are well made and I feel sure it will be given proper attention. I hope that this statement will have some influence in his discussions with his counterparts in Asmara, and I know that Glen Anders will be pleased that this letter has been written.

Again, thank you for your interest and support, especially in lending your name and the weight of InterAction behind this important issue.

Cheers,

Victoria M. Sheffield
Executive Director

cc: Joseph Kennedy, PhD, Africare, Vice President
Andrew Natsios, World Vision Relief and Development, Inc., Executive Director

the
International
Eye Foundation



American Council for Voluntary International Action

National Council

Manone Craig Benton
Robin Duke
Dorothy I. Height
Rev. Theodore M. Hesburgh
Marion Fennelly Levy
Charles H. Percy
Jill Ruckelshaus

August 30, 1996

Ambassador Amdemicael Kahsai
Eritrean Embassy
910 17th St., NW #400
Washington, DC 20006

**President &
Chief Executive Officer**

Julia Vadala Taft

Dear Ambassador Kahsai:

Thank you for your attention to the concerns of the private voluntary community from time to time. I am grateful for your openness to several of our members.

Chairperson
William Reese

Vice Chairperson
Kathryn Wolford

Secretary
Jose A. Aponse

Treasurer
John H. Costello

Assistant Secretary
Victoria M. Sheffield

Assistant Treasurer
Andrew Griffel

Executive Committee

Nancy Aossey
David Beckman
Robert Chase
Richard Cobb
Jane Covey
Peggy Curtin
Larry E. Dixon
Sam Evans
Neal Keny Guyer
Glen Ivers
Le Xuan Khoa
Charles MacCurmack
Jerry Michaud
Sally Montgomery
Andrew Natsios
John M. Palmer, III
Linda Pfeiffer
Stephen Richards
Frances Seymour
Elise Smith
Richard Walden
Martin Wenick

InterAction, as an umbrella organization of non-governmental organizations (NGOs), is writing to express concern regarding the Eritrean Legal Notice No. 20/1995 on the Income Tax Regulations. The Eritrean Ministry of Finance has asked that all international staff of non-governmental organizations working in Eritrea pay a 38% income tax to the Eritrean government. While we understand the government's desire to raise revenues by taxing expatriates, this potential tax raises some very grave concerns for the NGO community working in Eritrea as well as for the U.S. government. These concerns and the potential deleterious results of such a tax are summarized below and we trust will be helpful to you in seeking to be an advocate for a policy that will advance sustainable development:

- The majority of expatriates living in Eritrea are involved in humanitarian assistance activities and are working closely with the Eritrean government to help in its effort to rehabilitate its economy and accelerate development. Even if taxing expatriates is presumed feasible, such a tax would be taken out of the total assistance to the country, thereby depleting the amount of resources available for humanitarian and development assistance;
- Government and private donations provide most of the funding for the humanitarian assistance being carried out in Eritrea. These public and private donations are given expressly for humanitarian assistance and not for the purpose of paying taxes;
- This tax violates a current standing agreement between the Government of Eritrea and the NGO community that declares that international staff will not be taxed;

17 Massachusetts Avenue, NW
Suite 801
Washington, DC 20036
PHONE: (202) 667-8227
FAX: (202) 667-8236
(202) 667-4131
E-MAIL: ia@interaction.org
http://www.interaction.org/ia/

33

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- This tax will increase the cost of operating in Eritrea resulting in a reduction of funds to support Eritrea. Because of decreasing public and private support for foreign assistance worldwide, this increase in operating costs would place Eritrea at comparative disadvantage to other countries. The end result of this reduction would be an overall reduction in investment to Eritrea rather than increased revenue for Eritrea;
- Foreign citizens do not derive many of the benefits supported by the tax payments as they do from taxation in their own countries, e.g., the right to vote, schooling for their children, the right to own property, etc.; and,
- Such a policy is alien to most NGOs. It is very unlikely that governments and NGOs will operate under such a policy. In an international climate where donor assistance is decreasing and becoming selective such a policy will only marginalize Eritrea.

Because of the issues identified above, there is an international precedent of tax exemption for humanitarian assistance. Consequently, InterAction requests that the Ministry of Finance reconsider levying an income tax on expatriate NGO staff, under Legal Notice No. 20, in order to protect current and future assistance. We trust that this letter briefly expresses our concerns and hope you will pursue this matter with your Government to find a solution.

We appreciate your attention to this issue and would be happy to meet with you to discuss this issue further.

Sincerely,



Julia V. Taft
President and CEO

JVT/sd

CC: John Hicks, U.S. Ambassador to Eritrea
Glen Anders, USAID Eritrea Representative
Joseph Kennedy, Africare, Vice President
Victoria Sheffield, International Eye Foundation, Executive Director
Andrew Natsios, World Vision Relief and Development, Inc., Executive Director

ANNEX 8: REVIEWS OF DETAILED IMPLEMENTATION PLAN

REVIEW OF CSXI DETAILED IMPLEMENTATION PLANS (DIPS)

Summary of DIP Strengths and Weaknesses

Project: IEF/Eritrea Status (circle one): **New** **Expansion**

Reviewer's Name Sally K. Stansfield

Assigned Technical Area(s) EPI (25), CDD (15), PCM (15), Mal (15)

PART A - STRENGTHS

- The DIP is clear and well-written, and specifies an appropriate plan for phasing of interventions in this underserved and needy area.
- The plans for development of "quality assurance systems" are laudable. This intervention may be instrumental in building the capacity of the MOH to identify and solve problems.
- Another strength of the project lies in the plans for use of registers of mothers and children to monitor coverage with immunization and vitamin A supplementation and to track defaulters.
- The cold chain survey is an appropriate strategy to assist the MOH in monitoring and maintaining the effectiveness of the system.
- Although data are limited for the project area, the DIP makes good use of data from other sources in order to plan for project activities. Appropriate plans are incorporated to conduct a survey to address the information gaps, especially for the design of interventions for pneumonia case management, nutrition, and diarrheal disease control.
- The recognition of the importance to the community of epidemic measles, reflected in the decision to incorporate measles surveillance, is a project strength. It would help to clarify this activity, however, if a case definition had been included for the communities' use in identifying suspected cases.

- The project has strong collaboration with the MOH, which is principally responsible for implementation of project interventions. This arrangement bodes well for sustainability of project benefits.
- The DIP reflects a clear recognition of the "dire" implications of the late introduction of complementary foods in the project area. Interventions are appropriately targeted to address this critical problem.
- The plans to address issues of cost recovery are also appropriate. The DIP reflects the considerable thought which has already been given to the selection of strategies for cost recovery.

Signature: Sally K. Stangor

Date: 14/Jan/96

PART B - WEAKNESSES/AREAS FOR IMPROVEMENT/RECOMMENDATIONS

The change in project plan has resulted in a reduction of the population served from 300,000 to an estimated 30,000. This has resulted in a rather high cost per beneficiary.

** cost/beneficiary + program description of list of new objectives. → will need to rewrite budget.*

The reduction of beneficiaries to 10% of the number originally planned may be cause for reassessment of the budget and staffing patterns.

The objectives are generally reasonable, in light of the relatively small beneficiary population. The nutrition objective is well chosen, but may be associated with an overly ambitious target. Changes in weaning practices are clearly necessary in the project area, but will likely be somewhat difficult to achieve. Objectives #2 (% trained) and #3 (drug supplies) under the PCM and malaria interventions and objective #3 under EPI are simply activities in support of the care-seeking objectives (#1).

Reduce the target for the nutrition objective. The "objectives" which specify activities in support of EPI, PCM, and malaria represent intermediate process or quality indicators and should be tracked as such (rather than as project objectives).

The DIP points out that "EPI surveys will take place at least once every year during the project" and that the "MOH will be encouraged to complete its own survey of EPI coverage as well". *1/yr. ok. } combined. too many surveys.*

** weaning practices need to reduce.*

too many + see objectives vs "activities".

***Please sign and date each page below**

CSXI DIP Project Strengths and Weaknesses

PVO/Country Project

Reviewer's Name and Technical Area(s)

Signature

[Handwritten Signature]

Date

Page 3 of 3

Reconsider the plans to undertake such frequent surveys. Surveys twice more during the project period should be more than adequate for monitoring and evaluation.

No details are provided for any of the interventions about how quality of care will be assessed. Since there are plans to develop and deliver health education messages, it will also be important to assess the quality and effectiveness of these efforts.

As these interventions are further developed, determine the critical elements and key behaviors (for both providers and families) which might become the data needs for the "quality assurance system".

No information is provided regarding how the project will deal with chronic or bloody diarrhea.

Ensure that future annual reports specify how these issues will be addressed.

The pneumonia case management intervention remains sketchy, in part because more information is needed before strategies can be firmly developed. Some of these gaps could, however, have been addressed by outlining general approaches to strategy selection.

Provide a fuller description of the PCM intervention in future annual reports. Ensure that the current importance and planned future role of shopkeepers is addressed when discussing access to and use of antibiotics.

***Please sign and date each page below**

CSXI DIP Project Strengths and Weaknesses

PVO/Country Project

Reviewer's Name and Technical Area(s)

Signature Sally K. Stanger **Date** _____

The plans to treat children with the overlapping clinical diagnoses of pneumonia and malaria with cotrimoxazole are probably appropriate. Additional data should have been examined, however, to ensure that this policy is appropriate in light of the local epidemiology of malaria, including any drug resistance patterns.

It would be helpful to include any data regarding the proportion of malaria in the project area due to *falciparum* and to *vivax* in order to justify this decision.

of vivax characterizing

Also. not nec. have access to come by c stems up in KPC (REVISIT)

*Please sign and date each page below

CSXI DIP Project Strengths and Weaknesses

PVO/Country Project

Reviewer's Name and Technical Area(s)

Signature

Jelly K. Stantone

Date

Page 5 of 3

BASICS survey done where? Why such huge discrepancies?

Reported care seeking (i.e., for pneumonia) does not necessarily indicate adequate "access to health facilities or "an understanding of the need for care".

Are CHAs the same as "barefoot doctors"?

***Please sign and date each page below**

CSXI DIP Project Strengths and Weaknesses

PVO/Country Project

Reviewer's Name and Technical Area(s)

Signature

Sally K. Stanford

Date _____

**Detailed Implementation Plan
International Eye Foundation
Northern Red Sea Zone, Eritrea
Primary Health Care/Child Survival Project
9/30/95 - 9/29/99**

Reviewed by:

Tim Quick
AAAS Science & Diplomacy Fellow
USAID G/PHN/HN/CS

Overall, the detailed implementation plan (DIP) for IEF's PVC/CS project in the Northern Red Sea Zone of Eritrea is strong in the priorities that have been set and the approaches proposed. It reflects sensitivity and responsiveness to the particular situation in Eritrea at present -- for example, the extremely limited manpower and capacity within the MOH to implement programs. The full integration of the IEF project activities within the MOH may compromise short-term demonstrable results, but will benefit in capacity building and sustainability over the long-term. The phase-in strategy, beginning with EPI and vitamin A, followed by nutritional assessment for women and children, diarrhea case management, and ARI/malaria is practical and appropriate.

My greatest concern in this proposal is that the primary beneficiaries of this program are infants and children, but the primary implementors are mothers whose ability to respond and carry out activities may be compromised by their own malnutrition and poor health. Other than tetanus vaccinations and the possibility, in the long-term, of influencing dietary behaviors, this is not addressed in the DIP. I would suggest that, at a minimum, pregnant women be provided iron/folate supplements through TBAs or antenatal care. The prevalence of hookworm in this area is not indicated, but if it is a problem, deworming of pregnant women should be considered. Women, being more susceptible to malaria in pregnancy, might be targeted for insecticide-impregnated bednets (at least in the long-term) during this period. I appreciate the concern of IEF to focus its activities and to use a staged approach, but improving women's nutrition and health may be critical to improve birth outcomes, infant health and the ability of the mother to provide appropriate care for infants and children.

Specific comments:

p2-3: The goal of the project is to decrease infant and child morbidity and mortality in the Northern Red Sea Zone. However, the "measurable results", e.g. training and facilities assessment, comprehensive nutritional assessment, development and implementation of a nutrition communication strategy, distribution system for VA linked to EPI, the HIS, and cost-recovery system, may be important ACTIVITIES necessary (or on the "pathway", to use USAID-speak) to achieving results that contribute to the project goal, but these are not results in a conventional sense. This is not to quibble about semantics, but to express hope that the project will stay focused on results/objectives, as indicated on page 6, rather than on activities

(which may be very fluid given the challenges of Eritrea).

p5 (and throughout): Given the focus on EPI and VA, the DIP could be more explicit on how IEF and the project will link with other "players" for EPI and VA in Eritrea, including UNICEF, BASICS, and OMNI. For example, OMNI will be working with the MOH and UNICEF at the central level to develop a micronutrient strategy and, particularly, to strengthen the capacity within the MOH for nutrition/MN IEC. This will promote synergy rather than redundancy and will avoid further stretching the limited human resources of the MOH. Further, BHR/PVC has been given funds for TA from both OMNI and HKI to support the CS grants.

CONTACT ABT.

*POSSIBLE FOR OMNI TO ASSIST US
A BASICS AS WELL.*

*write to TB
mission
for plan
Eritrea*

p5 (and throughout): This is a very intensive program, i.e. evaluation of community needs, preliminary needs assessment for MOH training and facilities, strategy design for training and system strengthening, program monitoring and evaluation, and retraining across multiple interventions, that targets a relatively small (albeit needy) population at a substantial cost (the total grant probably approaches the annual aggregate GDP of this population). Even if the program objectives are achieved within the four years of the grant, how can these activities serve as models that can be replicated within Eritrea and the Greater Horn (this may be as much an issue for BHR/PVC as for IEF)? Will cost-effectiveness of the various aspects of the interventions and programs be evaluated such that this can guide MOH policy and program decisions beyond the lifetime of the IEF project in the Northern Red Sea Zone and elsewhere in the country?

*in
urgent*

p6: Re "80% of children 6-10 mo of age will receive appropriate weaning foods in addition to breast milk -- (1) I would encourage the use of "complementary" rather than "weaning" foods, (2) how is "appropriate" complementary foods to be determined, and (3) what is the basis for the 10 mo of age cut-off?

p6: Re "60% of children 6-71 mo of age will receive VA supplementation semi-annually", I don't believe the DIP actually indicates the schedule and manner in which this is to be done. It is also clear not clear what is the basis for setting the objective for providing VA to postpartum mothers at 30% or for limiting the "window" to 30 days post-delivery when WHO and IVACG have extended this to 1-2 months. A few suggestions:

(1) Since IEF anticipates working closely with TBAs and it is indicated that there is some use of safe-birthing kits, I would encourage the inclusion of the 200,000IU VAC for mothers to be included in the kit and to be given to mothers at birth. This is both opportunistic and it may be that it will be of greater benefit to the infant than if it is given to the mother weeks later (especially given the apparent high rate of breastfeeding and providing colostrum to newborns). Interestingly, a study in Indonesia that dosed newborns directly with 50,000IU of VA reduced infant mortality by 64% whereas giving the same dose to Nepalese infants but at later times in the 1st 2 mo of life showed no effect. There may be other reasons for this discrepancy and its not equivalent giving the VA to mom and elevating breast milk VA, but it MAY be beneficial to get the VA to the infant sooner rather than later. A number of studies are being implemented to address these issues.

*incubate
not some Q
all die +
may be connected
to VA capsule.*

(2) Even though there is a very high rate of exclusive breastfeeding, it can't be assumed that all infants are breastfed (maternal mortality must be fairly high) or fully breastfed -- for those infants, they should be given 25,000IU (WHO) or 50,000IU (IVACG) of VA at first contact within the first 6 mo of life. For all infants, how will VA administration be linked to EPI? DPT/OPV is scheduled at 6, 10, and 14 weeks of age and VA could be given at at least one of those contacts, as well as with the measles vaccine at 9 mo (there is not clear guidance on this from either WHO or IVACG). BASICS is proposing that VA (200,000IU) be provided to all children 1-6 yrs of age in conjunction with the Polio Initiative campaigns. This, however, would provide only one of at least two doses which should be administered each year -- the other(s) should be staggered 4-6 mo.

(3) With regard to VA and ICM, xerophthalmia (presumably health care workers will be trained in diagnosis of xerophthalmia) should be treated by VA on two consecutive days and again 1-4 wks later (according to IVACG, 50,000IU <6 mo of age, 100,000IU 6-12 mo of age, and 200,000IU >1 yr). In the presence of persistent PEM/kwashiorkor, IVACG recommends continuing dosing every 2-4 wks. With measles, treatment is similar with large doses on 2 consecutive days. For PEM, persistent diarrhea, ALRI and other acute infections, a single dose is provided and, with all these conditions, infants/children should be included in the VA prevention program. (Note: BASICS will be implementing its "MinPak" Initiative in Africa to integrate MN interventions with ICM -- these are consistent with what IEF is proposing in the DIP and this might serve as a "pilot" for this package).

(4) In response to the recent IVACG Policy Statement on clustering of xerophthalmia, all preschool siblings of children identified with xerophthalmia should be dosed with VA. Further, because of the greater risk of VAD in children living in proximity to xerophthalmic children, those communities should be specifically targeted for VA interventions (dietary, supplementation, and public health measures to relieve the burden of infection on children and mothers).

p8: How will IEF and Africare collaborate?

p12 (and throughout): The TBAs are to be central to a number of the interventions proposed by IEF and the DIP explains that they are compensated "in-kind" by the communities they serve. However, is it known or expected that the additional activities/interventions conducted through the TBAs will be recognized by their client households/communities as greater benefits and will the TBAs be compensated/remunerated accordingly? If not, what is the incentive for the TBAs to take on more responsibilities (and will this jeopardize sustainability)?

p13: With the very high rate of colostrum feeding and exclusive BF for 4-6 mo (and particularly if mothers are given VA at birth and possibly if infants are given VA with a DPT/OPV contact in the first 6 mo), it is unlikely VA status will be compromised except by recurrent and persistent infections. Thus, IEF has appropriately targeted complementary feeding practices and promotion of continued BF as critical to protect against the stunting and

Link VA to EPI
Be general a statement
lead to know each
Contact point

4/4

malnutrition that is common in Eritrean infants between 6-24 mo of age. The dietary assessment and formative research on dietary/cultural practices will be critical in identifying strategies to improve diets for both children and women.

p15: OMNI/UNICEF/MOH is taking the lead in salt iodization/IDD activities in Eritrea -- the emphasis is on quality assurance of iodized salt production and monitoring the levels of I (KIO₃) in the salt at point of consumption (household), probably through school surveys. While IEF may be requested to provide some logistical support to USI/IDD activities in the Northern Red Sea Zone, this should be very secondary to other nutrition and health activities.

p16: The DIP discusses the need to continue feeding during illness/diarrhea, but does not indicate that it will promote recovery feeding.

p17: "...personal hygiene to control and prevent diarrhea" is defined as?

p32: Re cost recovery, IEF might discuss this with its Bethesda neighbor, Partnerships for Health Reform (ABT Associates).

Iodization

IEC - Benedict
Tech - RITZ Vanderhoff (FRAN)
Mgt - Marg. Mc Ginnige.

ANNEX 9: DRAFT COUNTRY AGREEMENT

DRAFT

An Agreement Between

THE MINISTRY OF HEALTH OF THE STATE OF ERITREA

and

THE INTERNATIONAL EYE FOUNDATION

for a
CHILD SURVIVAL AND PRIMARY HEALTH CARE PROJECT
IN THE NORTHEASTERN RED SEA ZONE, NORTH OF MASSAWA

The Ministry of Health of the State of Eritrea (MOH) and the International Eye Foundation (IEF) agree to undertake a Child Survival Project in the Northeastern Red Sea Zone, North of Massawa, jointly as set forth in this Agreement (the Agreement). Unless specifically provided otherwise, the provisions of this Agreement and any obligation undertaken by the MOH or any facility, concession or privilege granted to IEF or any member thereof should apply for the duration of the Agreement and in Eritrea only.

Status of the Organization in Eritrea

The MOH recognises the International Eye Foundation (IEF), based at 7801 Norfolk Avenue, Bethesda, Maryland 20814 USA, as a private voluntary organization dedicated to the prevention and cure of blindness and child survival worldwide.

Members of the IEF shall refrain from any activity of a political nature in Eritrea and form any action or activity incompatible with the purpose of their mission and the nature of their duties or inconsistent with the spirit of the Agreement.

If the IEF wishes to establish an office in Eritrea, the IEF must first reach a separate agreement with the relevant governmental body, which is the Eritrea Relief and Rehabilitation Agency (ERRA).

I. THE OBLIGATIONS OF THE IEF.

Under the terms of the Agreement, IEF undertakes to support the provision of child survival and primary health care activities in the Northeastern Red Sea Zone, north of Massawa as set forth below.

Nature of the work.

In requesting assistance from IEF for child survival and primary health care activities, the Ministry aims to set in motion a process for the introduction and establishment of a primary health care system which meets the needs of those living in the Northeastern Red Sea Zone, north of Massawa. One of the Ministry's greatest assets is its members who are capable, committed and well-experienced. But after decades of isolation

from international contact and support, many managers and providers need further training and support to extend and update their knowledge base as well as to ensure that their practical skills give a high quality of care. This request for assistance is a vital, timely and complementary component of the Government's strategy to establish a system for the provision of primary health care. Responsibility for primary health care remains with the Ministry throughout this programme of external support, ensuring its relevance to the work of the Ministry and its sustainability in the longer-term. The specific contribution of IEF with the project description and budgetary terms and grant provisions of IEF's donors will be to:-

1. Provide material support in the form of furnishings and supplies for selected rural health stations.
2. Support a programme of immunisations for women and children.
3. Promote oral rehydration therapy for the management of diarrhoea.
4. Train and equip community- and health station-based outreach workers.
5. Assist with the development of MOH policy on community health workers and community-based health services through applied study and analysis.
6. Promote good nutrition among women and young children.
7. Promote early diagnosis of malaria and acute respiratory infections as well as appropriate treatment.
8. Support a programme of vitamin A supplementation semi-annually for women and children.

Timetable for implementation.

IEF will concert its best efforts to provide its scheduled support of this Child Survival and Primary Health Care (CS and PHC) Project from the date of signing through 29 September 1999, within the general framework of the agreed Field Project design and budget, and within the framework of a further Detailed Implementation Plan (DIP) and updated budget that the MOH/IEF will complete for IEF submission to its donors no later than 31 March 1996, provided subsequent concurrence is received from its donors.

Resource contributions.

1. Funds to the MOH for: developing the project; training and supporting health personnel; delivering health services; monitoring, evaluating and reporting on the project.
2. Equipment and supplies for the project from sources outside Eritrea.

Administration of project funds

Funds provided by IEF for CS and PHC activities, as outlined above, will be transferred to the MOH. Funds budgeted for the first quarter of the first year will be transferred following the signing of this Agreement. Funds for the following quarters of the first, second, third and fourth

years of the project will be transferred quarterly based upon submission by the MOH and IEF of agreed financial reports.

Oversight and control.

Ultimate responsibility for primary health care lies with the MOH. The immediate oversight and control of the support given by IEF will be the responsibility of the MOH, through the Zonal Health Department for the Northeastern Red Sea Zone, as coordinated by the Minister's Office.

Reporting

The IEF CS and PHC Project Advisor will prepare, in collaboration with the MOH, quarterly progress and financial reports on this project for submission to the Ministry, IEF and its donors.

Adherence to Ministry of Health policies.

The health and medical services supported by IEF will: adhere to the policies of the Ministry of Health for the organization and implementation of health interventions; conform to the reporting system of the Ministry of health for routine disease surveillance, epidemics, and on-going health activities (using the forms so provided by the Ministry of Health) as well as reporting requirements of the Ministry of Health more generally; and be executed in close cooperation with the Zonal Health Department and the central office of the MOH. The obligations of IEF under Agreement shall in no way be construed so as to require either IEF itself, a member or employee of it, or an Eritrean employee to act in any manner that is contrary to the Constitution of IEF or to the mission of IEF itself.

Local health personnel.

Since project direction, oversight and implementation will be carried out by the MOH as part of its normal responsibilities, the IEF Project Advisor will work in close collaboration with the Zonal Health Officials, including the Director and those responsible for training, health management information systems and administration/accounting, as well as the personnel based north of Massawa to carry out the CS and PHC activities.

Foreign health personnel.

The IEF will secure the approval for all expatriate health personnel to practice their profession in the context of this Agreement from the Ministry of Health prior to their arrival. To assist the Ministry of Health in evaluating their relevant qualifications and experience for approval, the following will be submitted:

- a. Two copies of their full curriculum vitae which details their professional qualifications, professional (post-graduate) experience, and official appointments;
- b. Two passport-size photographs;
- c. Notarized copies of professional certificates, educational degrees, and current license to practice;
- d. A certificate of physical and mental fitness to practice; and
- e. Two letters of recommendation, one of which will normally be from their most recent employer.

The MOH shall accept as valid permits and licenses for the practice of health professions or occupations in connection with this Agreement on the basis of the documentation outlined above.

Expatriate members will abide by the regulations governing aliens in Eritrea. They will refrain from any activity of a political nature in Eritrea and from any other action or activity incompatible with the purpose of IEF.

Agency representative

The IEF will designate an individual to liaise with, or represent the IEF in its dealings with the Government of Eritrea, and will notify in writing the Ministry of Health (and other appropriate government offices) of such appointment and any changes thereto. The IEF has appointed Rita Malkki as their liaison person or representative under the terms of this Agreement. The expatriate Child Survival and Primary Health Care Project Advisor for IEF will be Rita Malkki.

The Representative shall take all appropriate measures to ensure the observance of the obligations of this Agreement. She shall also take all appropriate measures to ensure the maintenance of discipline and good order among expatriate members and locally recruited personnel.

II. THE OBLIGATIONS OF THE MINISTRY OF HEALTH.

Under the terms of this Agreement, the Ministry of Health undertakes to encourage and facilitate the IEF's work as set forth below.

Approval of the work.

The Ministry of Health hereby grants its approval to the IEF to support Child Survival and Primary Health Care activities in the Northeastern Red Sea Zone, north of Massawa.

Nature of the work and resource contributions.

1. Policy guidance and in-kind support by central and zonal staff to key project planning, implementation, monitoring and evaluation activities.
2. To assume all responsibility for costs associated with the programmes established for child survival at the end of the project period.

Ministry of Health policies.

The Ministry of Health will provide IEF with copies of the Ministry's policies relevant to the provision of child survival and primary health care services.

Quality assurance.

The MOH will periodically consult with the IEF to review and evaluate child survival and primary health care activities provided through the Child Survival and Primary Health Care Project in the Northeastern Red Sea

Zone, north of Massawa to ensure that such services conform to a high standard of care and standards set by the MOH.

Visas, work permits, and residency documents.

The Ministry of Health will, upon request of the IEF representative, assist the IEF in securing the necessary visas, work permits, or other residency documents for the members of the IEF to accomplish the purposes of this Agreement.

Importation of project goods and personal effects.

Project-related equipment, supplies and vehicles as necessary for activities during the duration of the project may be imported free of duties and taxation. Personal effects and one personal vehicle belonging to the Project Advisor may be imported free of duties and taxation, with the understanding that these items will accompany the Project Advisor out of Eritrea upon his/her departure. Project-related equipment, supplies and vehicles will become the property of the Ministry of Health upon completion of the project.

Foreign permits and licenses.

The Ministry of Health will, upon the request of the IEF representative, assist the IEF in securing the Government's acceptance of permits of licenses issued to expatriate members of the IEF by another country as valid for the operation of transport or communication equipment within Eritrea, and for the practice of any profession or occupation in connection with the programme outlined in this Agreement.

Reporting

The MOH shall manage and account for use of IEF-provided funds in compliance with the development assistance policies of the MOH, IEF and IEF's donors, and shall make available for annual audit by IEF the project's sub-ledger and supporting documentation. The MOH shall collaborate with IEF's CS and PHC Project Advisor in the preparation of quarterly project financial and progress reports for IEF's donors.

III. THE AGREEMENT.

The Agreement shall enter into force upon signature of the IEF representative and duly authorized representative of the Ministry of Health and shall remain in force for a period of four years. Either party may terminate the Agreement by giving the other party three months written notice of such intention to terminate or upon breach of this Agreement. Either party may propose amendments to the Agreement which shall become effective upon the signature of the IEF representative and the duly authorized representative of the Ministry of Health. The IEF and the Ministry of Health may include supplemental arrangements or understandings to the Agreement.

In witness whereof the undersigned duly authorized representatives of IEF and the Government of Eritrea, respectively, have signed this agreement in two copies in English.

Neither party to this Agreement shall be held by the other party, for compensation from the death, disability, or other hazard suffered by an employee of the other party, as a result of their employment in the work financed under the programme agreed upon by the parties, the party employing him/her being solely responsible in respect of all claims that may arise therefrom.

For and on behalf of the International Eye Foundation:

Signature _____
Name _____
Title _____
Place, Date _____

For and on behalf of the Ministry of Health:

Signature _____
Name _____
Title _____
Place, Date _____

ANNEX 10: BUDGET PIPELINE ANALYSIS

55

1996 PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

| | | Actual Expenditures to Date 09/30/95 to 6/30/96 | | | Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99 | | | Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99 | | |
|---|--|--|---------------|----------------|---|----------------|------------------|---|----------------|------------------|
| | | AID | PVO | TOTAL | AID | PVO | TOTAL | AID | PVO | TOTAL |
| I. DIRECT COSTS | | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | | | | | | | | | | |
| 1. | Headquarters-wages/salaries | 7,443 | 7,251 | 14,694 | 50,579 | 50,771 | 101,350 | 58,022 | 58,022 | 116,044 |
| 2. | Field, Technical Personnel-wages/salaries | 11,693 | 11,692 | 23,385 | 228,975 | (11,692) | 217,283 | 240,668 | 0 | 240,668 |
| 3. | Field, Other Personnel-wages/salaries | 0 | 0 | 0 | 37,499 | 0 | 37,499 | 37,499 | 0 | 37,499 |
| 4. | Fringes - Headquarters + Field | 4,597 | 4,713 | 9,310 | 94,068 | 12,694 | 106,762 | 98,665 | 17,407 | 116,072 |
| SUBTOTAL - PERSONNEL | | 23,733 | 23,656 | 47,389 | 411,121 | 51,773 | 462,894 | 434,854 | 75,429 | 510,283 |
| B. TRAVEL/PER DIEM | | | | | | | | | | |
| 1. | Headquarters - Domestic (USA) | 414 | 580 | 994 | 381 | 775 | 1,156 | 795 | 1,355 | 2,150 |
| 2. | Headquarters - International | 2,581 | 3,074 | 5,655 | 40,756 | 15,460 | 56,216 | 43,337 | 18,534 | 61,871 |
| 3. | Field - in country | 7,691 | 0 | 7,691 | 118,409 | 0 | 118,409 | 126,100 | 0 | 126,100 |
| 4. | Field - International | 3,457 | 2,323 | 5,780 | 42,095 | 4,177 | 46,272 | 45,552 | 6,500 | 52,052 |
| SUBTOTAL - TRAVEL/PER DIEM | | 14,143 | 5,977 | 20,120 | 201,641 | 20,412 | 222,053 | 215,784 | 26,389 | 242,173 |
| C. CONSULTANCIES | | | | | | | | | | |
| 1. | Evaluation Consultants - Fees | 0 | 0 | 0 | 0 | 10,500 | 10,500 | 0 | 10,500 | 10,500 |
| 2. | Other Consultants - Fees | 0 | 0 | 0 | 20,500 | 7,500 | 28,000 | 20,500 | 7,500 | 28,000 |
| 3. | Consultant travel/per diem | 3,255 | 175 | 3,430 | (3,255) | 6,225 | 2,970 | 0 | 6,400 | 6,400 |
| SUBTOTAL - CONSULTANCIES | | 3,255 | 175 | 3,430 | 17,245 | 24,225 | 41,470 | 20,500 | 24,400 | 44,900 |
| D. PROCUREMENT (provide justification/explanation narrative) | | | | | | | | | | |
| 1. Supplies | | | | | | | | | | |
| a. | Headquarters | 0 | 574 | 574 | 19,000 | (574) | 18,426 | 19,000 | 0 | 19,000 |
| b. | Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | 0 | 0 | 0 | 12,100 | 24,000 | 36,100 | 12,100 | 24,000 | 36,100 |
| c. | Field - Other | 1,758 | 615 | 2,373 | 2,242 | (615) | 1,627 | 4,000 | 0 | 4,000 |
| 2. Equipment | | | | | | | | | | |
| a. | Headquarters | 0 | 0 | 0 | 0 | 2,000 | 2,000 | 0 | 2,000 | 2,000 |
| b. | Field | 0 | 3,513 | 3,513 | 0 | 75,787 | 75,787 | 0 | 79,300 | 79,300 |
| 3. Training | | | | | | | | | | |
| a. | Headquarters | 0 | 12 | 12 | 0 | (12) | (12) | 0 | 0 | 0 |
| b. | Field | 833 | 0 | 833 | 8,649 | 12,000 | 20,649 | 9,482 | 12,000 | 21,482 |
| SUBTOTAL - PROCUREMENT | | 2,591 | 4,714 | 7,305 | 41,991 | 112,586 | 154,577 | 44,582 | 117,300 | 161,882 |
| E. OTHER DIRECT COSTS (provide justification/explanation narrative) | | | | | | | | | | |
| 1. Communications | | | | | | | | | | |
| a. | Headquarters | 0 | 1,171 | 1,171 | 0 | 9,629 | 9,629 | 0 | 10,800 | 10,800 |
| b. | Field | 930 | 0 | 930 | 15,870 | 0 | 15,870 | 16,800 | 0 | 16,800 |
| 2. Facilities | | | | | | | | | | |
| a. | Headquarters | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| b. | Field | 7,962 | 4,200 | 12,162 | (4,762) | 15,800 | 11,038 | 3,200 | 20,000 | 23,200 |
| 3. Other | | | | | | | | | | |
| a. | Headquarters | 0 | 135 | 135 | 0 | 5,265 | 5,265 | 0 | 5,400 | 5,400 |
| b. | Field | 13,748 | 2,640 | 16,388 | 55,803 | (2,640) | 53,163 | 69,551 | 0 | 69,551 |
| SUBTOTAL - OTHER DIRECT | | 22,640 | 8,146 | 30,786 | 66,911 | 28,054 | 94,965 | 89,551 | 36,200 | 125,751 |
| TOTAL - DIRECT COSTS | | 66,362 | 42,668 | 109,030 | 738,910 | 237,050 | 975,960 | 805,272 | 279,718 | 1,084,990 |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | | | | | | | | | | |
| 1. | Headquarters | 10,206 | 6,022 | 16,228 | 120,248 | 26,120 | 146,368 | 130,454 | 32,142 | 162,596 |
| 2. | Field (if applicable) | | | | | | | | | |
| TOTAL - INDIRECT COSTS | | 10,206 | 6,022 | 16,228 | 120,248 | 26,120 | 146,368 | 130,454 | 32,142 | 162,596 |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | 76,568 | 48,690 | 125,258 | 859,158 | 263,170 | 1,122,328 | 935,726 | 311,860 | 1,247,586 |

1996 PIPELINE ANALYSIS: PART B - FIELD BUDGET

| | | Actual Expenditures to Date 09/30/95 to 6/30/96 | | | Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99 | | | Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99 | | |
|--|---|--|---------------|---------------|---|-----------------|----------------|---|----------------|----------------|
| | | AID | PVO | TOTAL | AID | PVO | TOTAL | AID | PVO | TOTAL |
| I. DIRECT COSTS | | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | | | | | | | | | | |
| | 1. Headquarters-wages/salaries | | | 0 | 0 | 0 | 0 | | | 0 |
| | 2. Field, Technical Personnel-wages/salaries | 11,693 | 11,692 | 23,385 | 228,975 | (11,692) | 217,283 | 240,668 | 0 | 240,668 |
| | 3. Field, Other Personnel-wages/salaries | 0 | 0 | 0 | 37,499 | 0 | 37,499 | 37,499 | 0 | 37,499 |
| | 4. Fringes - Headquarters + Field | 3,508 | 3,508 | 7,016 | 68,693 | (3,508) | 65,185 | 72,200 | 0 | 72,200 |
| | SUBTOTAL - PERSONNEL | 15,201 | 15,200 | 30,401 | 335,167 | (15,200) | 319,967 | 350,368 | 0 | 350,368 |
| B. TRAVEL/PER DIEM | | | | | | | | | | |
| | 1. Headquarters - Domestic (USA) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2. Headquarters - International | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 3. Field - in country | 7,691 | 0 | 7,691 | 118,409 | 0 | 118,409 | 126,100 | 0 | 126,100 |
| | 4. Field - International | 3,457 | 2,323 | 5,780 | 42,095 | 4,177 | 46,272 | 45,552 | 6,500 | 52,052 |
| | SUBTOTAL - TRAVEL/PER DIEM | 11,148 | 2,323 | 13,471 | 160,504 | 4,177 | 164,681 | 171,652 | 6,500 | 178,152 |
| C. CONSULTANCIES | | | | | | | | | | |
| | 1. Evaluation Consultants - Fees | 0 | 0 | 0 | 0 | 10,500 | 10,500 | 0 | 10,500 | 10,500 |
| | 2. Other Consultants - Fees | 0 | 0 | 0 | 20,500 | 7,500 | 28,000 | 20,500 | 7,500 | 28,000 |
| | 3. Consultant travel/per diem | 3,255 | 175 | 3,430 | (3,255) | 6,225 | 2,970 | 0 | 6,400 | 6,400 |
| | SUBTOTAL - CONSULTANCIES | 3,255 | 175 | 3,430 | 17,245 | 24,225 | 41,470 | 20,500 | 24,400 | 44,900 |
| D. PROCUREMENT (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Supplies | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | 0 | 0 | 0 | 12,100 | 24,000 | 36,100 | 12,100 | 24,000 | 36,100 |
| | c. Field - Other | 1,758 | 615 | 2,373 | 2,242 | (615) | 1,627 | 4,000 | 0 | 4,000 |
| | 2. Equipment | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 0 | 3,513 | 3,513 | 0 | 75,787 | 75,787 | 0 | 79,300 | 79,300 |
| | 3. Training | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 833 | 0 | 833 | 8,649 | 12,000 | 20,649 | 9,482 | 12,000 | 21,482 |
| | SUBTOTAL - PROCUREMENT | 2,591 | 4,128 | 6,719 | 22,991 | 111,172 | 134,163 | 25,582 | 115,300 | 140,882 |
| E. OTHER DIRECT COSTS (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Communications | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 930 | 0 | 930 | 15,870 | 0 | 15,870 | 16,800 | 0 | 16,800 |
| | 2. Facilities | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 7,962 | 4,200 | 12,162 | (4,762) | 15,800 | 11,038 | 3,200 | 20,000 | 23,200 |
| | 3. Other | | | | | | | | | |
| | a. Headquarters | | | 0 | 0 | 0 | 0 | | | 0 |
| | b. Field | 13,748 | 2,640 | 16,388 | 55,803 | (2,640) | 53,163 | 69,551 | 0 | 69,551 |
| | SUBTOTAL - OTHER DIRECT | 22,640 | 6,840 | 29,480 | 66,911 | 13,160 | 80,071 | 89,551 | 20,000 | 109,551 |
| TOTAL - DIRECT COSTS | | 54,835 | 28,666 | 83,501 | 602,818 | 137,534 | 740,352 | 657,653 | 166,200 | 823,853 |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | | | | | | | | | | |
| | 1. Headquarters | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2. Field (if applicable) | | | | | | | | | |
| TOTAL INDIRECT COSTS | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | 54,835 | 28,666 | 83,501 | 602,818 | 137,534 | 740,352 | 657,653 | 166,200 | 823,853 |

1996 PIPELINE ANALYSIS: PART A - HEADQUARTERS BUDGET

| | | Actual Expenditures to Date 09/30/95 to 6/30/96 | | | Projected Expenditures Against Remaining Obligated Funds 07/01/96 to 09/29/99 | | | Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99 | | |
|---|---|--|---------------|---------------|---|----------------|----------------|---|----------------|----------------|
| | | AID | FVC | TOTAL | AID | FVC | TOTAL | AID | FVC | TOTAL |
| I. DIRECT COSTS | | | | | | | | | | |
| A. PERSONNEL (salaries, wages, fringes) | | | | | | | | | | |
| | 1. Headquarters-wages/salaries | 7,443 | 7,251 | 14,694 | 50,579 | 50,771 | 101,350 | 58,022 | 58,022 | 116,044 |
| | 2. Field, Technical Personnel-wages/salaries | | | 0 | 0 | 0 | 0 | | | 0 |
| | 3. Field, Other Personnel-wages/salaries | | | 0 | 0 | 0 | 0 | | | 0 |
| | 4. Fringes - Headquarters + Field | 1,089 | 1,205 | 2,295 | 25,376 | 16,202 | 41,577 | 26,465 | 17,407 | 43,872 |
| | SUBTOTAL - PERSONNEL | 8,532 | 8,456 | 16,989 | 75,955 | 66,973 | 142,927 | 84,487 | 75,429 | 159,916 |
| B. TRAVEL/PER DIEM | | | | | | | | | | |
| | 1. Headquarters - Domestic (USA) | 414 | 580 | 994 | 381 | 775 | 1,156 | 795 | 1,355 | 2,150 |
| | 2. Headquarters - International | 2,581 | 3,074 | 5,655 | 40,756 | 15,460 | 56,216 | 43,337 | 18,534 | 61,871 |
| | 3. Field - in country | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 4. Field - International | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | SUBTOTAL - TRAVEL/PER DIEM | 2,995 | 3,654 | 6,649 | 41,137 | 16,235 | 57,372 | 44,132 | 19,889 | 64,021 |
| C. CONSULTANCIES | | | | | | | | | | |
| | 1. Evaluation Consultants - Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2. Other Consultants - Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 3. Consultant travel/per diem | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | SUBTOTAL - CONSULTANCIES | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| D. PROCUREMENT (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Supplies | | | | | | | | | |
| | a. Headquarters | 0 | 574 | 574 | 19,000 | (574) | 18,426 | 19,000 | 0 | 19,000 |
| | b. Field - Pharmaceuticals (ORS, Vit. A, drugs, etc.) | | | 0 | 0 | 0 | 0 | | | 0 |
| | c. Field - Other | | | 0 | 0 | 0 | 0 | | | 0 |
| | 2. Equipment | | | | | | | | | |
| | a. Headquarters | 0 | 0 | 0 | 0 | 2,000 | 2,000 | 0 | 2,000 | 2,000 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | 3. Training | | | | | | | | | |
| | a. Headquarters | 0 | 12 | 12 | 0 | (12) | (12) | 0 | 0 | 0 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | SUBTOTAL - PROCUREMENT | 0 | 586 | 586 | 19,000 | 1,414 | 20,414 | 19,000 | 2,000 | 21,000 |
| E. OTHER DIRECT COSTS (provide justification/explanation narrative) | | | | | | | | | | |
| | 1. Communications | | | | | | | | | |
| | a. Headquarters | 0 | 1,171 | 1,171 | 0 | 9,629 | 9,629 | 0 | 10,800 | 10,800 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | 2. Facilities | | | | | | | | | |
| | a. Headquarters | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | 3. Other | | | | | | | | | |
| | a. Headquarters | 0 | 135 | 135 | 0 | 5,265 | 5,265 | 0 | 5,400 | 5,400 |
| | b. Field | | | 0 | 0 | 0 | 0 | | | 0 |
| | SUBTOTAL - OTHER DIRECT | 0 | 1,306 | 1,306 | 0 | 14,894 | 14,894 | 0 | 16,200 | 16,200 |
| TOTAL - DIRECT COSTS | | 11,527 | 14,002 | 25,530 | 136,092 | 99,516 | 235,607 | 147,619 | 113,518 | 261,137 |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | | | | | | | | | | |
| | 1. Headquarters | 10,206 | 6,022 | 16,228 | 120,248 | 26,120 | 146,368 | 130,454 | 32,142 | 162,596 |
| | 2. Field (if applicable) | | | | | | | | | |
| TOTAL INDIRECT COSTS | | 10,206 | 6,022 | 16,228 | 120,248 | 26,120 | 146,368 | 130,454 | 32,142 | 162,596 |
| GRAND TOTAL (DIRECT AND INDIRECT COSTS) | | 21,733 | 20,024 | 41,758 | 256,340 | 125,636 | 381,975 | 278,073 | 145,660 | 423,733 |