

Agency for International Development
Washington, D.C. 20523

938-0500

PDFCU-694

SEP 23 1991

Mr. Arnold Simonse
President
International Eye Foundation
7801 Norfolk Avenue
Bethesda, MD 20814

Subject: Cooperative Agreement No. PDC-0284-A-00-1123-00

Dear Mr. Simonse:

Pursuant to the authority contained in the Foreign Assistance Act of 1961 and the Federal Grant and Cooperative Agreement Act of 1982, as amended, the Agency for International Development (hereinafter referred to as "A.I.D.") hereby provides to International Eye Foundation (hereinafter referred to as "IEF" or "Recipient") the sum set forth in Section 1C.2. of Attachment 1 of this Cooperative Agreement to provide financial support for the program described in Attachment 2 of this Cooperative Agreement entitled "Program Description."

This Cooperative Agreement is effective as of the date of this letter and funds obligated hereunder shall be used to reimburse the Recipient for allowable program expenditures for the period set forth in Section 1B. of Attachment 1 of this Cooperative Agreement.

The total estimated amount of this Cooperative Agreement is the amount set forth in Section 1C.1. of Attachment 1, of which the amount set forth in Section 1C.2. is hereby obligated. A.I.D. shall not be liable for reimbursing the Recipient for any costs in excess of the obligated amount. However, subject to Section 1C.4. of Attachment 1, additional funds may be obligated by A.I.D. until such time as the obligated amount may equal the total estimated amount of this Cooperative Agreement.

This Cooperative Agreement is made to the Recipient on the condition that the funds will be administered in accordance with the terms and conditions as set forth in the attachments listed under my signature below, which together constitute the entire Cooperative Agreement document and have been agreed to by your organization.

Please acknowledge receipt and acceptance of this Cooperative Agreement by signing all copies of this Cover Letter, retaining one copy for your files, and returning the remaining copies to the undersigned.

Sincerely yours,

Edward H. Thomas

Edward H. Thomas
Grant Officer
A.I.D./W Projects Division
Office of Procurement

Attachments:

1. Schedule
2. Program Description
3. Standard Provisions
4. Special Provision entitled "Restrictions on Lobbying"
5. A.I.D. Eligibility Rules
6. Closeout Procedures

ACKNOWLEDGED:

INTERNATIONAL EYE FOUNDATION

BY: *Victoria M. Sheffield*

TYPED NAME: Victoria M. Sheffield

TITLE: Executive Director

DATE: September 26, 1991

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FISCAL DATAA. GENERAL

- A.1. Total Estimated A.I.D. Amount: \$800,000
- A.2. Total Obligated A.I.D. Amount: \$750,000
- A.3. Cost-Sharing Amount (Non-Federal): \$264,570
- A.4. Other Contributions (Federal): \$ - 0 -
- A.5. Project No.: 938-0284 and 938-0500
- A.6. A.I.D. Project Office: FVA/PVC/CSH, Habis, C.
- A.7. Funding Source: A.I.D./W
- A.8. Tax I.D. No.: 52-0742301
- A.9. DUNS No.: 08-234-3377
- A.10. LOC No.: 72-00-1459

B. SPECIFIC

- B.1.(a) PIO/T No.: 938-0500-1385020 (\$250,000) and
938-0284-1381207 (\$500,000)
- B.1.(b) Appropriation: 72-1111021.7 (\$250,000) and
72-1111021.3 (\$500,000)
- B.1.(c) Allotment: 147-38-099-00-76-11 (\$250,000) and
143-38-099-00-76-11 (\$500,000)
- B.1.(d) BPC: EDCA-91-13810-KG11 (\$250,000) and
EDNA-91-13810-KG11 (\$500,000)
- B.1.(e) Amount: \$750,000

ATTACHMENT 1SCHEDULE1A. PURPOSE OF COOPERATIVE AGREEMENT

The purpose of this Cooperative Agreement is to provide financial support for the program described in Attachment 2 of this Cooperative Agreement entitled "Program Description."

1B. PERIOD OF COOPERATIVE AGREEMENT

1B.1. The effective date of this Cooperative Agreement is the date of the Cover Letter and the estimated completion date is August 31, 1994. Funds obligated hereunder (see Section 1C.2. below) shall be used to reimburse the Recipient for allowable program expenditures incurred by the Recipient in pursuit of program objectives at any time during the period beginning on the effective date of this Cooperative Agreement and ending on the estimated completion date.

1B.2. However, because this Cooperative Agreement is incrementally funded (see Section 1C.4. below), funds obligated hereunder are only anticipated to be sufficient for program expenditures through June 15, 1994.

1C. AMOUNT OF COOPERATIVE AGREEMENT AND PAYMENT

1C.1. The total estimated amount of this Cooperative Agreement for its full period, as set forth in Section 1B.1. above, is \$800,000.

1C.2. A.I.D. hereby obligates the amount of \$750,000 as partial funding of the total estimated amount set forth in Section 1C.1. above for program expenditures during the indicated period set forth in Section 1B. above. Notwithstanding said total estimated amount, A.I.D. shall not be liable for reimbursing the Recipient for any costs in excess of the obligated amount, except as specified in paragraph (f) of the Standard Provision of this Cooperative Agreement entitled "Revision of Grant Budget" (see also Section 1C.4. below).

1C.3. Payment shall be made to the Recipient in accordance with procedures set forth in the Standard Provision of this Cooperative Agreement entitled "Payment - Letter of Credit," as shown in Attachment 3.

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1C.4. As indicated in Section 1C.2. above, this Cooperative Agreement is partially funded. Until such time as the obligated amount (see Section 1C.2. above) shall equal the total estimated amount (see Section 1C.1. above) of this Cooperative Agreement, additional increments of funds may be obligated by A.I.D. under this Cooperative Agreement (by a Cooperative Agreement modification), subject to availability of funds, possible evaluation of the program, program priorities at the time, and the requirements of the Standard Provisions of this Cooperative Agreement entitled "Revision of Grant Budget" and, if applicable (see Section 1K.2. for applicability) "Cost Sharing (Matching)," as set forth in Attachment 3.

1C.5. The total estimated amount of the program described in Attachment 2 of this Cooperative Agreement is \$1,064,570, of which A.I.D. may provide the amount specified in Section 1C.1. above, and the Recipient will provide \$264,570 in accordance with Section 1L. below.

1D. COOPERATIVE AGREEMENT BUDGET

1D.1. The following is the Budget for the total estimated amount of this Cooperative Agreement (see Section 1C.1. above) for its full period (see Section 1B. above). The Recipient may not exceed the total estimated amount or the obligated amount of this Cooperative Agreement, whichever is less (see Sections 1C.1. and 1C.2., respectively, above). Except as specified in the Standard Provision of this Cooperative Agreement entitled "Revision of Grant Budget," as shown in Attachment 3, the Recipient may adjust line item amounts as may be reasonably necessary for the attainment of program objectives.

Revisions to the budget shall be in accordance with Section 1C. above and the Standard Provisions entitled "Revision of Grant Budget" and "Cost Sharing (Matching)."

1D.2. Budget

Cost Element	A.I.D.	Recipient/ Others (Non-Fed)	Total
Salaries	\$258,355	\$ 71,870	\$ 330,225
Fringe	95,884	19,166	115,050
Equipment/Maint.	10,450	14,200	24,650
Supplies	38,975	22,775	61,750
Evaluation Serv.	17,800	13,650	31,450
Travel/Transp Office/vehicle	129,950	58,950	188,900
Operation	91,621	16,800	108,421
Indirect Costs	<u>156,965</u>	<u>49,896</u>	<u>206,861</u>
	<u>\$800,000</u>	<u>\$267,316</u>	<u>\$1,067,307</u>

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1D.3. Inclusion of any cost in the budget of this Cooperative Agreement does not obviate the requirement for prior approval by the Agreement Officer of cost items designated as requiring prior approval by the applicable cost principles (see the Standard Provision of this Cooperative Agreement set forth in Attachment 3 entitled "Allowable Costs") and other terms and conditions of this Cooperative Agreement, unless specifically stated in Section 1I. below.

1E. REPORTING

1E.1. Financial Reporting

1E.1.(a) Financial reporting requirements shall be in accordance with the Standard Provision of this Cooperative Agreement entitled "Payment - Letter of Credit," as shown in Attachment 3.

1E.1.(b) All financial reports shall be submitted to A.I.D., Office of Financial Management, FA/FM/CMPD/DC, Room 700 SA-2, Washington, D.C. 20523-0209. In addition, three copies of all financial reports shall be submitted to the A.I.D. Project Office specified in the Cover Letter of this Cooperative Agreement, concurrently with submission of the Quarterly Technical Reports (See Section 1E.2. below).

1E.1.(c) The frequency of financial reporting and the due dates of reports shall be as specified in the Standard Provision of this Cooperative Agreement referred to in Section 1E.1.(a) above.

1E.1.(d) The Recipient's financial reports shall include expenditures of A.I.D. Cooperative Agreement funds provided hereunder, as well as non-federal matching funds and any other contributions in accordance with Section 1L. below.

1E.2(a) Detailed Implementation Plan

The Recipient shall submit a Detailed Implementation Plan (DIP) for each country program by April 1, 1992 in accordance with FVA/PVC guidelines. (Illustrative guidelines are available from FVA/PVC and will be furnished to you in the Fall of 1991.) This implementation plan should include a description of how the various child survival interventions will be

evaluated and should clearly define: (a) the objectives and outputs that each program will be held accountable for; (b) the specific indicators that will be used to measure program success in reaching objectives and outputs; (c) mechanisms for collecting data, i.e. surveys, sentinel systems, etc.; and (d) manpower and other resources needed for carrying out monitoring and evaluation activities with a revised budget. The DIP should include scheduled reports, internal and external evaluations, and line item budgets.

The Recipient will develop/adopt a program-specific Health Information System, responsive to needs of field programs and headquarters and be able to provide A.I.D. with information for tracking program performance. This system should be described in the first year progress report.

At the time this report is submitted to FVA/PVC, a copy will be sent simultaneously to the A.I.D. Mission in each respective country. All work to be charged to this Agreement, including preparation of final reports, must be completed prior to expiration of this grant.

1E.2(b) Annual Report

Five copies of the Annual Report will be submitted to the AID/FVA/PVC Project Officer by October 15 of each year of the program; the first report is due October 15, 1992. The annual report should follow the annual report guidelines and should summarize inputs, outputs, progress to date, constraints, and highlights from the preceding year. The Report should also include reporting on the standard A.I.D. indicators for ORT, immunization and growth monitoring and nutrition interventions which are required of all programs receiving child survival funding. For these child survival projects, a mid-term evaluation report will replace the 2nd annual report.

The Annual report will also include the "USAID Health and Child Survival Project Questionnaire." This must be completed each year of the grant (including the final year) and for each PVO-funded CS project. Other A.I.D.-funded grants, such as OPGs, should be identified if there is a relationship of that grant to this grant supported program.

During the life-of-program, program monitoring and information on a country-specific basis will be included in the annual reporting system. Field reports prepared by the recipient's regional and technical specialists, as well as FVA/PVC consultants will also be included in the Annual Report.

At the time this report is submitted to FVA/PVC, a copy will be sent simultaneously to the A.I.D. Mission in each respective country. All work to be charged to this Agreement, including preparation of final reports, must be completed prior to expiration of this grant.

1E.2(c) Interim Reporting

Prior to the required final performance reporting date, events may occur that have significant impact upon the program outcome. In such instances, the Recipient shall inform the Grant Officer in writing, and the AID/FVA/PVC Project Officer as soon as the following types of conditions are known:

a. Problems, delays or adverse conditions that will materially affect the ability to attain program objectives, prevent the meeting of time schedules, and goals, or preclude the attainment of program work activities by the established time period. This disclosure shall be accompanied by the statement of the action taken, or contemplated, and any assistance needed to resolve the situation.

b. Favorable developments or events that enable time schedules to be met or work activities to be performed sooner than originally projected, resulting in an earlier than planned project completion date.

At the time this report is submitted to FVA/PVC, a copy will be sent simultaneously to the A.I.D. Mission in each respective country. All work to be charged to this Agreement, including preparation of final reports, must be completed prior to expiration of this grant.

1E.2(d) Mid-Term Evaluation

A mid-term project evaluation will be scheduled in collaboration with AID. The Recipient should work closely with the FVA/PVC Project Officer to plan for this evaluation including scheduling and participants. The results of this evaluation will be submitted to FVA/PVC as a mid-term evaluation report in accordance with mid-term evaluation report guidelines provided by FVA/PVC. (NOTE: with prior A.I.D. written approval an annual report may take the place of a mid-term evaluation for expansion grants.)

At the time this report is submitted to FVA/PVC, a copy will be sent simultaneously to the A.I.D. Mission in each respective country. All work to be charged to this Agreement, including preparation of final reports, must be completed prior to expiration of this grant.

1E.2(e) Final Evaluation Report

A final independent evaluation in collaboration with A.I.D. will be carried out in the final year of the program to evaluate program effectiveness and impact. The final evaluation must be completed prior to the expiration date of the Agreement, in accordance with final evaluation guidelines provided by FVA/PVC. The final evaluation will be submitted to A.I.D. as part of the final report as explained below.

At the time this report is submitted to FVA/PVC, a copy will be sent simultaneously to the A.I.D. Mission in each respective country. All work to be charged to this Agreement, including preparation of final reports, must be completed prior to expiration of this grant.

1E.2(f) Final Report

No later than 90 days after the expiration of this Cooperative Agreement period, a final report following PVC final report guidelines and including items specified by the project officer is due. The final report includes but is not limited to, the findings of the final evaluation. The final report should follow the final evaluation guidelines, and items specified by the Project Officer. Five (5) copies will be submitted to the AID/FVA/PVC and one (1) copy to the Grant Officer whose address appears on the Cooperative Agreement cover letter.

The A.I.D. Child Survival and Health Reporting Schedule must be submitted as part of the final report as well as a full financial report including a complete pipeline analysis.

At the time this report is submitted to FVA/PVC, a copy will be sent simultaneously to the A.I.D. Mission in each respective country. All work to be charged to this Agreement, including preparation of final reports, must be completed prior to expiration of this grant.

1E.2.(g) Quarterly Reports

The Recipient shall submit five (5) copies of brief quarterly program performance reports, which coincide with the financial reporting periods described in Section 1E.1. above, to the A.I.D. Project Office specified in the Cover Letter of this Cooperative Agreement. In addition, two copies shall be submitted to A.I.D., PPC/CDIE/DI, Washington, DC 20523-1802. These reports shall be submitted within 30 days following the end of the reporting period, and shall briefly present the following information:

1E.2.(b)(1) A comparison of actual accomplishments with the goals established for the period, the findings of the investigator, or both. If the output of programs can be readily quantified, such quantitative data should be related to cost data for computation of unit costs.

1E.2.(b)(2) Reasons why established goals were not met, if applicable.

1E.2.(b)(3) Other pertinent information including the status of finances and expenditures and, when appropriate, analysis and explanation of cost overruns or high unit costs.

1E.2.(e) Trip Reports

Within 30 days following the completion of each international trip, the Recipient shall submit 3 copies of a trip report summarizing the accomplishments of the trip to the A.I.D. Project Officer specified in the cover letter of this Cooperative Agreement. If several individuals are travelling together to one site, a single report representing the group will suffice. The report shall include the purpose of the trip, technical observations, suggestions and recommendations, overall impressions of the site situation (if appropriate), and a list of persons visited with their title and organization affiliation.

1E.2.(f) Final Evaluation Report

The Recipient shall submit five (5) copies of a final evaluation report to the A.I.D. Project Officer specified in the cover letter of this grant. It will cover a final independent evaluation in collaboration with A.I.D. and shall be carried out the final year of the program to evaluate

program effectiveness and impact. This final evaluation shall be completed prior to the expiration date of the agreement, in accordance with final evaluation guidelines provided by FVA/PVC. The final evaluation report shall be submitted to A.I.D. as part of the final report as explained below.

1E.2.(g) Final Report

Within 90 days following the estimated completion date of this Cooperative Agreement (see Section 1B. above), the Recipient shall submit five (5) copies of a final report to the A.I.D. Project Office specified in the cover letter of this Cooperative Agreement. The Final Report includes but is not limited to, the findings of the Final Evaluation full financial accounting and pipeline analysis. In addition, two copies shall be submitted to A.I.D., PPC/CDIE/DI, Washington, DC 20523-1802. It will cover the entire period of the Cooperative Agreement and include all information shown in Sections 1E.2.(b) through 1E.2.(f) above. Additionally, at the time all required reports are submitted by the PVO to FVA/PVC, a copy should simultaneously be sent to the A.I.D. Mission in each respective country. Additionally, all work to be charged to this agreement, including preparation of final reports must be completed prior to expiration of this grant.

1F. SUBSTANTIAL INVOLVEMENT UNDERSTANDINGS

It is understood and agreed that A.I.D. will be substantially involved during performance of this Cooperative Agreement as follows:

1F.1 Detailed Implementation Plan (DIP) - The A.I.D. Project Officer will be consulted during the development of the DIP(s) and have the right of final approval of all areas of the DIP where A.I.D. funds are included.

1F.2. DIP Revisions - The A.I.D. Project Officer will be consulted and have the right of approval for revisions of the DIP which involves the use of A.I.D. funds.

1F.3. Field Visits - Pursuant to the requirement in paragraph (a) in the Standard Provisions of this Cooperative Agreement entitled "Air Travel and Transportation," the A.I.D. Project Officer must provide advance approval of all international travel. For the purposes of this Agreement the requirement for advance written approval in paragraph (a) is waived by FVA/PVC. The requirements in paragraphs (b) through (f) of the standard provision are not waived and remain applicable to this Agreement.

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1F.4 Field Activities - The following primary (core) country is approved for direct in country program support under the Cooperative Agreement: Malawi. Other countries may be approved during the period of the Agreement. Such approval shall be communicated by A.I.D. in writing after consultation with the relevant A.I.D. Mission. The A.I.D. Project Officer will be involved in, and must approve, the selection of sites, methodologies and strategies to be used in field activities in core countries funded under this Cooperative Agreement.

1F.5 Subcontracts and Subagreements - If required by Paragraphs (b)(5) or (b)(6) of the Standard Provisions entitled "Revision of Grant Budget," or the Standard Provision entitled "A.I.D. Eligibility Rules for Goods and Services," the Grant Officer must approve subcontracts (see the Standard Provision entitled "Procurement of Goods and Services") and subagreements (see the Standard Provision entitled "Subagreement").

1F.6 Evaluation - The scope of work for the independent mid-term and/or final evaluation must be developed with, and the evaluator(s) chosen to carry out this activity must be approved in advance by, the AID/FVA/PVC Project Officer. This approval must be communicated in writing. The Recipient is encouraged to provide at least one evaluator from its permanent staff for this evaluation(s). At least one evaluator must be an individual not currently employed by the Recipient. The AID/FVA/PVC Project Officer is to participate in the pre- and post-evaluation briefings and to receive six (6) copies of the completed evaluation report for FVA/PVC and one copy for each country evaluated.

1G. PROCUREMENT AND (SUB) CONTRACTING

1G.1. Applicability

This Section 1G. applies to the procurement of goods and services by the Recipient (i.e., contracts, purchase orders, etc.) from a supplier of goods and services (see the Standard Provisions of this Cooperative Agreement entitled "Procurement of Goods and Services" and "AID Eligibility Rules for Goods and Services"), and not to assistance provided by the Recipient (i.e., a [sub]grant or subagreement) to a subrecipient (see the Standard Provision of this Cooperative Agreement entitled "Subagreements").

1G.2. Requirements

In addition to other applicable provisions of this Cooperative Agreement, the Recipient shall comply with paragraph (b)(2) of the Standard Provision of this Cooperative Agreement entitled

"AID Eligibility Rules for Goods and Services," concerning total procurement value of more than \$250,000 under this Cooperative Agreement. Further thereto, the following is (are) the Authorized Geographic Code(s):

1G.2.(a) Authorized Geographic Codes

1G.2.(a) (1) Source, Origin, and Componentry of Goods and Commodities

1G.2.(a) (1) (A) Source, Origin, and Componentry

Except as specified in Sections 1G.2.(a)(1)(B) and 1G.2.(a)(1)(D) below, all goods/commodities shall have their source and origin in the United States of America, and shall meet A.I.D.'s componentry requirements, except as the Agreement Officer may otherwise agree in writing (see also Section 1G.2.[a][4] below).

1G.2.(a) (1) (B) Exception for Purchase/Procurement Transactions not Exceeding \$5,000

If the proposed purchase/procurement transaction does not exceed \$5,000 excluding transportation costs, paragraph (b)(1) of the Standard Provision of this Cooperative Agreement entitled "AID Eligibility Rules for Goods and Services" shall apply in lieu of Section 1G.2.(a)(1)(A) above.

1G.2.(a) (1) (C) Local Cost Financing

If, pursuant to Sections 1G.2.(a)(1)(A) or 1G.2.(a)(1)(B) above, the cooperating country is authorized for source and origin purposes, the Standard Provision of this Cooperative Agreement entitled "Local Cost Financing" will apply. Pursuant to said Standard Provision, indigenous goods and imported shelf items provided by local suppliers are eligible for local cost financing in quantities up to the total estimated cost of this Cooperative Agreement, subject to the restrictions stated in said Standard Provision, and Chapter 18 of Supplement B to A.I.D. Handbook 1, which, as may from time to time be amended, is incorporated herein as a part of this Cooperative Agreement by reference.

1G.2.(a) (1) (D) Restricted Goods

Notwithstanding the foregoing, the restricted goods listed in paragraph (a)(3) of the Standard Provision of this Cooperative Agreement entitled "AID Eligibility Rules for Goods and Services," and, if applicable (see Section 1G.2.[a][1][C] above or Section 1K. below for applicability), paragraph (e) of the

Standard Provision entitled "Local Cost Financing," must be specifically approved by the Agreement Officer, except to the extent that such approval may be provided in Section 11. below.

1G.2. (a) (2) Eligibility of Commodity-Related Services

1G.2. (a) (2) (A) Ocean Transportation

The eligibility of ocean transportation services is determined by the flag registry of the vessel. Notwithstanding the Standard Provision of this Cooperative Agreement entitled "Ocean Shipment of Goods," ocean shipping financed hereunder shall, except as the Agreement Officer may otherwise agree in writing, be financed only on flag vessels of the United States (A.I.D. Geographic Code 000). If the Agreement Officer approves the use of non-U.S. flag vessels, the Standard Provision of this Cooperative Agreement entitled "Ocean Shipment of Goods" will apply. Notwithstanding any of the foregoing, commodities shipped by a transportation medium owned, operated, or under the control of any country not included in A.I.D. Geographic Code 935 (see Section 1G.2.[a][4][B] below) are ineligible for A.I.D. financing hereunder, regardless of whether such transportation costs are financed hereunder. Moreover, commodities are ineligible for A.I.D. financing hereunder if shipped on a vessel which A.I.D. has designated as ineligible, regardless of whether such transportation costs are financed hereunder. Commodities are also ineligible for A.I.D. financing hereunder if shipped under an ocean charter that has not received prior approval of the Agreement Officer, regardless of whether such transportation costs are financed hereunder.

1G.2. (a) (2) (B) Dead Freight

Transportation costs attributable to dead freight are not eligible for A.I.D. financing.

1G.2. (a) (2) (C) Despatch and Demurrage

If the Recipient finances the delivery costs beyond the port of loading, the Recipient must refund to A.I.D. all despatch earned at the port of unloading. Demurrage costs are ineligible for A.I.D. financing.

1G.2. (a) (2) (D) Air Transportation

The eligibility of air travel and transportation services is determined by the flag registry of the aircraft. The Standard Provision of this Cooperative Agreement entitled "Air Travel and Transportation" applies. Commodities are ineligible for

A.I.D. financing hereunder if shipped under an air charter that has not received prior approval of the Agreement Officer, regardless of whether such transportation costs are financed hereunder.

1G.2. (a) (2) (E) Marine Insurance

The Authorized Geographic Code for marine insurance is the same as is set forth in Section 1G.2.(a)(3)(B) below. Paragraph (c) of the Standard Provision of this Cooperative Agreement entitled "AID Eligibility Rules for Goods and Services" applies. If the Cooperating Country is authorized for the placement of marine insurance but discriminates against any marine insurance company authorized to do business in any state of the United States, failure to insure all A.I.D.-financed commodities with U.S. insurance companies shall render the commodities ineligible for A.I.D. financing hereunder.

1G.2. (a) (2) (F) Other Delivery Services

No special eligibility requirements pertain to other delivery services (such as export packing, loading, commodity inspection services, and services of a freight forwarder) except that citizens or firms of any country not included in Geographic Code 935 (see Section 1G.2.[a][4][B] below) are ineligible as suppliers of delivery services, and non-U.S. citizens lawfully admitted for permanent residence in the U.S. are eligible regardless of their citizenship.

1G.2. (a) (2) (G) Incidental Services

Incidental services are defined as installation or erection of A.I.D.-financed equipment or the training of personnel in the maintenance, operation, and use of such equipment. No special eligibility requirements pertain to incidental services except that citizens or firms of any country not included in Geographic Code 935 (see Section 1G.2.[a][4][B] below) are ineligible as suppliers of incidental services, and non-U.S. citizens lawfully admitted for permanent residence in the U.S. are eligible regardless of their citizenship.

1G.2. (a) (2) (H) Local Cost Financing

If, pursuant to this Section 1G.2.(a)(2), the cooperating country is authorized for commodity-related services, the Standard Provision of this Cooperative Agreement entitled "Local Cost Financing" will apply. Pursuant to said Standard Provision, services provided by local suppliers are eligible for local cost financing in quantities up to the total estimated cost of this Cooperative Agreement, subject to the

restrictions stated in said Standard Provision, and Chapter 18 of Supplement B to A.I.D. Handbook 1, which, as may from time to time be amended, is incorporated herein as a part of this Cooperative Agreement by reference.

1G.2.(a)(3) Nationality of Supplier

1G.2.(a)(3)(A) Suppliers of Goods and Commodities

Except as specified in Section 1G.2.(a)(3)(C) below, the suppliers of goods and commodities shall have their nationality in the United States of America, except as the Agreement Officer may otherwise agree in writing.

1G.2.(a)(3)(B) Suppliers of Services (Other Than Commodity-Related Services)

Except as specified in Section 1G.2.(a)(3)(C) below, the suppliers of services (other than commodity-related services, as described in Section 1G.2.[a][2] above) shall have their nationality in the United States of America, except as the Agreement Officer may otherwise agree in writing.

1G.2.(a)(3)(C) Government Owned Organizations

Notwithstanding the foregoing, a Government Owned Organization, i.e., a firm operated as a commercial company or other organizations (including nonprofit organizations other than public educational institutions) which are wholly or partially owned by governments or agencies thereof, are not eligible as suppliers of goods and commodities, commodity-related services, or services (other than commodity-related services), except as the Agreement Officer may otherwise agree in writing.

1G.2.(a)(3)(D) Local Cost Financing

If, pursuant to this Section 1G.2.(a)(3), the cooperating country is authorized for supplier nationality purposes, the Standard Provision of this Cooperative Agreement entitled "Local Cost Financing" will apply. Pursuant to said Standard Provision, local suppliers are eligible for local cost financing of indigenous goods, imported shelf items, and services in quantities up to the total estimated cost of this Cooperative Agreement, subject to the restrictions stated in said Standard Provision, and Chapter 18 of Supplement B to A.I.D. Handbook 1, which, as may from time to time be amended, is incorporated herein as a part of this Cooperative Agreement by reference.

1G.2. (a) (4) Definitions**1G.2. (a) (4) (A) Source, Origin, Componentry, and Nationality of Supplier**

Source, origin, componentry requirements, and supplier nationality are defined in Chapter 5 of A.I.D. Handbook 1, Supplement B, which, as may be amended from time to time, is incorporated herein as a part of this Cooperative Agreement by reference (see also Attachment 5 of this Cooperative Agreement which reflects the substance of Chapter 5 of A.I.D. Handbook 1, Supplement B as of the effective date of this Cooperative Agreement).

1G.2. (a) (4) (B) A.I.D. Geographic Codes

A.I.D. Geographic Codes are defined in Appendix D of A.I.D. Handbook 18, which, as may be amended from time to time, is incorporated herein as a part of this Cooperative Agreement by reference (see also Attachment 5 of this Cooperative Agreement which reflects the substance of Appendix D of A.I.D. Handbook 18 as of the effective date of this Cooperative Agreement).

1G.3. Approvals

Inclusion of costs in the budget of this Cooperative Agreement for the purchase of nonexpendable equipment obviates neither the requirement of Section J.13. of OMB Circular A-21 (for educational institutions) or Section 13 of Attachment B of OMB Circular A-122 (for nonprofit organizations other than educational institutions) for prior approval of such purchases by the Agreement Officer, nor any other terms and conditions of this Cooperative Agreement, unless specifically stated in Section 1I. below.

1G.4. Title to Property

Title to property acquired hereunder shall vest in the Recipient, subject to the requirements of the Standard Provision of this Cooperative Agreement entitled "Title To and Use of Property (Grantee Title)" regarding use, accountability, and disposition of such property, except to the extent that disposition of property may be specified in Section 1I. below.

1H. INDIRECT COST RATES

1H.1. Pursuant to the Standard Provision of this Cooperative Agreement entitled "Negotiated Indirect Cost Rates - Provisional," an indirect cost rate or rates shall be

established for each of the Recipient's accounting periods which apply to this Cooperative Agreement. Pending establishment of final or revised provisional indirect cost rates, provisional payments on account of allowable indirect costs shall be made on the basis of the following negotiated provisional rate(s) applied to the base(s) which is (are) set forth below:

<u>Type</u>	<u>Rate</u>	<u>Base</u>	<u>Period</u>
Provisional	24.41%	1/	7/1/90 until amended

1/ Base of Application: Total direct cost but excluding non-expendable project equipment.

II. SPECIAL PROVISIONS

II.1. Limitations on Reimbursement of Costs of Compensation for Personal Services and Professional Service Costs

II.1.(a) Employee Salaries

Except as the Agreement Officer may otherwise agree in writing, A.I.D. shall not be liable for reimbursing the Recipient for any costs allocable to the salary portion of direct compensation paid by the Recipient to its employees for personal services which exceed the highest salary level for a Foreign Service Officer, Class 1 (FS-1), as periodically amended.

II.1.(b) Consultant Fees

Compensation for consultants retained by the Recipient hereunder shall not exceed, without specific approval of the rate by the Agreement Officer: either the highest rate of annual compensation received by the consultant during any full year of the immediately preceding three years; or the maximum rate of a Foreign Service Officer, Class 1 (FS-1) (as periodically amended), whichever is less. A daily rate is derived by dividing the annual compensation by 2,087 and multiplying the result by 8.

II.2. Publications

II.2.(a) The Recipient agrees to provide one copy of the manuscript of any proposed publication to the A.I.D. Project

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Officer not later than submission to the publisher, and to give serious consideration to any comments received from the A.I.D. Project Officer.

1I.2.(b) In the case of publication of any of the reports described in Section 1E.2. of this Cooperative Agreement, A.I.D. reserves the right to disclaim endorsement of the opinions expressed. For other publications, A.I.D. reserves the right to dissociate itself from sponsorship or publication. In both cases, the Recipient will consult with the A.I.D. Project Officer as to the nature and extent of any A.I.D. disclaimer of endorsement or dissociation from sponsorship or publication.

1I.2.(c) If A.I.D. does not choose to disclaim endorsement or dissociate itself from sponsorship or publication, the Recipient shall, in accordance with the Standard Provision of this Cooperative Agreement entitled "Publications," acknowledge A.I.D. support as follows:

"This publication was made possible through support provided by the Office of Private and Voluntary Cooperation, Bureau for Food and Voluntary Assistance, U.S. Agency for International Development, under Cooperative Agreement No. PDC-0284-A-00-1123-00."

1I.2.(d) In addition to providing one copy of all published works and lists of other written work produced under this Cooperative Agreement to the A.I.D. Project Officer, as required by paragraph (b) of the Standard Provision of this Cooperative Agreement entitled "Publications," the Recipient shall also provide two copies of such publications and lists to A.I.D., PPC/CDIE/DI, Washington, D.C. 20523-1802.

1I.3. Equipment Purchases

1I.3.(a) Requirement for Prior Approval

Pursuant to Sections 1D.3. and 1G.3. above and the Standard Provisions of this Cooperative Agreement entitled "Allowable Costs" and "Revision of Grant Budget," and by extension, Section 13 of Attachment B of OMB Circular A-122, the Recipient must obtain A.I.D. Agreement Officer approval for purchases of the following:

1I.3.(a)(1) General Purpose Equipment, which is defined as an article of nonexpendable tangible personal property which is usable for other than research, medical, scientific or technical activities, whether or not special modifications are needed to make them suitable for a particular purpose (e.g.,

office equipment and furnishings, air conditioning equipment, reproduction and printing equipment, motor vehicles, and automatic data processing equipment), having a useful life of more than two years and an acquisition cost of \$500 or more per unit); and

1I.3.(a)(2) Special Purpose Equipment, which is defined as an article of nonexpendable tangible personal property, which is used only for research, medical, scientific, or technical activities (e.g., microscopes, x-ray machines, surgical instruments, and spectrometers), and which has a useful life of more than two years and an acquisition cost of \$1,000 or more per unit).

1I.3.(b) Approvals

In furtherance of the foregoing, the Agreement Officer does hereby provide approval for the following purchases, which shall not be construed as authorization to exceed the total estimated amount or the obligated amount of this Cooperative Agreement, whichever is less (see Section 1C. above):

"N/A"

1I.3.(c) Exception for Automation Equipment

Any approval for the purchase of automation equipment which may be provided in Section 1I.4.(b) above or subsequently provided by the Agreement Officer is not valid if the total cost of purchases of automation equipment (e.g., computers, word processors, etc.), software, or related services made hereunder will exceed \$100,000. The Recipient must, under such circumstances, obtain the approval of the Agreement Officer for the total planned system of any automation equipment, software, or related services.

1I.3.(d) Compliance with A.I.D. Eligibility Rules

Any approvals provided in Section 1I.4.(b) above or subsequently provided by the Agreement Officer shall not serve to waive the A.I.D. eligibility rules described in Section 1G. of this Cooperative Agreement, unless specifically stated.

1I.4. Restricted Goods

Pursuant to Section 1G. above, paragraph (a)(3) of the Standard Provisions of this Cooperative Agreement entitled "AID Eligibility Rules for Goods and Services," and, if applicable (see Section 1K. below for applicability), paragraph (e) of the Standard Provision of this Cooperative Agreement entitled

"Local Cost Financing," the Agreement Officer's approval is required for purchase of the restricted goods described therein. In furtherance thereof, the Agreement Officer does hereby provide such approval to the extent set forth below. The Agreement Officer's approval is required for purchases of such restricted goods if all of the conditions set forth below are not met by the Recipient. Any approval provided below or subsequently provided by the Agreement Officer shall not serve to waive any terms and conditions of this Cooperative Agreement unless specifically stated.

1I.4.(a) Motor Vehicles

Motor vehicles, if approved for purchase under Section 1I.4.(b) above or subsequently approved by the Agreement Officer, must be of U.S. manufacture and must be of at least 51% U.S. componentry. The source of the motor vehicles, and the nationality of the supplier of the vehicles, must be in accordance with Section 1G.2. above. Motor vehicles are defined as self-propelled vehicles with passenger carriage capacity, such as highway trucks, passenger cars and busses, motorcycles, scooters, motorized bicycles, and utility vehicles. Excluded from this definition are industrial vehicles for materials handling and earthmoving, such as lift trucks, tractors, graders, scrapers, and off-the-highway trucks.

1I.4.(b) Pharmaceuticals

Pharmaceuticals may be purchased provided that all of the following conditions are met: (1) the pharmaceuticals must be safe and efficacious; (2) the pharmaceuticals must be of U.S. source and origin (see Section 1G. above); (3) the pharmaceuticals must be of at least 51% U.S. componentry (see Section 1G. above); (4) the pharmaceuticals must be purchased from a supplier whose nationality is in the U.S. (see Section 1G. above); (5) the pharmaceuticals must be in compliance with U.S. Food and Drug Administration (FDA) (or other controlling U.S. authority) regulations governing United States interstate shipment of pharmaceuticals; (6) the manufacturer of the pharmaceuticals must not infringe on U.S. patents; and (7) the pharmaceuticals must be competitively procured in accordance with the procurement policies and procedures of the Recipient and the Standard Provision of this Cooperative Agreement entitled "Procurement of Goods and Services."

1I.4.(c) Used Equipment

Used equipment may only be purchased with the prior written approval of the Agreement Officer.

1I.5. Limitation on Use of Funds

1I.5.(a) The Recipient shall not utilize funds provided by A.I.D. for any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference or training in connection with the growth or production in countries other than the United States of an agricultural commodity for export which would compete with a similar commodity grown or produced in the United States.

1I.5.(b) The reports described in Section 1E.2. shall contain a statement indicating the projects or activities to which United States funds have been attributed, together with a brief description of the activities adequate to show that United States funds have not been used for the purpose in Section 1I.6.(a) above.

1I.5.(c) The Recipient agrees to refund to A.I.D. upon request an amount equal to any United States funds used for the purposes prohibited by Section 1I.6.(a) above.

1I.5.(d) No funds provided by A.I.D. under this Cooperative Agreement shall be used to provide assistance, either directly or indirectly, to any country ineligible to receive assistance pursuant to the Foreign Assistance Act as amended, related appropriations acts, or other statutes and Executive Orders of the United States (also see the Standard Provision of this Cooperative Agreement entitled "Ineligible Countries").

1I.6. Defense Base Act (DBA) and/or Medical Evacuation Insurance

Pursuant to Section J.16. of OMB Circular A-21 (for educational institutions) or Section 18 of Attachment B of OMB Circular A-122 (for nonprofit organizations other than educational institutions), the Recipient is authorized to purchase DBA and/or medical evacuation insurance under this Cooperative Agreement. If DBA insurance is purchased, it shall be purchased from the insurance company or agent with which A.I.D. has a contract to provide DBA insurance for A.I.D. contracts. The Agreement Officer will provide the name, address, and telephone number of such insurance company or agent upon request.

1J. RESOLUTION OF CONFLICTS

Conflicts between any of the Attachments of this Cooperative Agreement shall be resolved by applying the following descending order of precedence:

- Attachment 1 - Schedule
- Attachment 3 - Standard Provisions
- Attachment 4 - Special Provision entitled "Restrictions on Lobbying"
- Attachment 5 - Closeout Procedures
- Attachment 2 - Program Description

1K. STANDARD PROVISIONS

The Standard Provisions set forth as Attachment 3 of this Cooperative Agreement consist of the following Standard Provisions denoted by an "X" which are attached hereto and made a part of this Cooperative Agreement:

1K.1. Mandatory Standard Provisions For U.S., Nongovernmental Grantees

- (X) Allowable Costs (November 1985)
- (X) Accounting, Audit, and Records (September 1990)
- (X) Refunds (September 1990)
- (X) Revision of Grant Budget (November 1985)
- (X) Termination and Suspension (May 1986)
- (X) Disputes (November 1989)
- (X) Ineligible Countries (May 1986)
- (X) Debarment, Suspension, and Other Responsibility Matters (March 1989)
- (X) Nondiscrimination (May 1986)
- (X) U.S. Officials Not to Benefit (November 1985)
- (X) Nonliability (November 1985)
- (X) Amendment (November 1985)
- (X) Notices (November 1985)

1K.2. Additional Standard Provisions For U.S., Nongovernmental Grantees

- (X) Payment - Letter of Credit (November 1985)
- () Payment - Periodic Advance (January 1988)
- () Payment - Cost Reimbursement (November 1985)
- (X) Air Travel and Transportation (November 1985)
- (X) Ocean Shipment of Goods (May 1986)
- (X) Procurement of Goods and Services (November 1985)
- (X) AID Eligibility Rules for Goods and Services (November 1985)

- (X) Subagreements (November 1985)
- (X) Local Cost Financing (November 1988)
- (X) Patent Rights (November 1985)
- (X) Publications (November 1985)
- () Negotiated Indirect Cost Rates - Predetermined (May 1986)
- (X) Negotiated Indirect Cost Rates - Provisional (May 1986)
- (X) Regulations Governing Employees (November 1985)
- () Participant Training (May 1986)
- () Voluntary Population Planning (August 1986)
- () Protection of the Individual as a Research Subject (November 1985)
- () Care of Laboratory Animals (November 1985)
- () Government Furnished Excess Personal Property (November 1985)
- (X) Title To and Use of Property (Grantee Title) (November 1985)
- () Title To and Care of Property (U.S. Government Title) (November 1985)
- () Title To and Care of Property (Cooperating Country Title) (November 1985)
- (X) Cost Sharing (Matching) (November 1985)
- (X) Use of Pouch Facilities (November 1985)
- (X) Conversion of United States Dollars to Local Currency (November 1985)

1L. COST SHARING AND OTHER CONTRIBUTIONS

1L.1. The Recipient agrees to expend an amount not less than (a) the amount shown in the budget of this Cooperative Agreement for financing by the Recipient and/or others from non-federal funds (see Sections 1D. and/or 1H.), and (b) the amount shown in the budget of this Cooperative Agreement for financing by the Recipient and/or others from other federal funds.

1L.2. The Standard Provision of this Cooperative Agreement entitled "Cost Sharing (Matching)" makes reference to project costs. "Project Costs" are defined in Attachment E of OMB Circular A-110 as all allowable costs (as set forth in the applicable cost principles [see the Standard Provision of this Cooperative Agreement entitled "Allowable Costs"]) incurred by a Recipient and the value of in-kind contributions made by the Recipient or third parties in accomplishing the objectives of this Cooperative Agreement during the program period.

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1L.3. The restrictions on the use of A.I.D. funds provided hereunder, as set forth in this Cooperative Agreement, do not apply to cost-sharing (matching) or other contributions unless such restrictions are stated in the applicable federal cost principles and/or imposed by the source of such cost-sharing (matching) funds or other contributions.

ATTACHMENT 2

PROGRAM DESCRIPTION

The Recipient's proposal entitled "Vitamin A for Child Survival Project" and dated December 1990 is attached hereto as the Program Description (Attachment 2) and is made a part of this Cooperative Agreement.

Section A: PVO SUMMARY TABLE

Section B: BACKGROUND/COMMITMENT TO CHILD SURVIVAL & HEALTH

B.1. Background

The International Eye Foundation is a private voluntary organization dedicated to the prevention and cure of blindness in developing countries. IEF field operations provide training, equipment and medicines, clinical services, operational research and development of community-based programs through support for indigenous eye care organizations in 10 countries of Latin America, the Caribbean, and Africa. The annual budget for 1990 was \$1.59 million, of which 87% was spent on direct program services. A small headquarters staff in Bethesda, Maryland provides support to IEF personnel in the field.

In 1961 when IEF was founded as the International Eye Bank under CARE-MEDICO auspices, its activities focused on the transfer of eye banking technology and the provision of advanced ophthalmological training. Since 1969, when IEF established itself as a private voluntary organization, the agency's approach has incorporated community-based primary eye care and blindness prevention activities. At the same time, specialized training in ophthalmology and the provision of the clinical services have continued to be a distinctive feature of many IEF programs.

The IEF has historically worked not only at the national but also at regional and sub-regional levels in the design and implementation of programs which provide eye care to the needy. IEF's strategy for primary eye care programs includes the following components:

1. Assisting service organizations and ministries of health in developing blindness prevention strategies and services which integrate preventative, promotive and therapeutic activities into the existing health care and social service systems.
2. Providing long-term training for all categories of health care workers in eye care appropriate to their level and function. This includes curricula and materials development.
3. Carrying out community-based surveys to determine the prevalence and etiology of blinding eye disease and developing appropriate alternative program strategies to address needs identified in initial assessment. IEF assistance programs are designed to complement government activities. Government counterparts are included in program planning, development and implementation. In designing and implementing programs, the IEF also works closely with other PVOs, and multilateral agencies.

B.2. Commitment to Child Survival and Health

IEF has come to view Child Survival interventions as key elements in its strategy to reduce and prevent blindness. Immunization activities are essential in preventing measles-induced blindness. Diarrheal disease and vitamin A interventions work together to prevent the blindness due to xerophthalmia, while child spacing, water and sanitation interventions act to prevent the eye disease due to trachoma, as well as nutritional deficiency diseases. The Child Survival Program emphasis on sustainability is also consistent with IEF's organizational strategy of strengthening primary health care delivery systems to prevent and cure blindness in developing countries.

IEF's CS-I project in the Lower Shire Valley (LSV) in Malawi was completed at the end of CY88. Four major health problems associated with blindness which are endemic to the LSV were addressed by that project, including: 1) vitamin A deficiency, 2) diarrheal disease, 3) trachoma, and 4) measles. IEF's activities in the CS-I project focused on providing support to the MOH in its immunization and ORT programs in the LSV, and distribution of vitamin A and tetracycline ointment using mobile teams.

The IEF is continuing project activities in Malawi with a second Child Survival (Vitamin A) intervention grant from the USAID Office of PVC. This two year vitamin A and nutrition project in the LSV was initiated in July 1989. The project was designed as a follow-on project to the CS-I Project, building on the "lessons learned" during that project period. In view of constraints in the project area, including limitations of project resources and infrastructure development, modest objectives and clearly feasible project activities were selected. In keeping with IEF's desire for future expansion into more comprehensive Child Survival activities an emphasis was placed on the development of health infrastructure at the village level.

In Guatemala, the IEF is currently implementing a broad range of Child Survival/Vitamin A activities with AID funding. In November 1990, IEF completed the final phase of a three-year vitamin A intervention project funded by the Office of Nutrition in 1987. This grant provided partial support for the development and testing of a Vitamin A-enriched post-convalescent refeeding mixture (called NutriAtol) for children under six, recovering from diarrhea and measles. A second NutriAtol distribution project is underway in another region of Guatemala with financing by the "Sight & Life" Task Force of the F. Hoffmann-La Roche Co., Basel, Switzerland.

In 1990, the IEF was awarded a CS-VI grant from the FVA/PVC Office of AID to expand its CS/Vitamin A activities in Guatemala. Key interventions in the CS-VI project include nutrition education, gardening and further development of the NutriAtol program.

Several on-going operational research projects have also been funded in Guatemala by the Office of Nutrition. One project has as its focus the examination of intra-household food distribution patterns and vitamin A consumption. Another involves strengthening the capacity in Guatemala to effect, interpret and apply vitamin-A analyses (plants, blood serum) using HPLC technology.

In Honduras another CS-VI project is currently getting underway in a peri-urban setting in Tegucigalpa. Key interventions include vitamin A capsule distribution, nutrition education, training primary health-care promoters in recognition and referral of cases of xerophthalmia, and the introduction of NutriAtol to a target population of children under-six.

Section C: TRACK RECORD IN CHILD SURVIVAL/VITAMIN A

IEF's ongoing Vitamin A Intervention Project (OTR-0550-A-00-9159-00) in Malawi had its mid-term review in October 1990, (see Mid-Term Evaluation attached to Malawi Proposal-Country Section). The evaluation documented the following project accomplishments in the first year of this two-year program:

"In the first year of a two-year effort, the Vitamin A Project has established an efficient structure that has permitted it to surpass its targets for vitamin A distribution to 80% of the children between 6 and 72 months and postpartum mothers. Through strong collaboration with the government in the area, a model for population-based programming has been established. The cornerstone of this operation is the Village Health Promoter and the roster of the members of the target population in the village that she maintains. Less progress has been achieved in the more difficult nutrition education component. Recommendations focus on the strengthening of the education aspect as well as expanding the effort in terms of additional child survival interventions (e.g., immunization, ORT, and even child spacing) and/or greater population coverage. In addition, the possibility is discussed of focusing IEF's follow-up effort on the management of a district-wide, community-based child survival program within the government structure."

IEF's recently completed Vitamin A Intervention Project (DAX-0045-G-SS-7104) in Guatemala was evaluated in November 1990. The evaluation documented the following project accomplishments:

- * The project succeeded in designing and commissioning the production of a vitamin A enriched food supplement (NutriAtol) for children convalescing from diarrhea and other infectious diseases.

- * An innovative service delivery method using rural schools to reach pre-school children and their mothers with preventative/curative measures was designed, field tested and fully operational by the EOPE.

* NutriAtol proved to be well accepted by mothers and children.

* The project served to focus activities of IEF's sister agency, the National Committee for the Blind and Deaf, on the importance of preventative measures in rural areas. Most prior NCBD activities were hospital based.

* The operations research component of the program generated valuable information including data on Vitamin A status in children and the local food consumption patterns.

The major issues specified in the evaluation report included improving supervision by placement of a full-time field supervisor in the target area; requiring direct reporting of promoters to the field supervisor; increasing the amount of time devoted to field supervision of promoters and teachers; and assuring additional clerical support. Additional recommendations include:

- * Closer collaboration with regional school authorities.
- * More interaction between promoters and school teachers.
- * Increase the Vitamin A content of the NutriAtol formula.
- * Design a sustainable long-range strategy based on education and agricultural extension to increase consumption of carotene containing vegetables.
- * Further evaluation of the effectiveness of training and methods of community motivation.
- * Improved data management and data quality assurance.

These issues have been discussed with field staff and the "Lessons Learned" and recommendations are being incorporated into the DIP of the current CS-VI project.

In Honduras, IEF is embarking on its first AID funded CS/Vitamin A Project. However, IEF has been active in assisting the MOH to improve eye care in the nation for many years. During that time, IEF has learned to function well with Honduran national professionals and has proven a capacity to provide adequate and relevant training to auxiliary/promoter-level persons. IEF has had three external evaluations of its prior programs from which relevant lessons have been learned. To address some of the deficits of past programs, the current program for Honduras includes: higher levels of Spanish language skills and Honduran national involvement; additional in-service training and reinforcement; sufficient and appropriate staff to manage all aspects of the program; and stronger HQ back-up. In addition, the Honduras project is benefitting from the lessons learned in the first Vitamin A Intervention program in neighboring Guatemala.

IEF's original CS project is the CS-I (PDC-0501-A-00-5107-00) project in Malawi, which was initiated in 1985 and completed at the end of CY88.

An external end-of-project evaluation was completed in December, 1988, documenting training activities completed, supplies distributed, vitamin A distribution coverage, a reduction of the prevalence of trachoma, and an increase in measles vaccine coverage. The Executive Summary of the 1988 evaluation is included as Appendix 1 of this proposal. (The complete document is on file in AID/PVC and available on request.)

The major issues specified in the CS-I Malawi evaluation report included the necessity to: create an "interface with the community through selection and training of Village Health Workers"; promote the demand for CS interventions; strengthen budget and staffing; and to increase networking and the use of technical assistance. The lessons learned in the implementation of that CS-I project were discussed with field staff, and are directly addressed in the design of the current Vitamin A project in Malawi.

A. Summary Description of Project

The International Eye Foundation has developed and implemented a community-based management system in 45 villages (9,000 children <6 and women of child-bearing age) in the Lower Shire Valley of Malawi which has been instrumental in targeting at-risk children. In the current project, IEF is delivering Vitamin A, encouraging nutrition education, starting ORT, and assisting EPI activities through IEF-trained village health volunteers.

The overall goal of IEF's proposed project is the reduction of infant and childhood mortality and morbidity in Malawi's Lower Shire Valley. Project objectives can be divided into service delivery and infrastructure building components. Through the current project, IEF has learned that without infrastructure building (Ministry of Health and other long-term service delivery organizations) the service delivery components will not be sustained. Thus, future IEF work will be within the existing structures of the Ministry of Health, two private voluntary hospitals, and the Adventist Development Relief Agency's child survival project. The beneficiary population for these interventions includes the estimated 265,250 members included in the specified target groups. IEF will provide a management structure to increase EPI response by an additional 50%, and increase ORT use by an additional 50%. IEF will work with the Ministry of Health to establish a community-based worker system in 90% of the villages in Chikwawa District and assist ADRA in achieving the same coverage in Nsanje District. IEF will also establish a community-based blindness prevention program in 50% of the villages. Other community-based activities assisted by IEF are the improvement of infant and child feeding practices and AIDS prevention and control. In the area of service delivery IEF will provide semi-annual vitamin A supplementation to 75% of children 6 months to 6 years of age and to 75% of mothers within 2 months of delivery. Through all of these activities IEF aims to reduce infant and child mortality by 30% in Chikwawa District and assist ADRA in Nsanje District to achieve a 50% reduction.

The project is designed for implementation over a four-year period, beginning in September 1991, with total annual budgets (HQ and field) of \$347,532 for year 1, \$372,572 for year 2, \$339,918 for year 3, and \$406,775 for year 4. Of the project budget total of \$1,466,797, an amount of \$1,100,000 is requested from the U.S. Agency for International Development. The International Eye Foundation will provide the balance of \$366,797. Other sources (MOH, etc.) are estimated at \$205,000.

B. Country Project Summary Table (Format E. on following page.)

C. Project Location/Background

C.1 Project Location

The project is located in the Lower Shire Valley (LSV) of Malawi a rural area comprising the two southern region districts of Chikwawa and Nsanje (see map). The valley is divided by the Shire River into the east bank (1/3 of the population) and west bank (2/3 of the population). Both the east and the west banks

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FORMATE: COUNTRY PROJECT SUMMARY TABLE

Organization: INTERNATIONAL EYE FOUNDATION

Country: MALAWI

Project Title: MALAWI VITAMIN A FOR CHILD SURVIVAL PROJECT

A. PROPOSED INTERVENTIONS AND TARGET POPULATION

Target Population

Intervention	0-11 Months	12-23 Months	24-60 Months	0-72 Months Vitamin A Only	Women 15-45 Years	Total Target Population ¹	Total Population In Service Area ²
ORT	15,200	14,000	49,300	90,500	110,000	200,500	571,500
Immunization							
Nutrition	15,200	14,000	49,300	90,500	110,000	200,500	571,500
Vitamin A	11,600	25,000	81,300	137,550	26,000	162,250	571,500
High Risk Births							
Malaria Control							
Other AIDS EDUC.							

¹Identify those to receive direct services (i.e., women and children)

²Include those not receiving direct services

Specify Data Source (circle one):

DC PVO Data Collection System; Best Guess; DK Don't Know; OTHER (specify) _____

B. EXISTING

INTERVENTIONS AND TARGET POPULATION

(Note: Complete the following only if expansion activities are being proposed.)

Target Population

Intervention	0-11 Months	12-23 Months	24-60 Months	0-72 Months Vitamin A Only	Women 15-45 Years	Total Target Population ¹	Total Population In Service Area ²
ORT							
Immunization							
Nutrition							
Vitamin A	1,850	1,775	5,615	9,2	8,985	18,225	42,000
High Risk Births							
Malaria Control							
Other _____							

¹Identify those to receive direct services (i.e., women and children)

²Include those not receiving direct services

Specify Data Source (circle one):

DC PVO Data Collection System; Best Guess; DK Don't Know; OTHER (specify) _____

FORMAT E: COUNTRY PROJECT SUMMARY TABLE (con't)

C. ACTIVITIES: Circle all activity codes that apply for each intervention.

- 1. ORT**
- 1 = Distribute ORS packets
 - 2 = ORT training
 - 3 = Promote ORT home-mix
 - 4 = Promote ORT home-base fluids
 - 5 = Dietary management of diarrhea
 - 6 = Hygiene education
 - 35 = Other Monitoring of ORT use
(Specify)

- 6. Malaria Control**
- 27 = Training
 - 28 = Health education
 - 29 = Treatment
 - 30 = Environmental actions
 - 31 = Residual insecticides
 - 32 = Larvaciding
 - 33 = Provision of bednets
 - 34 = Provision of commodities
 - 35 = Other _____
(Specify)

- 2. Immunization**
- 7 = Distribute vaccines
 - 8 = Immunize mother/children
 - 9 = Promote immunization
 - 10 = Training in immunization
 - 35 = Other Monitoring of EPI use
(Specify)

- 7. Other** Specify
- AIDS Education
-
-

- 3. Nutrition**
- 11 = distribute or provide food
 - 12 = distribute or provide Iron & Folic Acid
 - 13 = Distribute or provide scales & growth charts
 - 14 = counsel mother on breastfeeding and weaning practices
 - 15 = Promote growth monitoring
 - 16 = training in breastfeeding & weaning practices
 - 17 = training in growth monitoring
 - 35 = Other _____
(Specify)

- 4. Vitamin A**
- 18 = Vitamin A nutritional education
 - 19 = Vitamin A food production
 - 20 = Vitamin A supplementation
 - 21 = Vitamin A deficiency treatment
 - 22 = Vitamin A fortification
 - 35 = Other _____
(Specify)

- 5. High Risk Births**
- 23 = Distribute contraceptives
 - 24 = Sponsor training sessions on high-risk births
 - 25 = Promote breastfeeding to delay conception
 - 26 = Promote child spacing or family planning or space births
 - 35 = Other _____
(Specify)

are within the impact area for proposed project activities. The LSV was chosen because of its dense population, high rate of infant and child mortality and chronic malnutrition due to the frequent droughts. These problems have been greatly exacerbated by the recent integration in the villages and refugee camps of hundreds of thousands of displaced persons from Mozambique.

Current IEF CS activities are being conducted in the LSV. IEF has a trained staff, a good working relationship with the MOH, and the capability to expand Vitamin A/CS activities in the area.

C.2 Current Level of Infant/Child Mortality

Malawi has one of the highest child mortality rates in the world. Infant mortality is estimated at 151/1000 births and under-five mortality is 267/1000. In the difficult conditions of the LSV the infant mortality is estimated at 205/1000. Although children under 5 comprise 20% of the population, they account for 57% of all deaths.

The leading causes of death among children under five in Malawi are malnutrition, pneumonia, measles, malaria, and diarrhea. A 1983 nutritional survey conducted in the LSV by IEF, John Hopkins University, Helen Keller International, and the MOH showed a 22% prevalence of moderate to severe stunting (<90% height for age) and 3% prevalence of moderate to severe wasting (<80% weight for height). Ocular signs of vitamin A deficiency were found in 4% of children under 6, almost 10 times the rate WHO defines as a problem of public health significance. Blindness due to trachoma, vitamin A deficiency and cataract affects 1.5% of the population. This rate is believed to be the highest in Malawi and considerably higher (x3) than WHO criteria for a problem of public health significance. AIDS is a growing cause of infant mortality throughout Malawi. It is estimated from blood donor records that 9-15% of the rural population is HIV positive. Furthermore, the reduction in infant and child mortality, realized through EPI, vitamin A supplementation and other child survival services over the past year, has been reversed due to the AIDS epidemic.

An EPI survey conducted by the MOH in 1988 demonstrated that full immunization in Chikwawa District reached 72% and 57% in Nsanje District. National figures for ORT use are around 10%.

C.3 Current Status of Programming in CS/Vitamin A Interventions

In 1985 the MOH initiated a program in collaboration with UNICEF and CCD to bring immunization and ORT services to the LSV. Immunizations have been effectively delivered through under-five clinics and mobile teams although there is insufficient monitoring of the service delivery. In Chikwawa District there are 59 mobile clinics and 11 static clinics with an average coverage of 1,300 under-six children. High risk children are still not receiving immunization because a system does not exist to follow up on defaulting children. In 45 villages (about 5% of the under-six population) currently assisted by IEF, the vitamin A management system is being used to identify children that are

not fully immunized. IEF-trained village health promoters then ensure that these infants attend the next MOH under-five clinic. ORT "corners" have been established in health facilities. However, there has been no effective mechanism developed to improve access to ORT by promoting it at the village level. There are only limited birth spacing services available at health facilities with poor access for those not living near a health center.

Vitamin A is available through IEF to its current project villages although MOH supplies throughout the valley (and the rest of Malawi) are non-existent. Key CS participating agencies in the LSV include ADRA, the Catholic Church (Trinity Hospital, Montfort Hospital), UNHCR, and Medecins Sans Frontieres (MSF).

C.4 IEF's Current Infrastructure and Programming in Malawi

The IEF is currently conducting a program for the reduction of childhood mortality and preventable blindness in the LSV. Direct CS interventions include vitamin A supplementation and nutrition education. Equally important are infrastructure building activities such as targeting high risk children for immunization at MOH under-five clinics, identification of malnourished children and introduction of appropriate ORT, and health education to reduce the impact of blinding trachoma. Seventy-eight village health promoters have been trained and are in place in 45 villages supervised and supported by IEF.

C.5 IEF's Experience and Lessons Learned with CS

"Lessons learned" during the current CS project are mainly within the domain of management and infrastructure building. IEF has set up a system whereby all children are monitored by village health promoters for vitamin A and ORT. This management system is applicable to a number of CS interventions. There are a number of different agencies with a long-term commitment to CS activities in the LSV. IEF has learned the value of working within the structures of these agencies and the MOH by supporting their current CS activities with expertise that IEF can offer.

D. Project Design and Duration

D.1 Duration of Project

The duration of IEF's proposed CS project is 48 months from September 1991 to August 1995.

D.2 Project Goal, Objectives and Outputs

The overall goal of the proposed project is the reduction of infant and childhood mortality and morbidity.

Project Objectives:

Project objectives have been divided into service delivery and infrastructure building components. While service delivery is desired, without infrastructure building, the service delivery will not be sustained over time.

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SERVICE DELIVERY OBJECTIVES

1. Provide semi-annual vitamin A supplementation to 75% of children 6 months to 6 years of age.
2. Provide vitamin A supplementation to 75% of mothers within 2 months of delivery.
3. Lower infant & child mortality by 30% in Chikwawa District.

INFRASTRUCTURE BUILDING OBJECTIVES

1. Provide a management structure to increase EPI response by an additional 50%.
2. Provide a management structure to increase ORT use by an additional 50%.
3. Establish a community-based blindness prevention program in 50% of villages.
4. Improve infant and child feeding practices through bi-monthly nutrition education sessions in 80% of villages in the LSV.
5. Establish a community-based worker system in 90% of the villages in Chikwawa District. Assist ADRA in achieving the same coverage in Nsanje District.
6. Assist MOH in starting a village AIDS prevention and control program through the community-based worker system.

Outputs per year

Outputs are throughout the entire target population and in conjunction with specific organizations listed in section D.4.

1991-1992

1. Complete DIP.
2. Hire and train staff.
3. Establish coordination committee of all agencies involved in CS activities.
4. Establish monitoring system with all cooperating agencies.
5. Initiate vitamin A distribution and nutrition education activities.
6. Establish community based roster of all children under-six.
7. Initiate operations research.

Nsanje District-ADRA/MOH

1. Train 21 community health workers.
2. Train 150 village health promoters.

Nsanje District - Trinity Hospital

1. Train 20 village health workers.

Chikwawa District-MOH, Montfort Hospital

1. Train 250 village health promoters.
2. Train 18 health surveillance assistants.
3. Train 50 traditional birth attendants.

1992-1993

1. Initiate EPI monitoring in villages with trained promoters/workers.
2. Establish community based roster of all children under six.

3. Annual report.
4. Establish on-going evaluation system.
5. Include AIDS prevention and control in training programs.

Nsanje District-ADRA CS Grant

1. Train additional 250 village health promoters.
2. Establish management structure for increasing EPI & ORT.

Nsanje District-Trinity Hospital

1. Train additional 10 community health workers.
2. Establish management structure for increasing EPI & ORT.

Chikwawa District-MOH, Montfort Hospital

1. Train additional 350 village health promoters.
2. Train additional 50 traditional birth attendants.
3. Establish management structure for increasing EPI & ORT.

1993-1994

1. Mid-term Evaluation/Annual report.
2. Train trainers (MOH) and supervise their TOT sessions.
3. Train supervisors.
4. Start process of turning over monitoring system to agencies.

Nsanje District-ADRA CS Grant

1. Train additional (remaining) 100 village health promoters.
2. Establish management structure for increasing EPI & ORT.

Nsanje District-Trinity Hospital

1. Train remaining community health workers.
2. Establish management structure for increasing EPI & ORT.

Chikwawa District-MOH & Montfort Hospital

1. Train additional (remaining) 200 village health promoters.
2. Train additional traditional birth attendants.
3. Establish management structure for increasing EPI & ORT.
4. Lower infant and under-five mortality by 20% in project villages.

1994-1995

1. Turn over monitoring system to agencies & MOH.
2. Final evaluation.
3. Reduce active trachoma by 30%.
4. Reduce infant and under-five mortality by 30% in project villages.

D.3 Proposed Project Interventions

The primary target population is defined as all infants, children under 5, and women within two months of delivery. For blindness prevention activities the target population is the entire population of the LSV. Vitamin A and management activities are directed at the primary target population. IEF service delivery interventions are as follows:

1. Vitamin A Semi-annual Vitamin A supplementation will be provided to all children 6 months to 6 years of age and women within 2 months of delivery. Nutrition education will focus on

improving the consumption of vitamin A rich foods as well as energy-dense foods among the target population. (50%)

2. Blindness Prevention Village health promoters will be taught basic eye disease detection, care, referral, and education. They will be the front line to reduce the burden of eye disease in these communities from trachoma, conjunctivitis, and cataract. Primary interventions are hygiene related which will assist other diseases related to poor hygiene. (20%)

IEF infrastructure building interventions are as follows:

1. EPI monitoring A roster with all children in target villages will be created and used to ensure that EPI activities reach infants at high risk for non-response. (15%)

2. ORT monitoring The roster will also be used to target those children identified as malnourished. These children will be encouraged by the village health promoter to attend under-five clinics, improve nutritional practices, and provide ORT. (15%)

3. AIDS prevention and control There are no AIDS prevention and control activities in the LSV nor are there education messages developed for the rural population. When these become available the project will assist in disseminating the information through the appropriate village source.

D.4 Project Approaches

IEF will use a number of approaches to achieve its goal. Primarily, IEF will work within the existing infrastructure of a number of governmental and non-governmental organizations in the LSV by strengthening the services already available (EPI & ORT) in the LSV. IEF will initiate services (vitamin A supplementation, nutrition education, VHP training) that are currently not available in the LSV except in villages where IEF has been working as part of its current CS grant. Thus, IEF will help sustain existing CS programmes and increase collaboration between the various groups in the LSV. IEF will prepare a memorandum of agreement with the MOH (Chikwawa District and Nsanje District), Montfort Hospital, Trinity Hospital, and ADRA.

Nsanje District - ADRA/MOH

IEF will provide training of village health workers and health assistants in the ADRA/MOH project. IEF will also ensure that adequate supplies of vitamin A and basic eye drugs are available. IEF will work with ADRA to introduce a management system to improve immunization coverage and ORT use. ADRA will assume supervision and support of VHP's supported by IEF under the current USAID grant.

Nsanje District - Trinity Hospital

IEF will also assist Trinity Hospital's outreach program by training existing VHP's and providing vitamin A. IEF will also work with Trinity to establish and operate a management system for EPI, vitamin A and ORT.

Chikwawa District - MOH, Montfort Hospital

IEF will work with the MOH and Montfort Hospital (Catholic) to select VHP's in a fashion similar to that which IEF has done in the current CS grant. Initial villages selected will be those where the mobile under-five clinic does monthly visits. IEF will train VHP's and provide vitamin A. IEF will assist the MOH in supervision of VHP's. IEF will also train MOH supervisors and TBA's. IEF will work with the MOH to establish a community based monitoring system for vitamin A, EPI coverage, and ORT use. IEF will continue to use VHP's in villages of Chikwawa District covered by IEF's current USAID supported project.

D.5 Target Population

Nsanje District (includes ADRA/MOH-supported & Trinity Hospital

The Malawian population in Nsanje District (1987 census) is 201,311, of which about 54,250 are children under 6 years of age. There are about 11,250 women who give birth annually.

Chikwawa District (includes MOH & Montfort Hospital

The Malawian population of Chikwawa is 370,200 (1990 estimate). There are approximately 90,500 children under six and about 15,500 women give birth annually. (See Format E).

D.6 Differences Between Current Activities and Proposed Activities

Compared with IEF's current activities in 45 villages in the LSV (total population=42,000) the proposed project will involve the entire village-based Malawian population of both Chikwawa and Nsanje Districts (total population over 570,000). This increase in population served is balanced by the fact that IEF will work completely within existing infrastructures in the LSV. In the 45 villages IEF is currently working, IEF works directly with the village health committees, MOH health surveillance assistants (HSA's), and conducts its own vitamin A rallies.

Compared to the current activities, in the proposed project IEF will relinquish much of the logistic decision-making and supervisory activities. In its place IEF will assume more responsibilities in training (especially training of trainers), program supervision, and coordination of NGO and MOH activities in the LSV. Vitamin A activities will be fully integrated into mobile and static under-five services. Community based rosters will be the key component in the management of EPI, vitamin A and ORT activities of the NGO's and MOH, targeting pockets (villages or areas) of low acceptance of EPI, frequent episodes of illness requiring ORT, and potentially blinding diseases. Management of these services will be developed to become a long-term community-based method for health improvement.

D.7 Malawi Child Survival Strategies

The proposed project fits within current plans for child survival by expanding the availability of vitamin A and improving the service delivery of existing programs. This will help sustain adequate immunization levels and improve ORT use after the

completion of the proposed project. Infrastructure building activities are strongly recommended by USAID/Malawi.

D.8 Coordination with In-Country Agencies

1. MOH (District Health Officer (DHO)/Chikwawa and Nsanje)
IEF has met with the DHO/Chikwawa (Dr. Chappel) and discussed the plans for the next proposed project. He is in favor of the changes and welcomes the idea of IEF working with the MOH in Chikwawa. He is pleased that IEF will start integrating current activities with MOH in the next series of mass campaigns. These will be used as test sites. IEF will attend the first combined under-five/vitamin A clinics and will use the opportunity to see how best the integration can occur.

The DHO/Nsanje (Dr. Klassman) is on leave until January 1991. Preliminary communication with the DHO has indicated that Nsanje District personnel are interested in IEF involvement in these activities.

2. Central Medical Stores (CMS)/Blantyre
IEF met with head of CMS (Mrs. Jonkman) as there is no vitamin A in the valley except at IEF. The district hospitals have a limited budget and have already used up their funds by August 1990. Inadequate amounts of Vitamin A were included in their previous requests primarily because of funding shortages. The current order of vitamin A will only cover about 10% of the children under 6 in the LSV. There is a need for about 280,000 capsules for children in the LSV ($700,000 \times .20 \times 2$ capsules/year) plus 35,000 capsules for women who give birth ($700,000 \times .05 \times 1$). It has been suggested that vitamin A orders should be done through the Districts rather than outside the system such as what IEF is currently doing. Therefore, the money IEF allocates to procure Vitamin A, will now go through the Districts and be tagged specifically for Vitamin A orders. This will help the district to realize that they must order the capsules and pay the cost when the project comes to an end.

3. Regional Health Office/Blantyre
The planned program involving Chikwawa District (MOH & Montfort Hospital), ADRA/Nsanje District was reviewed with the Regional Health Officer (Dr. Jonkman) who is in favor of greater integration with the MOH. A letter of support is attached as appendix B.

4. ADRA/Blantyre
A close working relationship has been established between ADRA and IEF through Randy Purviance (ADRA Country Director) and Bee Biggs (ADRA Child Survival Coordinator) for their Nsanje District project. ADRA is very interested in collaborating with IEF and ADRA would be willing to have IEF current VHPs in Nsanje become their "mother visitors". IEF and ADRA would do some joint staffing, training collaboration, and create consistent records (Nsanje & Chikwawa). A letter of intent written by ADRA is included in appendix B.

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5. Trinity Hospital (Nsanje District) & Montfort Hospital (Chikwawa District)

IEF will collaborate with Trinity Hospital, a Catholic sponsored facility in Nsanje District. Trinity has an outreach program within which IEF can provide vitamin A supplementation, nutrition education, community-based management and prevention of blindness activities. IEF has met with the directors of Montfort Hospital (Dr. Sok and the head matron) who express their full support for collaboration with the planned activities.

D.9 Community Priorities

Working with community based volunteers is not a new phenomenon but one that has been praised and derided. In the setting of the LSV it is essential to utilize the resources available in the communities since external resources are too few to adequately cover the population. The underlying strength of IEF's current activities and of this project is the use of community based volunteers. The community is responsible for the selection of the volunteer. The importance of vitamin A to childhood survival is not well-understood by LSV communities. Nevertheless, the importance of childhood survival is without question. Project activities will be sustained if the community realizes and understands the benefits generated by the work of the volunteers. Feedback to the community is essential to achieve this. Current IEF activities in this area (compilation of number of infant and child deaths, vitamin A rosters, etc.) are essential baseline measures for educating the community about the benefits generated by volunteer activities.

D.10 Private Sector Support and Involvement

IEF will collaborate closely with all agencies involved in child survival activities in the LSV. IEF's intention to work completely within existing health care agencies will enable IEF (with ADRA) to establish a LSV child survival advisory group to share "lessons learned" from project activities, ensure that activities do not overlap, and help establish consistent health education (nutrition, AIDS, vitamin A) messages and recording procedures. IEF will work to see that the advisory committee is sustained within the MOH well after completion of IEF's project.

The collaborative approach to service delivery, as planned for this project, will strengthen the existing health care infrastructure which will make it more likely to be sustained after the project ends.

E. Human Resources

E.1 - E.4 Key Positions, Roles & Responsibilities, Staff Numbers, and Seconded Personnel

Country Director (24 person months or 50% time)

The country director has experience in project management, planning and direction. The country director would train the project director, oversee all aspects of the project, assist in some training (PCV's training coordinator) and maintain contacts with other agencies. The country director has been hired.

Project Director (48 person months or 100% time)

The project director will have experience in project management, planning and administration. The project director will be responsible for administrating the project, conducting advisory meetings, monitoring the health information system and all reporting. The project director will be hired locally.

Consultant Ophthalmologist (19 person months or 40% time)

The consultant ophthalmologist has experience in developing prevention of blindness and training activities. The consultant ophthalmologist will be responsible for all tertiary referrals of ophthalmic conditions by OMA's. The consultant ophthalmologist will also contribute to the technical content of training. The consultant ophthalmologist has been hired.

Training Coordinator (48 person months or 100% time)

The training coordinator has experience in developing and conducting training courses in child survival activities for peripheral health workers. The training coordinator will be responsible for organizing all training sessions, establishing curriculum, and evaluating progress of the trainees. The training coordinator will also be responsible for the training of the trainers. The training coordinator has been hired.

Administrative Coordinator (48 person months or 100% time)

The administrative coordinator will have training and experience in financial management of health-related projects. The administrative coordinator will be responsible for financial planning, management and reporting. The administrative coordinator has been hired.

Trainer/Supervisor (3) 144 person months or 100% time)

The trainer/supervisors (TS's) will be individuals with at least three months formal training in child survival activities and two years work experience in the field. After training, the TS's will be responsible for supervising the activities of HSA's and village health promoters. The TS's have not been hired.

Ophthalmic Medical Assistants (3) (22 person months or 15% time)

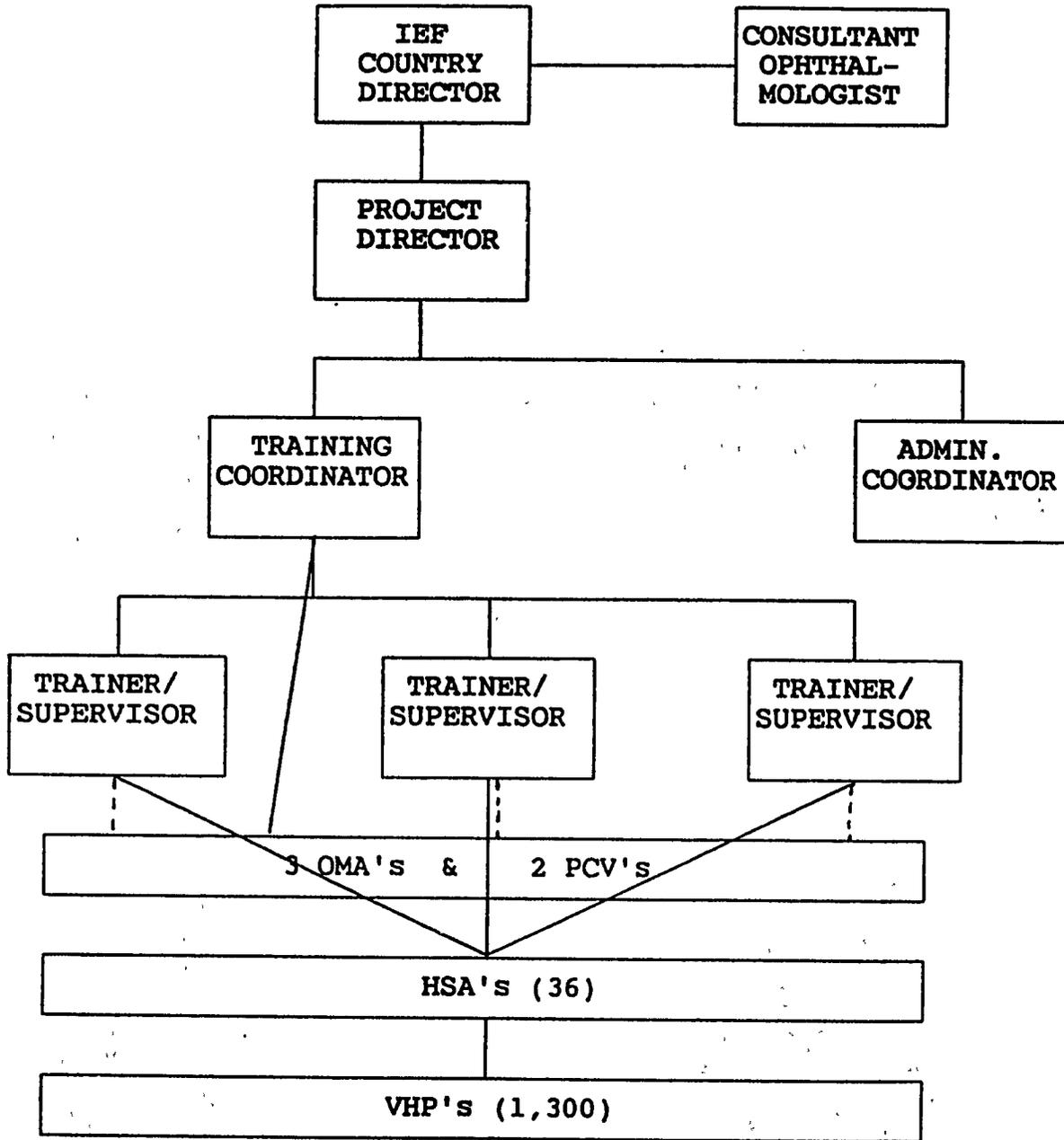
The ophthalmic medical assistants (OMA's) will be trained and certified by the Malawi government and based in the LSV. The OMA's will be responsible for conducting training packages in primary eye care. The OMA's will also be responsible for treatment of referral cases of clinical vitamin A deficiency and other eye diseases. The OMA's are employees of the MOH and will be seconded to the project to conduct the training programs for short periods.

Peace Corps Volunteers (2-3) (96-144 person months or 100% time)

In the current IEF grant two Peace Corps Volunteers (PCV's) have been instrumental in maintaining support of vitamin A activities in project villages. The PCV's will be child survival officers made available by PC/Malawi. The PCV's will be responsible for conduction operations research through a variety of scientific methods. The PCV's will also assist in the supervision and training of HSA's and VHP's. A request for 2-3 PCV's has been made to PC/Malawi and the MOH.

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IEF/ MALAWI ORGANIZATIONAL STRUCTURE



— DIRECT
- - - INDIRECT

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Sample surveys will be used to conduct operations research in the target area. With the establishment of the community based rosters the size and distribution of the target population will be known ensuring more accuracy in the construction of sample sizes for on-going research.

F.3 Dates for Monitoring and Evaluation Activities

As in the current IEF project, data will be collected from VHP's on a monthly basis to permit immediate compilation and interpretation of trends in health indicators. Feedback to the VHP's will also be timely. In the present IEF project the information (and financial report) is submitted monthly. Due to the size of the proposed project this will be changed. Reports will be submitted every three months. This time frame will also allow for consistency of reporting with ADRA. Computer software, tailored for this purpose has already been developed by ISTI (VITAL) and this will assist in the preparation of reports. Changes to the software will be investigated with ADRA to lead to a system that is used throughout the LSV.

F.4 Technical Consultants

A technical consultant from IEF/HQ with experience in constructing and maintaining appropriate health information systems will assist the project in (re) developing the health information system. It is anticipated that the mid-project and end-of-project evaluation will include a sample survey. A technical consultant with experience in health survey methodology will be employed to design and carry out these surveys.

F.5 Data Collection

Primary data collection will be carried out by the VHP's and HSA's. Compilation will be conducted by the Training Coordinator and the Project Director.

G. Schedule of Activities

G.1 See Format F (on following page)

G.2 Constraints to Achieving Project Objectives

A primary constraint to achieving goal #3 (service delivery) in this project is the high prevalence (9-15) of AIDS in the LSV. The incidence of HIV infection and clinical AIDS in newborns and infants is expected to increase. Already in Malawi the reduction of childhood mortality has been reversed by AIDS. It is likely that this trend will continue. It may be possible through the rosters to determine deaths due to AIDS. This will be investigated and if it proves feasible, this will be included in the reporting system.

Nutrition education has been the weakest component of IEF's current project. Considerable barriers to improved nutrition (unavailability of many indigenous vitamin A rich foods, drought and famine, lack of backyard gardening) has led to frustration. IEF has had to refocus its nutrition education to only two or

FORMAT F: COUNTRY SCHEDULES OF ACTIVITIES

COUNTRY: Malawi

ORGANIZATION: International Eye Foundation

SCHEDULE OF ACTIVITIES BY QUARTER (Check box to specify quarter and year)

	YEAR 1				YEAR 2				YEAR 3				YEAR 4				YEAR 5			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
1. Personnel In Position – specify e.g.																				
Project manager	X																			
Technical		X																		
Community/village health workers		X							X											
Support	X								X											
Other Trainers	X																			
2. Detailed Implementation Plan (DIP) (due 6 months after grant is signed)																				
Design/planning	X																			
Preparation of DIP	X																			
3. Health Information Systems (HIS) – specify e.g.																				
Design/preparation of HIS	X																			
Consultants/contract to design/assist with HIS	X																			
Baseline survey (Already Available)																				
Design/preparation																				
Data collection																				
Data analysis																				
Dissemination and feedback to community and project management																				
Registration/record System		X							X											
Design/preparation (Already available)										X										
Ongoing implementation			X																	
Dissemination & feedback to the community & Project Management																				
4. Training – specify e.g.																				
Design and preparation	X																			
Training of trainers	X																			
Training sessions (On Going)		X																		
5. Procurement Of Supplies																				

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FORMAT F: COUNTRY SCHEDULES OF ACTIVITIES (con't)

SCHEDULE OF ACTIVITIES BY QUARTER (Check box to specify quarter and year)

	YEAR 1				YEAR 2				YEAR 3				YEAR 4				YEAR 5			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
6. Services Delivery Initiated			X																	
AREA 1																				
ORT																				
Immunization (Monitoring)																				
Nutrition																				
Growth Monitoring Promotion			X																	
Nutrition Education			X																	
Other																				
Vitamin A (specify) (Supplementation)			X																	
High Risk Births																				
AREA 2																				
ORT																				
Immunization																				
Nutrition																				
Growth Monitoring Promotion																				
Nutrition Education																				
Other																				
Vitamin A (specify)																				
High Risk Births																				
7. Technical Assistance - specify e.g.																				
HO/HO/Regional office visits			X						X											
Local consultants		X																		
External technical assistance			X						X											
8. Progress Reports																				
Annual project reviews									X											
Annual reports									X											
Midterm evaluation									X											
Final Evaluation/report																				X

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three messages and avoid the "shotgun" approach commonly used. As IEF nutrition education improves in quality some changes may be seen in the villages. Nevertheless, the time needed to generate long-lasting change is probably greater than the four year period of this project. It is hoped that the activities of the VHP's will be sustained by the MOH so that, given additional time, nutritional changes may be realized.

Since IEF's role in this project is not administrative it will have to rely completely upon the administrative capabilities of the MOH, Mountfort Hospital, Trinity Hospital, and to some extent, ADRA. An attempt has been made to create targets that reflect some of the obstacles that will be encountered in this project.

Volunteers are a key element to the success of this project. In IEF's current project 78 VHP's have been trained. At the end of November 1990 there have been 4 (5%) dropouts, two due to death of the VHP (one during childbirth, the second presumed due to AIDS), and two for other reasons. One of these women was offered a paying job by World Vision and the second moved with her husband to another area. In IEF's current project VHP's are provided uniforms and shoes upon completion of training. One bar of soap is given every month. In 1990, the MOH has recommended that incentives such as uniforms and shoes not be given to village volunteers. Thus, in the proposed project these items will not be provided. It will be up to the IEF, MOH, ADRA, Mountfort and Trinity Hospitals to devise an appropriate (and consistent) set of incentives to encourage the participation of village women in the project. IEF and ADRA will initiate this investigation soon so that both the IEF and ADRA projects will have established a consistent and workable system before the start of the work.

At this time, there are an insufficient number of HSA's in Chikwawa District. USAID/World Bank have provided funds to MOH to increase the number of HSA's throughout Malawi ten fold starting in 1991.

H. Financial Plan

H.1 See Format G, (on following pages)

I. Procurement:

A. Equipment/Supplies: Provision has been made for necessary office equipment and supplies to ensure adequate project management, appropriate technical and medical equipment to support CS interventions and adequate provision of health education materials. Emphasis has been placed on development and support of the HIS (e.g. computer equipment, roster bag/books and other data collection materials).

B. Services/Consultants: Funds have been allocated for sufficient consultant technical assistance to support all aspects of the development and monitoring of the HIS throughout the project. Further funds for assistance in training, communications/social marketing and printing (for the data collection system) have been allocated.

H.2 Project Budget Justification

Several key program factors provide justification for the total estimated budget including:

- * The geographic dimensions of the catchment area and the target population of 570,000.
- * Poor travel conditions within the project area (bad roads) necessitating an adequate number of vehicles.
- * The two districts which comprise the catchment area, Nsanje and Chikwawa, have been chronically underserved in terms of health services.
- * The steadily increasing number of displaced persons from Mozambique seeking refugee in the catchment area.

* The increase in number of interventions as compared to the current CS program.

* The shift in focus to work through and strengthen the infrastructure of health care service delivery at the village level throughout the entire LSV.

I. Sustainability Strategy

Various methods will be used to help sustain the project after the completion of funding. The project director (to be hired) will be a Malawian. This person will be trained by the IEF country director, and the current IEF project director. Thus, expatriate involvement will phase out over the period of the project. With the development of the SHARED project by USAID/Malawi to develop indigenous private voluntary organizations, IEF will investigate the possibility of continued support at the end of the project period. IEF has obtained support for other activities in Malawi by local manufacturers (for constructing wells) and the Lions Club. These will also be approached to sustain support of the work.

IEF views one of its major goals of the project to strengthen the existing health delivery infrastructure in the LSV. Strengthening these infrastructures will help ensure that the activities that are associated with this project will continue through the MOH and private hospitals working in the LSV. It is anticipated that vitamin A supplementation will be needed in the LSV beyond the project period. IEF will work toward ensuring that supplementation will become part of MOH child survival activities.

It is not anticipated that cost recovery methods will be employed in this project.

J. Collaboration

J.1 Collaboration With Other Organizations

IEF will collaborate with existing organizations in the LSV, primarily ADRA, in all aspects of the project implementation. Since IEF is providing a service (vitamin A) that is currently not available in the LSV (except through IEF in its current project area and through MSF to Mozambican refugees) duplication of services is not expected.

J.2 Peace Corps

In its current project IEF is using two Peace Corps volunteers. Since their end of service in September 1991, IEF has requested two or three new PCV's to start at that time. As in the current project, PCV's will not be involved in administrative activities but in supervising field based activities, training, and operations research.

AID 1360 1 3871 *PIO:T	AGENCY FOR INTERNATIONAL DEVELOPMENT PROJECT IMPLEMENTATION ORDER/TECHNICAL SERVICES	3. Cooperating Country Centrally Funded	Page 1 of _____ Pages
		2. PIO:T No See Attachment	3. <input checked="" type="checkbox"/> Original or Amendment No. _____
		4. Project Activity No. and Title International Eye Foundation (IEF)	

DISTRIBUTION	5. Appropriation Symbol See Attachment		6. Budget Plan Code See Attachment	
	7. Obligation Status <input checked="" type="checkbox"/> Administrative Reservation <input type="checkbox"/> Implementing Document		8. Project Assistance Completion Date (Mo., Day, Yr.)	
	9. Authorized Agent A.I.D./W		10. This PIO:T is in full conformance with PRO:AG No Date	
	11a. Type of Action and Governing AID Handbook <input type="checkbox"/> AID Contract (HB 14) <input checked="" type="checkbox"/> AID Grant or Cooperative Agreement (HB 13) <input type="checkbox"/> PASA-RSSA (HB 12) <input type="checkbox"/> Other		11b. Contract/Grant/Cooperative Agreement/ PASA/RSSA Reference Number (if this is an Amendment)	
	12. Estimated Financing (A detailed budget in support of column (2) is attached as Attachment No. _____)			

Maximum AID Financing Available	A Dollars	(1) Previous Total	(2) Increase	(3) Decrease	(4) Total to Date
				-0-	750,000
	B U.S. Owned Local Currency				

13. Mission References
Previously funded under OTR-0500-A-00-9159-00

14A. Instructions to Authorized Agent: SER/OP/W/MS is requested to execute a three-year child survival agreement with International Eye Foundation (IEF) for a total LOP of \$800,000 for a three-year project in Malawi effective September 1, 1991 to August 31, 1994. For FY 1991 \$250,000 will be provided from the child survival fund and \$500,000 from the Vitamin A account. The remaining 50,000 will be provided in a later PIO:T from FY 1992 funds.

Please clear this agreement with Project Officer before sending to PVO.

14B. Address of Voucher Paying Office
**PPM/FM/CMPD, Room 700, SA-2
Washington, D.C. 20523**

15. Clearances—Include typed name, office symbol, telephone number and date for all clearances.

A. The Project Officer certifies that the specifications in the statement of work or program description are technically adequate. FVA/PVC/CSH: CHabis <i>[Signature]</i>	Phone No. 32616	B. The statement of work or program description lies within the purview of the initiating office and approved agency programs. FVA/PVC/IPS:LWatlington <i>[Signature]</i>	Date
	Date 5/23/91		5/23/91
	C. FVA/PVC/CSH: JMcEnaney <i>[Signature]</i>		
D. Funds for the services requested are available. HTzan	Date 5/23/91	E. FVA/PPM/PMS: EJefferson <i>[Signature]</i>	Date 5/29/91
	Date 5/30/91		

16. For the Cooperating Country: The terms and conditions set forth herein are hereby agreed to
Signature _____ Date _____

17. For the Agency for International Development
[Signature] Date **5/29/91**
Title **Carlos Quiros, Director, FVA/PPM**

*See HB 3, Sup. A, App. C, Att B, for preparation instructions. Note: The completed form contains sensitive information whose unauthorized disclosure may subject an employee to disciplinary action.

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Grantee: International Eye Foundation (IEF)

Project No.: 938-0500
Appropriation No.: 72-1111021.7
Allotment: 147-38-099-00-76-11
Budget Plan Code: EDCA-91 13810 KG11
Amount: \$ 250,000
Obligation No.: 1385020

FUNDS RESERVED BY:

Initials: HTren
Date Posted: 5/30/91
PFM/FM/A/PNP
OFFICE OF FINANCIAL MANAGEMENT

Project No.: 938-0284
Appropriation No.: 72-1111021.3
Allotment: 143-38-099-00-76-11
Budget Plan Code: EDNA-91 13810 KG11
Amount: \$ 500,000
Obligation NO.: 1381207

FUNDS RESERVED BY:

Initials: HTren
Date Posted: 5/30/91
PFM/FM/A/PNP
OFFICE OF FINANCIAL MANAGEMENT

Project No.:
Appropriation No.:
Allotment:
Budget Plan Code:
Amount: \$
Obligation No.:

Project No.:
Appropriation No.:
Allotment:
Budget Plan Code:
Amount: \$
Obligation No.: