





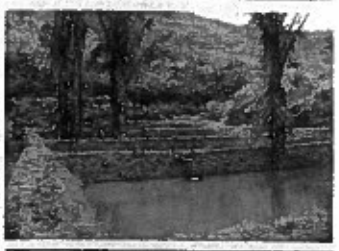


MADAGASCAR GREEN HEALTHY COMMUNITIES PROJECT

Packard Foundation Grant # 2001-18055

FINAL REPORT

January 2002 – September 2005

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A. EXECUTIVE SUMMARY

Financed by the David and Lucile Packard Foundation, the « Madagascar Green Healthy Communities » Project has completed its fourth[1] and final year of implementation. This report constitutes the final report for grant n° 2001-18055. Known as MGHC, the project integrated health, population and environment actions in endangered forest and coastal ecological zones, and was inplemented by JSI Research and Training Institute, Inc. in collaboration with national and international partners including *Voahary Salama*[2], Chemonics International, and a wide variety of rural associations working at the community level.

MGHC achieved at least 80% of its overall objectives, including increased use of modern contraception; improving natural resources management; increasing farmers' incomes and food security; and improving health status of local populations. Positive changes in attitudes and behaviors among members of targeted communities during the 2002-2005 period of MGHC implementation include:

- Increased use of modern contraception from 21.5% in 2002 to 26.5% in 2005. Women are more motivated to space births to protect the health of their families, while men are more motivated to limit the number of births because of the economic difficulty of supporting a large family.
- Elimination of slash and burn agriculture (« tavy ») and the almost complete stop to strip exploitation of natural resources in project zones;
- Increased reforestation of zones ranging from 4 to 14 hectares and 660 to 3000 plants varying by site with average participation by target communities of 80% of households; 28% to 75% of households now practice advanced techniques of soil conservation;
- 81% of the national objective for 2015 for forest and coastal resource transfer to community management has been met within the MGHC project zones;
- Improved household living standards for six of ten households (62%) ; these improvements include food security, savings, and increased variety of agricultural activity and income;
- Improved maternal and child health including:
  - Decrease in child malnutrition from 25% to 20%;
  - Increase in use of prenatal services (73%) and maternity services (41%);
  - Increase in exclusive breastfeeding to 59%;
  - Increase in infants completely vaccinated by 12 months to 79% by 2004, compared to 47% at the national level.

Additional details of project results are available in section D. of this report.

While the project achieved significant measurable technical results, it also layed the groundwork for continued community action for improved human and environmental health. MGHC built capacity among local organizations, supported stronger ties with government services and decision-makers, and created links to supplies of social marketing products. JSI worked hard to leverage resources to provide additional support for the activities and create networks that will foster sustained results now that the project has closed.

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[1] January 2002 through October 2005.

[2] Project sub grantees included : ADRA, AINGA, ASOS, LDI, MICET, MITSINJO, Ny Tanintsika, SAF/FJKM, SAGE, Voahary Salama.

DESCRIPTION

In response to the interdependent problems of rapid demographic growth, slow economic growth, and the extensive, unsustainable use of natural resources, MGHC and its partners from Voahary Salama implemented activities in environmentally important and isolated communities[3] from January 2002 through September 2005. The ultimate goal of the MGHC project is for the population to have improved health and nutritional status, live in a clean environment, and be able to effectively manage local natural resources in the zones peripheral to the rainforest. This goal reflects an overall aim to achieve equilibrium between population growth, economic growth and use of natural resources. MGHC and its partners focused their efforts on improving the management of natural resources and the economic conditions in targeted rural communities, impacting the lives about 17,920 people or 2,986 households[4].

To achieve this goal, the project used several different integrated approaches including social mobilisation, reinforcement of community partners, and social marketing in particular the Champion Community approach, which is reinforced by a radio programme. These integrated approaches increased the capacity of local communities and encouraged them to take responsibility for their own health and food security, while adopting practices that also protect the environment. The intermediate results were:

1. Increased use of modern contraception;
2. Improved natural resources management;
3. Increased farmers' incomes and food security;
4. Improved health status of local populations.

CONTEXT

Madagascar is one of the rare countries in the world with abundant natural resources as well as broad ecological diversity. However, this important biodiversity is menaced by high levels of deforestation, irrational exploitation of resources, and other factors including rapid population growth (2.8%)[5], and the extreme poverty of the population (69.6%). These factors lead to a precarious state of health for most Malagasy, including high rates of infant, child and maternal mortality, generalized malnutrition, and a high incidence of infectious disease. Given this situation, the Malagasy government elaborated national policies within the Poverty Reduction Strategy Paper to support rapid and durable development[6].

The project was launched in a difficult context of socio-political crisis which has disastrous consequences for the populations in isolated areas. For example, in Ikongo, 282 people died of « type A » influenza in August 2002, representing 45% of national mortality during this period.[7]

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[3] Forest corridor of Ranomafana- Andringitra and Mantadia-Zahamena in the Anosy region, around Andohahela Park and the dry forest of the southwest, and in the north in the DIANA region (Diego II, Ambilobe, Nosy-Be, Ambanja)
[4] Source : RRA Surveys in target villages, AINGA – ASOS – MITSIJO – Ny Tanintsika – SAF/FJKM — SAGE, 2003.
[5] Source : RGPH (General Census), 1993.
[6] PSRP: Finalised in July, 2003 with first up date in June, 2005.
[7] Source : Ministry of Health and Family Planning, Madagascar, Rapport de la situation épidémique du virus « Influenza » par province et par district, 19 août 2002.

In 2003, the two USAID projects that supported MGHC (*Jereo Salama Isika* and Landscape Development Interventions) ended, leaving MGHC as the primary financing source for health, population and environment activities. In 2004-2005, the country faced another economic crisis due to the limited availability of the staple food, rice; this affected all segments of the population. It coincided with the annual period of food shortage for rural families, and led to a reversal of agricultural practices and additional environmental destruction.[8] During this period, President Ravalomanana reframed the role of family planning in national development, integrating it into national priorities and changing the name of the Ministry of Health to the Ministry of Health and Family Planning. Simultaneously, the process of decentralization was accelerated through establishment of twenty-two regions in the country. Overall, the period of MGHC implementation was one of crisis and great change at both the community and national levels.

D. PROGRESS

Quantitative Results

Thirty-three counties (communes) with 98,034 inhabitants, living in 11 districts, 7 regions and four of six provinces were the intervention regions. Of the target population, 88,000 people benefited from project activities, or a coverage rate of 89.8%.[9]

Increasing the Use of Modern Contraceptive Methods

Modern Contraception (N = 206)		
Current use	33%	68
Use before project implementation	25%	17
Use during project implementation	75%	51

Family planning was one of the components of MGHC that evolved successfully. The household survey completed as part of the final project evaluation showed that utilization varied among sites from 20% to 43%, and that 74% of people surveyed declared having started using modern contraceptive during the period of project implementation. Access to both contraceptives and counselling improved, although access to long-term methods remains problematic for rural populations. In terms of Couple Years of Protection for oral and injectible contraceptives, results in 2005 are 32% and 67% respectively as compared to 30% and 62% in 2002.

Improving the Management of Natural Resources

Globally, the indicators show a reduction in the exploitation of protected natural resources by populations living adjacent to protected areas, reaching total elimination of these practices in some project areas. In addition, implementation of practices that preserve, restore and increase the local value of the environment also were completed. Activities leading to the abandonment of slash and burn agriculture had 58% -100% success rates. Results of the 2005 household survey show that 80% of the population actively participated in the reforestation projects promoted by MGHC, and that up to 65% of surveyed households declare that they are practicing at least one method of soil conservation (anti-erosion plantings, canalization, etc). Of a total of 49,633 hectares of forest land and marine zone transferred to protected status, 48,790 hectares were

[8] The price of a kilo of rice rose from 2.400 francs to 3.500 – 6.000 francs.

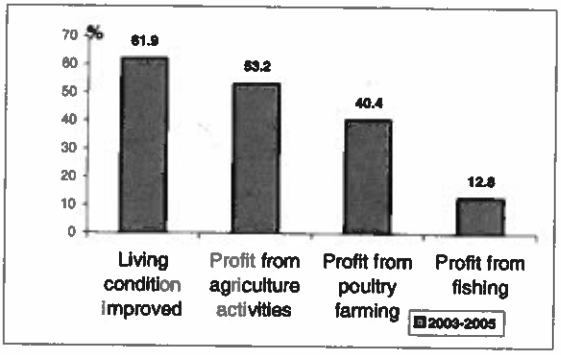
[9] Whole population benefiting from the project at the end of the project based on NGOs reports (2005). Compared to the RRA data in page 3, this shows how big is the progress made from villages to Fokontany or commune in terms of coverage.

transferred during the project period; this equals 81% of the national objective established for 2015.

Improving Household Revenue and Food Security

The objective was to assist families to find alternative sources of revenue other than direct, unsustainable use of adjacent natural resources. Overall, six out of ten households stated in the survey that their living conditions improved by using new methods for agricultural production or animal husbandry.

The graph summarizes the proportion of households surveyed that generated income by adopting new practices. In addition, some activities led to an evolution from a subsistence economy to a market economy, such as the cultivation of natural ginger root which saw production increase from 4.5 tons per hectare to 9 tons per hectare between 2003-2005. The average annual harvest now equals 560 tons for the rural peasant cooperative of Koloharena in the county of Beforona which has 1600 active members.

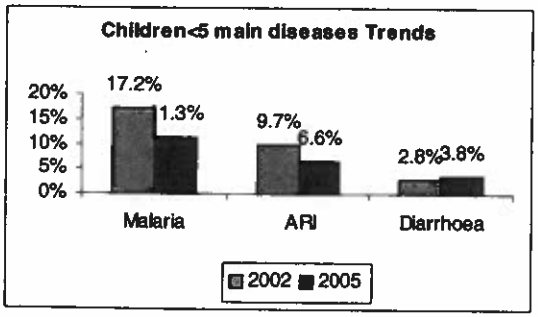


Source : FOCUS, HHS, 2005

Improving the Health Status of the Local Population

The availability of accessible expert services to support and reinforce community efforts has had a positive impact on the health of the target population. Together, community educators, social marketing services and health providers have produced the following results:

- Use of prenatal services has risen to between 56% and 100%, and the rate of assisted deliveries in health centers has increased from 29% in 2002 to 41% in 2005;
- Maternity mortality as recorded in local health centers has declined by half between 2003 and 2005, from 320 to 160 deaths per 100,000 live births; [10]



Sources : CSB, RMA, 2002 - 2005

- Childhood malnutrition rate for children under the age of 5 registered at the health center [11] declined to 20% in 2005 from 25% in 2002;
- Immunization of 94 % of children 12-24 months living in target zones has been completed according to EPI standards (National results are 80%);
- Immunization of 73% of children 12 months old months living in target zones has been completed compared to 47% at

[10] At national level, DHS 2003-2004 shows Prenatal Care: 80% - Delivery at Basic Health Center: 31,8%.

[11] Malnutrition of children followed at health centers is defined according to children in the yellow or red bands using the brachial width measurement.

- Potable water is available in 30% of target households (2004 household survey) compared with 23% availability in rural households according to the 2003-2004 DHS .[12]

[12] Sources : FOCUS, Household Survey, 2005

Quantitative Results Summary		
	2002	2005
Increasing the use of Modern contraceptive Methods		
Number of CBDW trained and operational	144	244
Number of regular users	1500	2500
Prenatal Care rate	ND	73,1%
Contraceptive Coverage Rate	21,5%	26,3%
Couple Year of Protection (Oral contraceptives)	29,9%	31,7%
Couple Year of Protection (Injectibles)	62,5%	67,2%
Improving the Management of Natural Resources		
% of Households involved in new agricultural techniques	ND	57%
Number of functional supply centers	3	50
Number of new production practices implemented	0	5
Number of households adopting new environmental conservation techniques	238	2443
Total reforested surfaces (hectares)	4,5	45.599
Rate of deforestation	0,83%	0,01%
Total surface area cultivated by slash and burn by district (hectares)	250	0
Adoption rate of new production practices		15 - 38%
Yield rate per hectare (rice)	1 ton	2,05 tons
Preserved species rate	ND	100%
Improving Household revenue and Food security		
Number of conservation-enterprise activities developed	ND	3
Additional income generated through supplemental income		39,1 - 84,8%
Number of credit beneficiaries (Households)	1277	11460
Adoption rate of new agricultural techniques	0,33%	22%
Improving the Health status of the local population		
% households with young children purchasing and actively use child and mother health cards	90%	91,3%
Number of village water systems or latrines built	0	344
% of women exclusively breastfeeding for 6 months	ND	59,2%
Number of vaccination diplomas distributed	505	2500
% households using treated bednets	ND	47,1%
Infant Nutrition status (Malnutrition rate)	24,9%	20,2%
Vitamin A coverage rate	0	90,4%
Malaria Incidence (children <5)	17,2%	11,3%
Diarrhoea prevalence rate	7,9%**	3,8%
ARI prevalence rate	9,7%	6,6%
STI prevalence rate	1,9%	1,2%
Immunization rate	ND	65,5 - 99,1%
% children under 12 months completely vaccinated	90%	91,4%
Maternal mortality rate	3,2‰ *	5‰
% Live birth in Health Centers	95,8% *	98%
% Delivery at Health Centers	29,1%	40,9%

ND : Non Determined

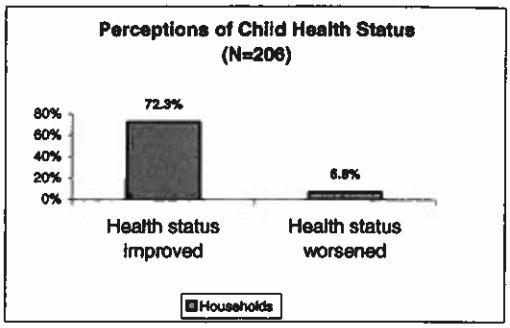
(*) : 2003

(**): Household Survey, Entr'aide, 2004

Sources: CSB Reports, Project annual reports, final evaluation reports, 2002, 2003, 2004, 2005

Qualitative Description

According to household survey results, the integrated health, population and environment work of the project gave them tangible benefits. The implementation methods of MGHC proved to be both effective and efficient. The chart indicates parental perceptions of how their children's health status has changed during the implementation of MGHC. Other qualitative results include:



Source : FOCUS, HHS, 2005

- Use of modern family planning contributed to increase status of women and increased their availability for economic activities[13];
- Increased level of responsibility by local authorities and communities for environmental protection, with an improved understanding at all levels of the value of the environment and negative consequences of its destruction;[14]
- Creation of two video/DVD documents to inform and disseminate health-population-environment approaches to regional, national and international leaders;
- Testing the Champion Community/County approach, developed in and for forest zones, in coastal and estuary areas since 2003 supported by UNDP; the approach proved successful;
- Assistance to and participation in *Voahary Salama*, especially the evolution from a consortium to an association of twenty-nine international and national non-governmental organizations;
- Significant leveraging of UNESCO funds to extend the same model and approach into two additional districts;
- Development of rural radio as a development partner, contributing to the overall mobilization of local mass-media and accelerating the absorption of new information leading to changed behaviors and practices by target households.

E. ORGANIZATIONAL CHANGES

There were no major organizational changes during the final project year.

F. LESSONS LEARNED/FUTURE CHALLENGES

A number of lessons learned were accumulated over the four years of the MGHC Project. The most important ones include:

1. Use Prior Experiences, even from Multiple Sectors, to Increase Momentum and Achievements

Madagascar Green Healthy Communities Project capitalized to a large extent upon the work done by prior projects in both the health/population sector and in the environment/conservation sector.

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[13] Source : Ny Tanintsika, N. interview , Ankarefobe, CR Ambolomadinika, 2005

[14] *« Depuis que nous nous sommes engagés dans la gestion de la forêt d'Analabe, l'eau est disponible toute l'année, ce qui nous a permis de diversifier nos productions et de boire de l'eau potable. La commune avoisinante en a aussi bénéficiée. »*, interview with CLB of Mahagaga, CR Mosorolava, 2005

Prior achievements were adapted to new elements and gave overall MGHC Project interventions an innovative and proactive character that permitted the Project to achieve rapid results and the communities to benefit from the cumulative effect of a broad spectrum of continuous actions.[15]

2. Project Implementation has led to the Galvanization of Additional Financial Resources.

MGHC Project staff did not expect this to happen, which made the results even more surprising. Examples of these additional resources include :

- The Champion Community/County approach was a catalyst for local authorities to identify and obtain additional local development financing;
- The mobilization of technical and financial partners led to a tripling in the number of managed sources of potable water in target villages;[16]
- The success of micro-credit revolving funds enabled the number of beneficiaries to double and the production in some areas to double in two years as well (ginger).[17]

3. Successful Program Models have been demonstrated that can be Replicated Elsewhere.

For example, inexpensive community mobilization techniques can mobilize rural communities and provide significant program results within 1-2 years. [18] « The Champion Community approach used in Madagascar is an excellent model that has proven ability to mobilize strong community participation to achieve clearly defined, multi-sectoral targets within a one-year period. »[19]

4. Non-governmental Organizations can work in more than their one Sector of Expertise with Success.

In MGHC project zones, the project worked with health organizations and environment-based organizations, and both types successfully implemented the health-population-environment project. Strong leadership, good reputation within the community, good staff and acceptance of the integrated program as well as support from MGHC and local authorities were important to this success.

5.Integration of a Micro-Credit Program can lead to extensive Community Engagement.

The addition of a micro-credit program was added to respond to community needs and address some of the real barriers to improved use of local resources. Poverty and lack of access to credit were quasi-total conditions in MGHC Project zones. MGHC staff and local organizations noted that the micro-credit funded activities enabled communities to better manage natural and coastal resources while simultaneously increasing household food security and often times income.

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[15] FOCUS, Final evaluation Report, MGHC, 2005.
[16] Water supplies infrastructures built with collaboration of FIKRIFAMA/BM, Peace Corps Volunteers, World Bank/ FID: 68 water supplies by gravity system, 1 water tower, 3 water tanks.
[17] Micro-credit expected results: 600 tons by 2005 by 1200 peasant farmers; Actual results: 1300 tons in 2004 by 1620 farmers.
[18] Source : Mid-project Review, Packard Foundation, November 2003.
[19] Source : John Pielemeier, PHE Program Review Report, Packard Foundation and USAID, August 2005.

6. Integrated PHE Programs may produce Better Results than Sectoral Programs.

Many factors may have combined to produce the results from MGHC, but other sources also note a global trend in better results from integrated Population-Environment or Health-Population-Environment programs.

> « Although Operations Research results have not always been statistically significant, the "on the ground" results have been significant enough to convince most PE and PHE practitioners that integrated programs have better results than single-sector programs and are more programmatically efficient. »[20]

Looking forward, JSI can predict little in terms of true, long-term sustainability of MGHC Project achievements. However, the project did validate the competency of local management of resources and assure the transfer of development skills to county and community leaders. These leaders did put into place a more organized coordination and management structure, which in the midterm should be able to use their own resources and knowledge to assure the sustainability of improvements. Overall, if MGHC has proven the effectiveness in achieving specific local development objectives, the accomplishments at this point are not enough to guarantee their long-term viability.

G. DISSEMINATION

In accordance with the MGHC Work Plan and the results of the mid-term evaluation, the final two years of the project were oriented towards -among other items- broader dissemination of the integrated approaches for health-population-environment especially the Champion Community/County. Therefore, MGHC had the opportunity to share its best practices and lessons learned in a variety of venues :

«...Ministers Jean Louis Robinson (Health and Family Planning) and Zafilaza (Population) attended the dissemination conference and congratulated MGHC and participants. They encouraged the population to continue their efforts ».

- Regional: In the context of the integration of MGHC approaches in County and Regional Development Plans, these approaches became tools for local and regional development. *« ...Champion Community was a great success. It is now time to scale it up to the regional level »*[21]. Two videos/DVDs are now available for local and regional dissemination, especially of the Champion County approach.

  National: During the National Day for Health and the Workshop for the Dissemination of the Champion Community Approach in June- July 2004, and the MGHC Final Dissemination Conference in October 2005, national leaders from private and public sector groups attended. Broad use of media, including newspapers and radio, Video and DVD, have enabled

[20] Source: John Pielemeier, "PHE Program Review Report", Packard Foundation and USAID, August 2005.
[21] Sources Madagascar Newspapers Malaza, October 21, 2005, « MGHC : le projet est terminé » - Express, October 22, 2005, Développement : les communes à l'heure du marketing social.

many throughout the country to learn about MGHC approaches and results.

- International: MGHC disseminated approaches and success stories whenever possible. This took place primarily as it advocated with donors and governments for funding for integrated programs, and through sharing with other countries and development partners in Africa and the USA. Specific examples include technical support to Tanzania, Mali, and Ethiopia, and presentation of MGHC approaches and results at Global Health Council Conferences and JSI International Division meetings. JSI will continue to disseminate MGHC results through its occasional paper series (2006), library and website.

Overall, dissemination in Madagascar was widespread and used multiple channels. More could be done to disseminate the results regionally in Africa and throughout the world. Unfortunately, the trend for major donors seems to be away from integrated health-population-environment programs but better dissemination and advocacy may make a difference. In Madagascar, JSI and its implementing partners hope to continue to see counties and communities working together to improve health, decrease population growth, and improve the environment in this rare and beautiful country.

H. LEVERAGING

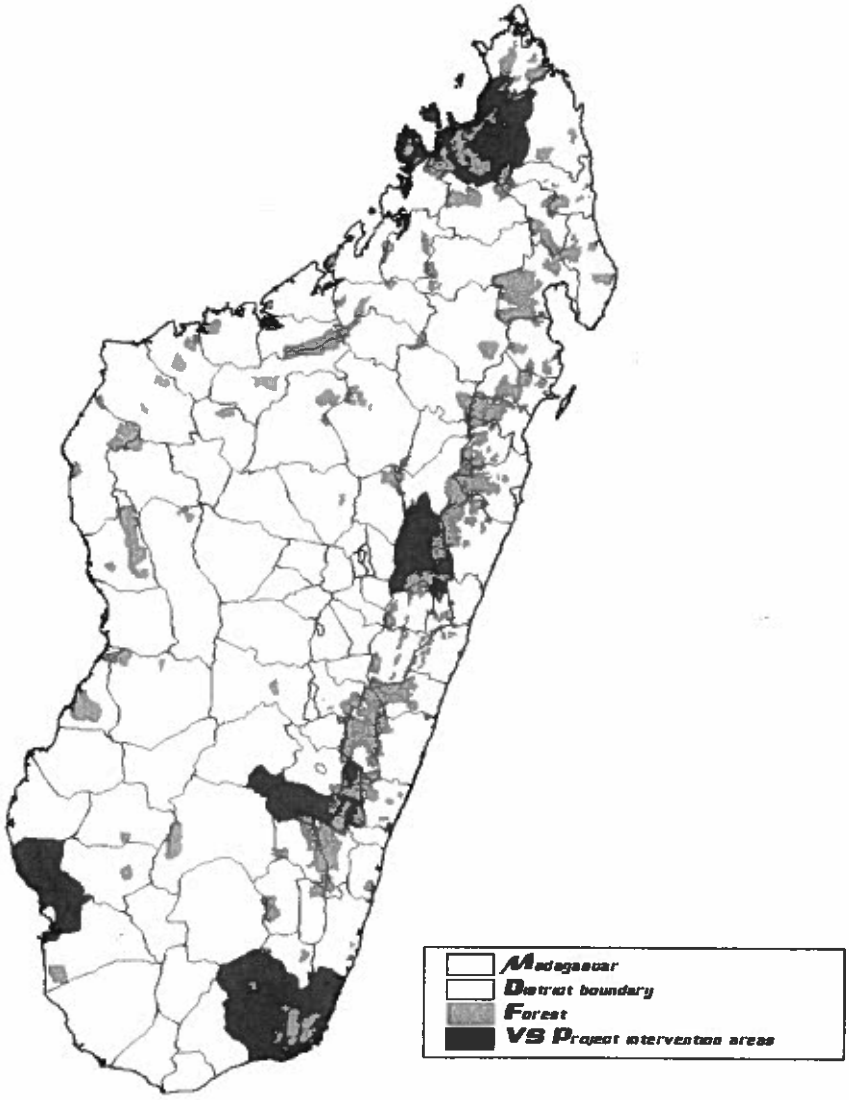
From the outset, JSI tried to leverage MGHC funds with funds and contributions from a variety of other sources, both Malagasy and international. This strategy of mobilizing additional funds through solicitation of multiple partners produced a multiplier effect for available resources and increased both the population and the range of geographic areas than benefited from project approaches. Some of the notable leveraging that took place included :

- UNESCO has extended project reach through replication in other districts next to sensitive ecological zones ;
- USAID has committed to taking the Champion County approach to a larger scale, to 300 counties « Kaominina Mendrika » through the SantéNet health sector project by 2008;
- World Bank projects have funded improved potable water sources, reforestation and infrastructure for health.

Overall, JSI estimates that MGHC leveraged at least $212,000 US[22] during the four years of the project, not including the major infusion of technical and financial support to come from USAID's expansion. In addition, human resource leveraging valued at $679,859 and goods and services of $295,821 were also leveraged. The total of this estimated leveraging is therefore $1,188,246 (see Appendix 3) .

[22] Partners: ASOS, Communities, ERI, FAO, FID, FIKRIFAMA/BM, Japanese Association, LDI, SAGE, UNESCO, EHP/ECHO.

Appendix 1 : Project Map Area



Appendix 2: News Releases

MADAGASCAR *laza* N°287 Jeudi 20 octobre 2005

Madagascar Green Health
Le projet est terminé

Le projet MGHC a atteint ses objectifs (Mamy R.)

Objectifs atteints pour le projet MGHC ou Madagascar Green Health Communities, en l'occurrence, promouvoir les stratégies dans les activités intégrées : santé, population, environnement. Ce projet, mis en oeuvre par le JSI ou John Snow Inc et financé exclusivement par le couple David et Lucile Packard, a pris fin en septembre dernier après exercice d'une durée de 4 ans, depuis janvier 2002.

En guise de clôture, un atelier, faisant office de bilan de ce projet MGHC ou, plus communément, Madagascar Vert Santé de la population, s'est tenu hier au Hilton Madagascar. Le partage d'expériences en matière d'approche intégrée "santé, population et environnement" a été discuté au cours de la séance, ainsi que la détermination des potentialités pour la pérennisation des actions dans le contexte de développement local et régional. L'objectif principal du projet MGHC est de promouvoir des stratégies et des activités intégrées de santé-population- environnement.

7 sites répartis dans les régions de DIANA, Beforona, ont été concernés par ce projet. Ces zones ont été choisies en fonction des liens avec "le corridor", l'éloignement des centres de santé de base et les zones d'intérêt écologiques. A l'issue de ce projet, les communes d'intervention de la MGCH se sont déclarées satisfaites des résultats obtenus notamment le renforcement des capacités et le changement des comportements humains en vue d'un développement socio-économique durable.

Le maire de la commune de Beforona affirme déjà que le projet a engendré un développement considérable dans sa région, à l'exemple des 80 % des cultivateurs de gingembre qui adoptent actuellement les techniques écologiques modernes pour un rendement de 1.000 tonnes en 3 ans. Les "tokontany" ne se limitent plus à la culture traditionnelle, les cultures contre-saison (pisciculture, culture maraîchère) font maintenant partie des activités. 65 pisciculteurs dans 5 tokontany, ainsi que la plantation de 9.000 pieds de litchis ont été réalisés. En outre, des progrès en matière de protection environnementale ont été constatés. A citer l'exemple de l'exploitation de charbon de bois dans le site d'Analamazaotra, la pratique illicite de charbonnage a largement diminué. De ce fait, les charbonniers sont devenus de surveillants efficaces de la forêt.

En ce qui concerne la santé de la population, 47,1 % des ménages utilisent les moustiquaires, selon toujours le rapport du projet. Ceci a permis de réduire le nombre de victimes du paludisme.

Rappelons enfin que 250 personnes ont participé à cet atelier de clôture.

Nina A.

L'Express SAMEDI 22 OCTOBRE 2005 7

DÉVELOPPEMENT

Les communes à l'heure du marketing social

Appendix 3: Leveraging

Partners	Financial support	Human resources	Goods and services	Amount (USD)
Financial partners				**58,744.42**
UNESCO	57,173.00			57,173.00
ERI	1,285.71			1,285.71
DON JAPONAIS	285.71			285.71
Technical partners				**277,351.95**
USAID			175,975.71	175,975.71
FAO			10,833.82	10,833.82
DODWELL TRUST		16,460.32	23,618.68	40,079.00
FID			16,420.57	16,420.57
FIKRIFAMA			26,185.71	26,185.71
PSDR			1,428.57	1,428.57
PEACE CORPS			6,428.57	6,428.57
Other projects				**299,766.59**
PSI		1,671.41	114.28	1,785.69
LDI	13,142.85	97,942.84	7,619.04	118,704.73
ADRA		14,329.29	137.14	14,466.43
EHP/ECHO	107,219.00	19,682.14		126,901.14
JSI		18,848.92	19,059.68	37,908.60
Local NGOs				**238,312.14**
SAGE	7,055.32	51,907.28	1,371.42	60,334.02
NY TANINTSIKA		27,267.83	742.85	28,010.68
AINGA		10,277.13		10,277.13
ASOS	26,403.18		1,600.00	28,003.18
SAF/FJKM		61,110.00		61,110.00
MICET		3,667.14		3,667.14
MITSINJO		20,910.00		20,910.00
Koloharena / Tongalaza		21,714.28	4,285.71	25,999.99
Public Sector				**314,071.29**
Ministry Of Health and Family Planning		274,399.92		274,399.92
Ministry of Population, Social protection and Leisures		10,742.83		10,742.83
Ministry of Environment, Water and Forest		20,699.98		20,699.98
Ministry of Decentralization and Regional Development		8,228.56		8,228.56
TOTAL Amount	**212,564.77**	**679,859.87**	**295,821.75**	**1,188,246.39**