INTERAGENCY AGREEMENT
BETWEEN THE U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
AND
THE CENTERS FOR DISEASE CONTROL AND PREVENTION

1. Project Title: Infectious Disease Results Package	2. Project Number: 936-3100 Phoenix/NMS#: Award Number:	
3. Resource Code: 4100800	4. Activity Name: CDC IAA	
5. Fund Account/Symbol (see page 2)	6. Fiscal Year: 2006	
7. Completion Date: September 30, 2011	8. Original __X__ or Amendment No.	
9A. Prior Funding	9B. Funding Obligated this Document $11,139,731	9C. New Total Funding $11,139,731
10. Authority: Section 632(b) of the Foreign Assistance Act of 1961, as amended.		
11. This Interagency Agreement (IAA) will support activities in control and prevention of infectious diseases, including collaborative activities in support of strategy and program development, implementation, operations research, training, monitoring, and evaluation of maternal health, child health, HIV/AIDS and infectious disease activities undertaken by USAID.		
12. Liaison Offices/Additional Representatives		
A. Centers for Disease Control and Prevention Michelle Copeland (404) 639-3189	B. U.S. Agency for International Development Emily Wainwright (202) 712-4569	
13A. Signature by Authorized Representative: CENTERS FOR DISEASE CONTROL AND PREVENTION BY: _____ NAME: Dr. Stephen Blount, MD TITLE: Director Office of Global Health Office of the Director DATE: _____	13B. Signature by Authorized Representative: U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT BY: _____ NAME: Gloria D. Steele TITLE: Senior Deputy Assistant Administrator Bureau for Global Health DATE: _____	
14. This Interagency Agreement consists of this face sheet and the following items (if checked): __ Revised Schedule X Annex B - Revised Financial Plan and Budget	X Annex A – Program Description X Annex C - Standard Provisions	

ACCOUNTING AND APPROPRIATION DATA SHEET
IAA with the Centers for Disease Control and Prevention
Award No.

A. GENERAL

1.	Total Estimated Cost:	$ 100,000,000
2.	Total Amount Obligated prior to Action:	$ 0
3.	Total Amount Obligated this Action:	$ 11,139,731
4.	Total Amount Obligated	$ 0
5.	Project Number:	936-3100
6.	USAID Project Officer:	Emily Wainwright GH/HIDN/ID 3.07-043, 3rd Floor, RRB Washington, DC 20523-3700

B. SPECIFIC

1.	NMS/Phoenix Request Number:	000001777
2.	Organizational Symbol:	GH/HIDN/ID
3.	Resource Category Code:	4100800
4.	Activity Name:	Umbrella CDC IAA
5.	Fund Account/ Allotment Symbols:	CD 06/07 SO 3 $450,000 CD 06/07 SO 5 $2,430,000
	Field support:	06GH-AFR-TBD-GH-06-2006: $1,307,000 06GH-AFR-GH-6-2006.A: $900,000 06/GH-ANE-GH-06-2006.B: $200,000
	Maard:	USAID/Indonesia: $50,000 USAID/Mexico: $454,731
6.	**Total Obligation Amount:**	**$ 11,139,731**

Schedule

A. PURPOSE OF AGREEMENT

1. This Agreement between the Centers for Disease Control and Prevention (CDC) and the United States Agency for International Development (USAID) is entered into under the authority of Section 632(b) of the Foreign Assistance Act of 1961, as amended. The Agreement defines the procedures under which USAID will reimburse CDC to implement the program for the Cooperating Countries (as further defined in Section H of this Schedule) in accordance with this Agreement.

2. For purposes of this Agreement, the term "Cooperating Country" means the country receiving assistance under this Agreement and includes the countries defined in this Agreement, and such other countries as USAID and CDC may agree to in writing.

B. PERIOD OF AGREEMENT

Date of signature of USAID representative in Block 13.B of the face sheet of this Agreement to September 30, 2011.

C. PURPOSE OF PROGRAM

The Program, as further described in Annex A, consists of assistance to strengthen the delivery of field support and programming to USAID missions through the provision of technical and program support from CDC and to carry out appropriate research for the development of new and appropriate approaches and technologies in response to near and longer-term field needs. The Program will support activities in control and prevention of infectious diseases, as well as system strengthening activities represented by quality assurance, health financing, and health and management information.

D. FISCAL TERMS

1. Execution of this Agreement constitutes an obligation by USAID of the funds specified in Block 9B of the face sheet of this Agreement.

2. USAID funding for the Program is limited to the total obligated funding (Block 9C of the face sheet of this Agreement). Unless USAID agrees otherwise in writing, funds obligated under this Agreement are available for Program expenditures from the date of this Agreement through the Program Completion Date specified in Block 7 on the face sheet of this Agreement. USAID may obligate contributions in excess of its initial obligation by one or more amendments to this Agreement, subject to the availability of funds and mutual agreement of USAID and CDC to proceed at the time of any such amendments. If CDC chooses to continue Program activities after USAID funding has been exhausted, CDC agrees to use its own funds for that purpose. As a matter of its internal policy, CDC will consider expenses exceeding USAID funds to be the responsibility of CDC.

3. The financial plan in Annex B sets forth the budget for implementation of the Program. Within the total budget amount for the Program, CDC may adjust individual line items, provided that (1) any adjusted line item does not change by more than 15 percent of the amount shown for that line item in the financial plan and (2) CDC obtains prior written approval from the USAID CTO.

E. BILLING; FINANCIAL, AND OTHER REPORTS

1. CDC must bill USAID through the Intra-governmental Payment and Collection system.

The USAID financial contact person is the Office Chief, M/FM/CMP/IBU, at 202-712-0519 (telephone) and 202-216-3543 (fax). The USAID Agency Location Code (ALC) for billings is 72-000001 the EIN Code is 4720000010, and the DUNS number is 126424600.

2. CDC must furnish the original and two (2) copies of each quarterly financial report required under Section C of the Standard Provisions (Annex C) of this Agreement to the above-stated address. Such quarterly reports are due on February 28, May 31, August 31, and November 30 of each year. In addition, a copy of each financial report shall be submitted to:

USAID
Emily Wainwright
GH/HIDN/NUT
Cognizant Technical Officer
Ronald Reagan Building
Room 3.07-075M
Washington DC 20523-3700

3. CDC must use the categories of obligations and expenditures set forth in Annex B of this Agreement. CDC must provide this information both in summary form for the entire Program and separately by Cooperating Country.

F. PROGRAM PERFORMANCE PLANNING AND REPORTING

1. Overall Project Description and Annual Work Plans

a. Workplans: CDC shall submit, in form and substance satisfactory to USAID, annual country and program-specific work plans. A proposed format for the work plan is included in Attachment 1. The workplans shall:

i. Specify benchmarks of progress toward achieving the Program goals and objectives;

ii. Identify major activities to be undertaken by CDC, including participant training, and indicators for determining the timing and measuring the progress of each activity, and

iii. Identify resources to be used to achieve Program activities and the timeframe for their development.

b. First Year Work Plan and Approval: Annex A of this Agreement is the approved work plan unless otherwise stated.

c. Monitoring and Reporting: CDC will use the annual workplans to monitor its progress in executing and achieving the objectives of this Agreement. During program implementation, either CDC or USAID may recommend revisions to the workplans as necessary. However, revisions must be approved by CDC and USAID in writing before any changes are implemented.

2. Reports

a. Periodic Progress Reports: CDC shall provide to USAID, in form and substance satisfactory to USAID, bi-annual reports on progress toward achieving Program objectives and implementing approved workplans. These reports are due April 30 (mid-year) and October 31 (annual report) of each year. These reports shall include, but not be limited to, the following information: status of achieving goals, objectives and benchmarks specified in the annual workplan; progress or completion of components, elements or activities against planned targets; description of overall Program status, other accomplishments and major highlights of Program implementation; identification and explanation of significant problems or delays related to achievement of objectives or activities; a brief summary of significant corrective actions and major activities planned for the subsequent reporting period.

The mid-year and annual reports should be 2-3 pages in length for each activity (see Annex A). A proposed format is provided in Attachment 2. Additional information or important documents developed as part of the activity can be attached to the reporting form. USAID and CDC may negotiate more comprehensive reporting requirements for specific activities. If more comprehensive reporting requirements are negotiated that report should be submitted in lieu of the proposed format to avoid duplicate reporting. For USAID Mission-funded activities, CDC should submit reports directly to the appropriate USAID Mission.

In accordance with E.2 above, CDC shall also submit to USAID on a quarterly basis a financial report that includes budget information,

disaggregated by budget category, on accrued expenditures, commitments, and disbursements of funds provided under this Agreement. CDC must use the categories of obligations and expenditures set forth in Annex B of this agreement.

b. Final Progress Report: Not later than 60 days following the Completion Date of the Program or each activity listed in Annex A, CDC must prepare and submit to USAID, in form and substance satisfactory to USAID, a final report of country activities financed under this Agreement. The final report must provide a chronological summary of the information required generally for the periodic progress reports from the beginning of the country program or activity to its completion; and an assessment by CDC, to the extent feasible, of the impacts of the Program.

c. In addition to the reports outlined in sections F.2.a and F.2.b, CDC shall provide quarterly reports and trip reports to USAID Mission Programs as requested.

3. CDC must furnish to the Additional Representative of USAID noted in block 12B of the face sheet of this Agreement two copies of all financial and other reports required under this Agreement, along with an electronic copy of each report, or such other data processing format as USAID may agree to in writing.

4. The CDC requirements for monitoring, evaluation, and reporting for activities carried out under this Agreement are subject to change based on Congressional requirements. USAID will notify CDC of any such changes as they occur.

G. PROGRAM PLANNING AND COORDINATION

1. Consultation

CDC and USAID will cooperate to assure that the purpose of this Agreement will be accomplished. To this end, CDC and USAID, at the request of either, will exchange views on the progress of the Program, the performance of obligations under this Agreement, and the performance of any consultants, contractors, or suppliers engaged in the Program, and other matters relating to the Program.

2. Coordination

CDC must make best efforts to coordinate its activities with those of other U.S. Government financed programs and other donors providing assistance substantially similar to that of CDC in the Cooperating Country(ies).

3. Compliance with USAID Policy Guidance

The cognizant USAID representative shall be responsible for coordinating the implementation of USAID-funded activities of CDC under this Agreement. CDC shall ensure that its employees, contractors, and grantees comply fully with this provision.

From time to time, the Bureau for Global Health Assistant Administrator, his or her Deputy, or the HIDN Office Director may provide additional policy or operational guidance in writing to CDC or its representatives in carrying out foreign assistance programs and activities worldwide, including this Program. CDC agrees to comply with such guidance so long as it is consistent with this Agreement and with laws governing operation of CDC.

4. Communication

Any notice, request, document, report, or other communication submitted by either CDC or USAID, unless this Agreement expressly provides otherwise or the parties otherwise agree in writing, will be sent to the other party's Authorized Representative or Additional Representative noted in block 12A and 12B of the face sheet of this Agreement.

5. Notification

CDC must notify USAID promptly in writing of any audits of activities financed by this Agreement initiated by or at the request of CDC, its Inspector General, the Office of Management and Budget, or the General Accounting Office.

6. Program Evaluation

At the option of USAID, CDC will undertake or cause to be undertaken, within the total budget specified in the Financial Plan and Budget in Annex B of this Agreement, an external evaluation of the Program, and if deemed appropriate by both parties a mid-term evaluation. CDC and USAID must agree on the terms of reference for the evaluation and an appropriate schedule for conducting it. Evaluations may include:

a. evaluation of progress toward attainment of Program objectives;

b. identification and evaluation of problem areas or constraints that may inhibit attainment of Program objectives;

c. assessment of how such information may be used to help overcome such problems; and

d. evaluation of the overall impact of the Program on Program objectives.

7. Information Requirements for Training Activities

CDC will provide reports to USAID through USAID's required participant training database, "TraiNet," in accordance with USAID Automated Directives System Chapter 253. CDC must enter in the database data for each person trained under the Program. The data will include biographical, programmatic, administrative, and logistical information that will facilitate USAID's reporting to Congress.

H. SPECIAL PROVISIONS

1. Country Eligibility

For the purposes of this Agreement, the term "Cooperating Country" or "recipient country" shall mean a country receiving assistance under this Agreement. Except as the parties may otherwise agree in writing, all USAID presence countries are eligible for assistance. Discussion of specific countries to be supported under this agreement will be discussed in Annex A and the Annual Workplan required under section F.1 of the Schedule.

a. Funds provided under this Agreement may not be used for activities that constitute "furnishing assistance" to a country or countries which USAID informs CDC are ineligible for assistance, except as USAID may advise otherwise. Examples of activities that constitute "furnishing assistance" to a country include assistance directly to a country's public or private sector, assistance to a USAID Mission to implement a strategic or special objective, or assistance to another donor or nongovernmental organization to assist it in assisting the country. Examples of activities that are not considered to be assistance to a country include assisting USAID to develop a strategic plan for its own future planning or conducting an evaluation of past activities, where the information developed is not transmitted to the country or to another donor to use in assisting the country.

2. Environmental Regulations.

CDC must comply with USAID environmental regulations (Code of Federal Regulations (CFR), Title 22, Part 216, "Regulation 16") in carrying out the Program. USAID has granted a categorical exclusion for the Program under the terms of Regulation 16, and upon request, will furnish a copy of the categorical exclusion to CDC. USAID expects that no further action under Regulation 16 is required for the Program unless CDC undertakes activities under this Agreement other than those described in the categorical exclusion. However, if further action becomes necessary, USAID will, upon request, provide further guidance to help CDC comply with Regulation 16.

3. Source and Origin of Commodities; Nationality of Suppliers of Commodities and Services.

The following provisions apply to this Agreement except as USAID may otherwise agree in writing.

a. Except as this Agreement provides otherwise, CDC must comply with 22 CFR Part 228 and USAID Automated Directives System (ADS) Chapters 310 and 311. The terms "source," "origin," "nationality," "foreign policy-restricted countries" and "Geographic Code," as used in this Agreement, have the definitions set forth in 22 CFR 228.

b. The USAID Authorized Geographic Code for the source and origin of commodities financed under this Agreement and for the nationality of the suppliers of commodities financed under this Agreement will be "000," the United States. The USAID Authorized Geographic Code for the nationality of the suppliers of services financed under this Agreement will be "935," any area or country including the Cooperating Country(ies) but excluding foreign policy-restricted countries.

c. Commodities financed under this Agreement must have their source and origin in a country or area included in the USAID Authorized Geographic Code applicable to this Agreement or in the cooperating country. Suppliers of commodities or services will have a country or area included in the relevant USAID Authorized Geographic Code or the cooperating country as their place of nationality.

d. Subject to the prior written approval of USAID, CDC may authorize the source, origin, and nationality of a procurement in a country other than as specified in this Agreement, only if:

(1) The procurement is of commodities or services of a type that is not produced in and available for purchase in any country authorized under this Agreement; or

(2) The Authorized Representative of CDC determines in writing on a case-by-case basis that procurement in such other country is necessary (a) to meet unforeseen circumstances, such as emergency situations, or (b) to promote efficiency in the use of United States foreign assistance resources, including to avoid impairment of foreign assistance objectives.

The authorization for procurement under this paragraph must be in writing and must set forth the basis for the authorization. CDC must provide USAID a copy of the authorization.

e. For purposes only of determining the authorized source and origin of commodities and the nationality of suppliers of commodities and services, the term “cooperating country” includes the independent states of the former Soviet Union.

4. Management of the IAA and Funds Release

a. Administrative Management by CDC and USAID

The legal basis to establish this Agreement with CDC is found within the authorization for the Infectious Disease Project (936-3100).

The Office of Global Health (OGH) will serve as the focal point at CDC for facilitating the administration of the IAA. OGH will coordinate administrative and financial reporting activities with respect to each CTO. Each CTO will be responsible for the administrative activities associated with each project including tracking of expenses, preparation of internal financial documentation and will submit reports as required by OGH based on USAID requirements in this IAA. OGH will be responsible for compiling the required information and submitting to USAID.

b. Programmatic Management by CDC and USAID

Both CDC and USAID will designate a programmatic project officer for each of the components included in this IAA to deal with scientific and programmatic issues.

With funds provided in OGH overhead, CDC shall designate a full-time Project Manager in OGH dedicated to the management and programmatic oversight of this Agreement. This staff person will be responsible for coordinating with USAID and providing administrative, financial, and technical input to the activities funded under this agreement. A job description for the Project Manager is included in Attachment 3. CDC shall also designate administrative staff time to support the management of this Agreement.

As indicated in section B of the Standard Provisions, staffing responsibilities, including logistics, relocation, and travel is the sole responsibility of the Center or Division at CDC receiving funds through this Agreement.

c. Release of IAA Funds

IAA funds will be used to support the activities described in Annex A and the Annual Work Plans under Section F.1 of this Schedule. Any changes to the approved budget over the course of the year will require the written approval of the appropriate USAID and CDC personnel.

The total overhead rate to be applied to this agreement is 20%.

a. 9% of the total overhead goes to CDC Corporate Headquarters.
b. 7% of the total overhead goes to the CDC implementing Center receiving the funding.
c. 4% of the total overhead goes to OGH.

The full-time staff position and administrative support referred to in section H.4.b shall be supported with the 4% overhead rate which goes to the CDC Office of Global Health. As negotiated on a case-by-case basis by USAID and CDC, funding through this Agreement that is functioning as a pass through CDC will be subject to a total overhead rate of 5%.

5. Section 487

Under Section 487 of the Foreign Assistance Act of 1961 (FAA) (Section 487), as amended, no assistance may be provided under this Agreement to or through any individual or entity where the United States Government has reason to believe that the individual, the entity or a "key individual" of the entity is or has been involved in "drug trafficking activities" (including "money laundering") (all quoted terms in this clause having the meanings given them in Section 487 and USAID Automated Directives System (ADS) Chapter 206). If assistance under this Agreement is to be provided by CDC to an individual or entity in or from a "covered country," or if CDC knows or has a reasonable suspicion that the proposed individual, entity, or "key individual" of the entity is or has been involved in "drug trafficking activities," then CDC is responsible for ensuring that the assistance is provided in a manner consistent with the provisions of Section 487 and ADS 206, including, as applicable

(i) Submitting the names of each "key individual" and "covered participant" to the Country Narcotics Coordinator at the relevant United States Embassy for clearance;

(ii) Obtaining certifications in the forms of the “Key Individual Certification – Narcotics Offenses and Drug Trafficking” and the “Participant Certification - Narcotics Offenses and Drug Trafficking,” as set forth ADS 206, from each "key individual" and "covered participant"; and

(iii) Including in any agreement that CDC may enter into with a "first-tier recipient" or "covered participant" the appropriate clause(s) substantially in the form(s) attached as Attachment 1 of this Schedule.

6. Support To Terrorism

CDC is reminded that U.S. Executive Orders and U.S. laws prohibit transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of CDC to ensure that all

subagreements, contracts, and grants issued under this Agreement comply with these Executive Orders and laws.

7. Crediting of Publications

USAID shall be prominently acknowledged in all publications, videos or other information/media products resulting from or describing the results of activities funded or partially funded through this Agreement. Acknowledgements must identify the sponsoring USAID Office and Bureau or Mission as well as the U.S. Agency for International Development substantially as follows: "This [research, publication, video or other information/media product (specify)] was made possible through support provided by the Office of _____, Bureau for _____, U.S. Agency for International Development, under the terms of an Interagency Agreement with CDC. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the U.S. Agency for International Development."

CDC shall provide the USAID Cognizant Technical Officer one copy of all published works developed in connection with this Agreement with lists of other written work produced under the award.

In addition, CDC shall submit one electronic or one hard copy of final documents (electronic copies are preferred) to PPC/CDIE/DIO at the following address:

USAID Development Experience Clearinghouse (DEC)
ATTN: Document Acquisitions
1611 Kent Street, Suite 200
Arlington, VA 22209-2111
Internet e-mail address: docsubmit@dec.cdie.org
Homepage: http://www.dec.org

Electronic documents may be submitted as e-mail attachments, and should consist of only one electronic file that comprises the complete and final equivalent of the paper copy; otherwise, a hard copy should be sent. Acceptable software formats for electronic documents include Microsoft Word, WordPerfect, Microsoft Excel and Portable Document Format (PDF).

Each document submitted to PPC/CDIE/DIO should include the following information: 1) descriptive title; 2) author(s) name; 3) award number; 4) sponsoring USAID office; 5) date of publication; 6) software name and version (if electronic document is sent).

USAID reserves a royalty-free nonexclusive and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use for Government purposes any work that may result from this Agreement.

I. ORDER OF PRECEDENCE

Conflicts between any parts of this Agreement will be resolved by applying the following descending order of precedence:

Face Sheet
Schedule
Annex C, Standard Provisions
Annex B, Financial Plan and Budget
Annex A, Program Description

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Annex A:
Program Description

The overall goal of USAID's health program is to increase life expectancy and improve the quality of life in USAID assisted countries among high risk groups particularly children and women. The Bureau for Global Health's (GH) efforts are designed to strengthen the delivery of field support and programming to USAID missions through the provision of technical and program support and to carry out appropriate research for the development of new and appropriate approaches and technologies in response to near and longer-term field needs. To accomplish this, GH has established a portfolio that addresses activities including infectious diseases, maternal and child health, environmental health, HIV/AIDS and STD control and prevention, as well as system strengthening activities represented by quality assurance, health financing, drug management, and health and management information. In 1998, this portfolio was expanded to include infectious diseases initiative, which is focused on: containing and responding to the development and spread of antimicrobial resistance; control of tuberculosis; prevention and control of malaria, and the surveillance and response to infectious diseases.

As part of its health mandate, USAID works closely with other U.S. and international organizations. The Centers for Disease Control and Prevention is a world-renowned source of specialized technical experience and expertise in the international health field – not otherwise available through the private sector. CDC experts represent a range of capabilities encompassing all phases of program development, from design of field projects, through implementation and monitoring, to evaluation and program replication steps.

GH has entered into an agreement through CDC's Office of Global Health with the appropriate centers or divisions within the CDC for:

1. Technical and program support for the development and implementation of appropriate global/regional/country-level health programs and strategies;
2. Monitoring and evaluation of global/regional/country-level health activities, projects, and programs, and
3. Studies, assessments, evaluations and other research activities to assist in policy dialogue, planning and formulating health programs.

The IAA is intended to support broad USAID-CDC collaborations in HIV/AIDS, environmental health, tuberculosis, child survival, malaria, disease surveillance, and antimicrobial resistance as well as work in other health areas.

Specifically, it is expected that through the IAA, CDC's relevant technical and program divisions be supported to provide technical input and assistance in the development, implementation, and/or evaluation of health programs and studies, including:

- Global strategy development
- Technical analyses

- Demonstration activities and feasibility studies
- Capacity building
- Policy reform
- Operations and applied research
- Project evaluation and assessments
- Monitoring and evaluation
- Workshops and conferences
- Education/information strategies

Below are component areas to be supported through the IAA over the next year with FY 2006 funding.

Section I:

GLOBAL BUREAU FUNDS

Country/Region: Global
Title Describing the Activity: Tuberculosis Control Activities
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells
Bureau or Mission contact following the activity: Christy Hanson, GH/HIDN
Amount, type and year of funds to be obligated: $1,000,000
Time Frame if appropriate:

Global Tuberculosis Control Activities

The International Research and Programs Branch of the Division of Tuberculosis Elimination at CDC has as its main objectives to contribute to the control of the global tuberculosis (TB) epidemic by focusing on areas in which CDC has relevant experience and can make the most difference. These areas include control of the multidrug resistant (MDR) TB epidemic, control of the epidemic of HIV-associated TB, DOTS expansion and strengthening through TB control program capacity building, improving TB infection control practices, and control of childhood TB. Though CDC has been given a mandate to contribute to global TB control efforts, the mandate to do this work, as such, is unfunded. USAID remains a critical collaborative partner for CDC in global TB control efforts.

Building on experience gained through addressing the resurgence of TB in the United States during the late 1980's and early 1990's, CDC works to improve the quality of TB control programs internationally in priority countries including those with a high burden of TB, in particular the WHO-designated "high burden countries" (HBC), those with having a high burden of HIV-associated TB, in particular those countries involved with CDC's Global AIDS Program (GAP) and more recently the focus countries of the President's Emergency Plan for AIDS Relief, those with epidemic MDR TB, and those with a strategic interest for TB control efforts in the U.S. CDC efforts for improving TB control in a given country focus on collaborating with the national government, relevant non-governmental organizations (NGOs), as well as other national and international agencies, to develop well-coordinated and complementary programs of technical assistance for TB control.

Component 1: CDC support for the international response to the global MDR TB epidemic

Anticipated budget: $300,000
Time frame: 10/1/06-9/30/07
Project Officer: Peter Cegielski, MD, MPH, Team Leader for MDR TB, IRPB, DTBE

In many regions of the world, multidrug-resistant (MDR) TB threatens national, international, and local efforts to reduce TB-related morbidity and mortality. A coordinated international response to the MDR TB epidemic began in approximately 1998 with the launch of the DOTS-Plus initiative, in which CDC has been a key partner

from the outset. WHO's Green Light Committee (GLC) is a central component of this initiative. The CDC was a founding member of the GLC in 2000, and CDC currently chairs the GLC. The mandate of the GLC is to promote access to quality-assured, deeply discounted second-line drugs (SLDs) while at the same time ensuring the drugs are used properly so that broader use of these drugs does not generate even worse resistance. The GLC evaluates and advises proposed DOTS-Plus projects to ensure they meet international guidelines. Once they do, GLC approves the project to preferentially priced SLDs through WHO's procurement agent. Afterwards, GLC monitors and assists the projects to maximize the likelihood of success and minimize new drug resistance. Since June 2000, more than 70 projects on 5 continents have applied to the GLC; of these, ~40 projects have been approved representing over 20,000 MDR TB patients started on treatment.

Starting in 2002, the Global Fund Against AIDS, TB, and Malaria (GFATM) has required grantees to apply for and obtain GLC approval before using GFATM funds to procure SLDs for TB. To date, this is the only component of the GFATM process that requires and provides technical program assistance to improve the quality of GFATM-funded programs. The net effect of this policy has been to substantially lower the financial barrier for national TB control programs to address MDR TB. WHO estimates the GLC has saved the GFATM approaching US $100 million compared to treatment of the same number of patients with locally procured drugs (not quality assured) at prevailing market prices in the same countries and well over US $100 million compared to market prices in affluent countries.

In addition, CDC technical advisors contribute actively to developing and revising numerous national and WHO global policy guidelines on MDR TB through bilateral efforts and through the Stop-TB Partnership Working Group on MDR TB. In addition to the technical support and on-going capacity building work, during 2005-2006, CDC led efforts in partnership with WHO and the global network of supranational TB reference laboratories capitalizing on support provided by USAID to begin the task of measuring extensively drug resistant TB, or XDR TB. This form of MDR TB is defined as MDR TB with resistance to at least 3 additional classes of second-line drugs and represents a form of potentially untreatable TB. Evidence clearly shows that this form of TB exists on all continents save Antarctica (See MMWR publication from March 2006) and, as of yet, anecdotal but extremely alarming reports from South Africa indicate that large hospital-based outbreaks of XDR TB are occurring among PLHIV on effective treatment with anti-retroviral therapy resulting in extremely high death rates. Further evaluation of the scope of the XDR TB burden using a more population-based approach is urgently needed.

Through these and related activities, CDC has played a leading role in developing human capacity in many facets of TB control. In all of these respects, CDC is having a significant impact on MDR TB control globally.

USAID has been a central partner and supporter of CDC's international TB activities. For 2006-2007, we propose four major activities for USAID support for CDC's role in the partnership of transnational agencies working to control MDR TB.

1. Support for on-going CDC participation in the GLC, including attendance at regular meetings, participating in site visits to evaluate and monitor GLC DOTS-Plus projects, streamlining GLC review and approval procedures, and short-term consultancies to assist with review of applications and site monitoring.

2. Completion of analysis and dissemination of evidence on which to base global policy for MDR TB control, including treatment and management. This activity requires:
    - Short-term fellow to complete analyses and exposition of data from GLC projects approved in 2001;
    - Limited travel for completion of data collection and meeting attendance for completing MDR TB/DOTS-Plus guidelines development

3. MDR TB research including: determining the frequency of and antecedents of emerging resistance to SLDs in GLC-approved compared to non-GLC DOTS-Plus projects and causes of new drug resistance in GLC-approved projects (PETTS) and estimating the prevalence of second-line anti-TB drug resistance (extensively drug resistant MDR TB, or XDR TB). These projects involve:
    - Establishing a clinical and epidemiological data base with standardized data input from each GLC and non-GLC project (PETTS) and establishing a database for second-line anti-TB drug resistance testing data from the supra-national reference laboratory network (Extra-resistant MDR TB),
    - Establishing an archive of mycobacterial isolates from participating projects over the full course of each patient's treatment,
    - On these isolates, performing DST and DNA finger printing in a centralized reference laboratory (to insure uniform technique and consistent high quality procedures),
    - Analyzing the results in relation to the clinical and epidemiological data to assess the emergence of anti-microbial drug resistance in GLC approved/assisted projects
    - Developing a strategic plan and initiating implementation for measuring XDR TB using a population-based approach

4. Building human resource capacity for the global control of MDR TB through consultant training including participation in DOTS-Plus consultants training and trainee participation in GLC/DOTS-Plus monitoring and evaluation missions and GLC-related meetings.
    - Overhead per trainee for one year of training estimated @ $15,000 - $20,000 for courses, shadowing monitoring missions, and expenses

Component 1 MDR TB Proposed Budget

1. Travel to GLC meetings, 3 per year @ 3000 ea. Site evaluation and monitoring missions 2 @ 5000 ea. Subtotal	9,000 10,000	 19,000
2. Development of strategic plan and initiation of global project to measure extent of extensively drug resistant (XDR) TB using a population-based approach	71,000	71,000
3. Completion of GLC evaluation (PETTS study): Antimicrobial drug resistance - Monitoring visits 4 trips @ 5000 ea. (13 sites total) - Shipping specimens to CDC (FY06) - Specimen testing at CDC (FY06) - Project assistant (FY06) - Support to project sites 4 @ 10,000 ea. (FY06) Subtotal	 20,000 35,000 60,000 25,000 70,000	 210,000
TOTAL		$300,000

Component 2: CDC support for the international response to the global TB/HIV epidemic

Total budget: $200,000, Time frame: 10/1/06-9/30/07
Project Officer: Charles Wells, MD, Chief, IRPB, DTBE

Background
Tuberculosis (TB) is one of the leading causes of morbidity and mortality among adults worldwide. Each year, approximately 9 million cases of TB and 2 million deaths from TB occur globally, and it is estimated that one-third of the world's population is infected with *Mycobacterium tuberculosis* (MTB), the cause of TB. HIV increases the risk of progression to TB disease among those with TB infection by five- to ten-fold. As a result, the global HIV epidemic has caused tremendous increases in the burden of TB in regions of high HIV prevalence over the past two decades, especially sub-Saharan Africa. For example, Botswana where HIV prevalence among adults is estimated to be 36%, the annual incidence of TB increased from 200 cases per 100,000 population in 1986 to 623 cases per 100,000 in 2002. In contrast the incidence of TB in the U.S. in 2004 was 5 cases per 100,000. Furthermore, HIV prevalence among TB patients in Botswana ranges from 60% to 80%, TB mortality is as high as 20% - 30% in some districts, and 40% of hospitalized AIDS patients who died had autopsy evidence of TB.

From the perspective of HIV, TB is the leading cause of opportunistic infections among people living with HIV/AIDS (PLWHA) worldwide. Current estimates are that 30% to 40% of HIV-related deaths are due to TB. Additionally, some evidence exists suggesting that developing TB can lead to more rapid progression of HIV disease. From the

perspective of both diseases and from PLWHA in settings of a generalized HIV epidemic and high TB burden, preventing TB is imperative.

Preventive therapy (PT) for TB, generally through treatment with the anti-TB drug isoniazid for 6 to 12 months (or IPT), has been clearly demonstrated to decrease the risk of developing TB among those with MTB infection. Building on results of prior studies in settings of low TB burden such as the U.S., multiple clinical trials conducted in countries of high TB burden during the 1990's demonstrated that IPT can reduce the risk for TB among PLWHA by as much as 60%. As a result, WHO and UNAIDS issued recommendations in 1997 for the use of 6 months of IPT as a key strategy for preventing TB among PLWHA. Since that time, several developments have occurred leading to the need to further investigate the appropriate duration of IPT. Follow-up studies of the earlier clinical trials demonstrated that, unlike IPT used in settings of low TB burden, the protective effect of 6 months of IPT in settings of high burden for PLWHA diminishes within 1 to 2 years after treatment completion. Some studies have even shown that within 2 years after completing IPT, the risk for TB among PLWHA in high TB burden settings essentially returns to baseline levels prior to a patient's receiving IPT.

The Botswana National IPT Clinical Trial

In response to the country's overwhelming TB epidemic and the exceedingly high mortality from TB among PLWHA, the MOH of Botswana developed, implemented and successfully completed a pilot study during 2000-2001 for providing IPT according to WHO/UNAIDS recommendations. Among 1000 PLWHA coming from voluntary counseling and testing centers who enrolled in the pilot study, nearly 70% completed the 6 months of treatment. Additionally, operational research demonstrated that a concise assessment of symptoms for TB performed by nurses was sufficient to rule out active TB among participants in an effort to prevent inappropriate use of IPT and surveys conducted among healthcare workers and patients indicated that IPT was well received and fairly easily incorporated into HIV/AIDS treatment and care services. Based on this positive experience, the MOH proceeded with the roll out of a national initiative to offer access to IPT for all PLWHA beginning in late 2003.

With the launch of the national IPT pilot study in 2000, the MOH, in collaboration with CDC's Division of Tuberculosis Elimination and the BOTUSA Project, developed plans for a clinical trial to evaluate the optimal duration of IPT given previous findings that the benefits conferred with 6 months of IPT for PLWHA begin to wane shortly after completion of treatment. By 2002, protocol development for the national IPT clinical trial was completed and approval in both Botswana and the U.S. was achieved. The study was designed as a randomized, double-blind, placebo-controlled trial comparing the standard WHO/UNAIDS-recommended treatment with 6 months of IPT to "lifelong" IPT defined in the study as treatment for 3 years. The final sample size determined for the study was 1800 patients – 900 to receive 6 months of daily IPT and 30 months of placebo and 900 to receive daily IPT for 36 months. Launch of the national IPT clinical trial ultimately occurred in November 2004 with enrollment set to complete in late April 2006. Completion of the study is expected to occur in April 2009. Building on this clinical trial, the opportunity arose to assess performance of a new diagnostic technology

for identifying MTB infection among PLWHA in this TB endemic setting. A nested clinical trial supported by USAID and evaluating the use of the QuantiFERON-TB Gold In-Tube test (QFT-GIT), a cytokine quantification assay for the diagnosis of latent TB, was launched during the second half of enrollment of the IPT trial (September 2005).

Critical TB/HIV research questions potentially addressable by the Botswana National IPT Clinical Trial:

- Is treatment with IPT for 3 years superior in protecting against TB disease in comparison to current treatment recommendations of 6 months for PLWHA in TB endemic settings?
- Does treatment with extended duration IPT confer protection against TB among tuberculin skin test (TST)-negative PLWHA?
- Is treatment with extended duration IPT safe for PLWHA?
- Is a symptom assessment sufficient to rule out active TB among candidates for IPT? (Validation of Botswana's national screening algorithm for IPT which uses symptom screening alone.)
- Does the use of IPT in asymptomatic PLWHA select for isoniazid resistant TB?
- What is the added benefit of ARV treatment with IPT in protection against TB?
- Is IPT of extended duration feasible in terms of maintaining patient adherence?
- Does the QFT-GIT test perform better than TST in identifying MTB infection (latent TB) among PLWHA?
- Do QFT-GIT results predict PLWHA who go on to develop active TB?

Proposal for partnership

Due to severe resource constraints currently being experienced by DTBE, the ability to complete the Botswana IPT trial is now questionable. Partnerships involving the sharing of resources are urgently needed to ensure completion of this critical, policy-defining study for TB-HIV and HIV/AIDS treatment and care. In particular over the next 2 to 3 years, resources for additional staffing to support the trial, resources for additional manufacturing of study drug and placebo, resources for supplies and technical expert consultancies for the QFT-GIT nested trial, resources for quality laboratory support for the trial, and resources applied to strategies for maintaining patient enrollment and participation in the study are needed beyond the base level of DTBE financial support ($1.2 million per annum) for the existing staff and supplies for the study. The study should complete by the 2nd or 3rd quarter of 2009.

	FY06	FY07	FY08	FY09
Program Manager (FSN)	$25,000	$50,000	$50,000	$50,000
Study drug manufacturing, packaging, labeling, randomization, and shipment and storage	$200,000	$70,000	$70,000	-
QFT-GIT supplies and technical consultancies	$40,000	$40,000	$40,000	$20,000
Statistician, ½ PSC	$20,000	$40,000	$40,000	$40,000

Certified mycobacteriology laboratory support for MTB culture and anti-TB drug susceptibility testing	$50,000	$50,000	$50,000	$20,000
Support for strategies to promote patient participation and adherence	$20,000	$40,000	$40,000	$10,000
Clinical trial software license renewal	$21,000	$21,500	$22,000	$22,500
Total	$376,000	$311,500	$312,000	$162,500

Component 3: DOTS Expansion and National TB Program Capacity Building Activities

Total budget: $500,000
Time frame: 10/1/05-9/30/06
Project Officer: Charles Wells, M.D., Chief, International Research and Programs Branch.
One of CDC's key priorities as a member of the Stop-TB Partnership is to support DOTS expansion in a number of countries and to contribute to the DOTS-expansion process in areas where CDC has strength and experience. In addition to extensive country-level support for DOTS expansion (supported by various USAID country missions) in HBC such as Russia, Brazil, and India, CDC seconded a technical advisor in 2000 at the International Union Against TB and Lung Disease (IUATLD), one of the leading NGO's focused on global TB control.

1. On-going support to maintain the CDC technical advisor (Dr. Paula Fujiwara) based at the IUATLD currently serving as a Senior Technical Advisor, IUATLD Board Member, coordinator of IUATLD's TB/HIV program, and TB technical advisor for a number of developing countries to which IUATLD provides support in TB control.

DOTS Expansion and NTP Capacity Building		
1. Assignee at IUATLD	500,000	
TOTAL		$500,000

Country/Region: Global
Title Describing the Activity: Antimicrobial Resistance
Center/Division and Project Officer at CDC the activity was negotiated with: NCIRD/DBD/RBD, Cindy Friedman
Bureau or Mission contact following the activity: Anthony Boni, GH/HIDN
Amount, type and year of funds to be obligated: $300,000
Time Frame if appropriate:

ANTIMICROBIAL RESISTANCE (Total Funding: $300,000)

NCIRD/Respiratory Diseases Branch

The overall goal of the USAID program is to slow the spread and emergence of antimicrobial resistance. Key activities include enhancing methods to detect resistance, supporting investigations to improve the understanding of resistance, improving the use of high-quality antimicrobial drugs, and developing and implementing country-level interventions to control antimicrobial resistance. Specifically, CDC's technical contribution will include:

- Participating in the development of country-level AMR strategies, to include surveillance and/or laboratory capacity strengthening and dissemination of best practices;
- Investigating strategies that prevent the emergence and spread of resistance;
- Providing epidemiological and laboratory support.
- Providing expertise to develop effective communication and advocacy strategies for AMR

The IAA will provide support for CDC technical assistance, training and laboratory support, participation in strategic planning activities and intervention design, and the conduct of focused investigations and research.

Budget Line Items for FY2005 AMR Activities

		Funding
1	Determine the AMR effects of cotrimoxazole prophylaxis for HIV patients	$124 ,000
4	Conduct infection prevention and treatment research (e.g. Evaluating the use of chlorhexidine as a prevention method for neonatal sepsis)	$ 60,000
5	Evaluate the use of the laboratory manual for antimicrobial susceptibility testing	$ 16,000
6	Expand the use of effective communication and advocacy strategies to disseminate information on AMR and the need for appropriate use of antimicrobials	$ 40,000

Subtotal = $ 240,000
Overhead @ 20% = $60,000
Total= $300,000

Country/Region: Africa (Ghana, Kenya, Uganda, Zimbabwe)
Title Describing the Activity: Strengthening African Infectious Disease Surveillance Capacity
Center/Division and Project Officer at CDC the activity was negotiated with: COGH/DESCD, Peter Nsubuga
Bureau or Mission contact following the activity: Murray Trostle, GH/HIDN
Amount, type and year of funds to be obligated: $900,000
Time Frame if appropriate: 1 year

Strengthening African Infectious Disease Surveillance Capacity

Background

The central discipline associated with the ability to collect, analyze, interpret, and act on surveillance information is epidemiology. Developed countries have constructed their public health and disease control strategies around the principles of epidemiology. Without strong capacity in this area, developing countries will not be able to build and use disease surveillance systems that serve their broad array of needs and they will remain highly vulnerable to the threats of emerging and reemerging infectious diseases. They will also remain highly dependent on external assistance and unable to set and execute their own health priorities.

Africa has lagged far behind the rest of the world in the development of Field Epidemiology Training Programs (FETPs). Currently only four epidemiology training programs exist in Africa (Ghana, Kenya, Uganda and Zimbabwe). These programs offer two-year training to qualified candidates in field epidemiology. The Kenyan program offers joint training for applied epidemiologists and public health laboratorians and has extended its reach in the region by training several trainees from Tanzania. In 2005, these programs formed a regional network called the African Field Epidemiology Network (AFENET). This network represents a formal alliance between the four programs and seeks to build long term and sustained epidemiological and surveillance capacities in Africa.

While currently receiving some support from international donors and host country governments, the FETPs in Africa still require additional attention to be able to fulfill their training obligations. In addition, there is an urgent need not only to strengthen the existing programs, but also to expand to other parts of Africa, particularly French-speaking Africa. Support to AFENET and the FETPs will strengthen public health capacity in the region by developing and supporting expertise in applied epidemiology and public health practice.

Activities

Funds allocated in this grant will be passed through the CDC Cooperative Agreement with AFENET. With these funds, AFENET will provide direct grants to the African FETPs and cover operational costs, as outlined below.

AFENET will submit a plan of action to USAID and CDC no later than 45 days from the date of the grant, which includes projected activities, anticipated accomplishments and expenditures over the next year. The plan of action will also identify indicators that AFENET will monitor and report quarterly. This plan must be reviewed and approved by USAID and CDC.

AFENET will submit two types of reports on a quarterly basis to USAID and CDC:

1) Financial reports (including expenditures and accruals over the past quarter)
2) Program reports (including activities during the previous quarter, status of indicators identified in the plan of action, identification of problems and obstacles and ways to overcome them, and proposed activities for the next quarter)

The financial and program reports will include separate sections for FETP support (section 1.1 below) and AFENET support (section 1.2 below) and will be compiled and submitted as a complete package to USAID and CDC on a quarterly basis.

1.1 FETPs **$500,000**

AFENET will solicit and collect proposals from the four African FETPs, and in consultation with USAID and CDC, evaluate the proposals and make recommendations to the programs on how they might strengthen their approach in the context of local needs. Once the final proposals have been approved by AFENET, and the results shared with USAID and CDC, grants will be made by AFENET directly to the country programs.

Grants to FETPs must be finalized no later than 90 days from the date of the grant to AFENET.

Funds allocated for AFENET to provide direct grants to the African FETPs may support, but are not limited to, the following types of activities:

- develop new course work consistent with the needs of programs such as malaria control, HIV/AIDS prevention, maternal and child health, etc.
- provide small grants to post-graduates for applied research and development activities in epidemiology
- strengthen linkages between FETPs and host ministries of health in public health practice
- strengthen surveillance, outbreak investigation, and public health response
- provide general support for the overall training program
- further develop linkages between applied epidemiology and public health laboratory practice

These activities should be consistent with overall efforts to strengthen the long-term viability of the training programs and expand the role of field epidemiology within the practice of public health in the country.

FETP Country Budget

Country	**Amount**
Ghana	$125,000
Kenya	$125,000
Uganda	$125,000
Zimbabwe	$125,000
Total	**$500,000**

1.2 AFENET **$250,000**

Funds allocated for operational support to AFENET may support, but are not limited to, the following:

- personnel salary support for AFENET Coordinator and ½ time administrative support staff person
- travel (site visits)
- logistics, supplies and communication

AFENET Budget

	Amount
AFENET operational support	$250,000
Total	**$250,000**

Funds are designated for operational support for AFENET, which in addition to operational costs may include: provision of technical assistance to the national programs, management of the country-specific FETP grants, expansion of resources for AFENET, support costs to prepare funding applications to other donors, country visits to promote and develop new field epidemiology and laboratory training programs in African countries, or other purposes as mutually agreed by USAID, CDC and AFENET.

Total Budget

	Amount
AFENET	$250,000
FETPs	$500,000
CDC overhead (20%)	$150,000
Total	**$900,000**

Country/Region: Global
Title Describing the Activity: Household water management technical assistance
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DFBMD, Eric Mintz
Bureau or Mission contact following the activity: John Borrazzo/Rochelle Rainey, GH/HIDN
Amount, type and year of funds to be obligated: $350,000
Time Frame if appropriate:

ENVIRONMENTAL HEALTH (Total Funding: $350,000)

NCID/DBMD

Collaboration on Safe Water Systems (SWS) and handwashing

Under this IAA, the USAID Bureau for Global Health and CDC's Center for Infectious Diseases will collaborate to further develop program approaches on Safe Water Systems and on handwashing. These activities will:

- leverage current USAID (and other) SWS investment (e.g. Zambia, Madagascar, Kenya, Afghanistan, Haiti, and Haiti, in order to improve the overall programmatic approach, with respect to users, coverage, scale, cost (including innovative approaches to production, and distribution), and sustainability;
- improve operations in these programs, and provide documentation of improved program effectiveness, providing an example for use in other country programs;
- focus not only on the social marketing approach of PSI but also other programmatic approaches likely to assist in taking Safe Water Systems efforts to scale;
- explore SWS as a program entry point for other hygiene interventions, i.e. handwashing and sanitation promotion;
- and provide technical assistance to USAID for initiating SWS program planning in additional countries.

A written workplan for SWS activities through September 30, 2007 will be mutually agreed by USAID and CDC no later than September 30, 2006.

Country/Region: Worldwide
Title Describing the Activity: Malaria Vaccine research in Non-Human Primates/MVDP (non-PMI)
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DPD/Malaria, Bill Collins and John Barnwell
Bureau or Mission contact following the activity: Carter Diggs, GH/ID
Amount, type and year of funds to be obligated: $230,000
Time Frame if appropriate: Long term (>10 years)

The Host/Parasite Biology Section of the Biology and Diagnostics Branch of the Division of Parasitic Diseases, CID, CDC shall assist the USAID Malaria Vaccine Development Program (MVDP) through:

1. Maintenance and operation of a facility in which studies on malaria vaccines can be performed in nonhuman primates. The facility shall include:

    a. the capability of handling animals in the strict accordance with HHS/PHS and USDA guidelines for the care and handling of laboratory animals;
    b. the capability to perform procedures for immunizing animals, phlebotomy, challenge studies, monitoring clinical status, splenectomy, necropsy, etc.;
    c. the capability for primate health (veterinary) care (including routine clinical and laboratory evaluation);
    d. a primate database, describing the medical history (including malaria exposure, exposure to Freund's adjuvant, splenectomy, etc.) and current status of each animal; and
    e. the capability to establish and maintain appropriate species and strains of plasmodia as well as those needed for specific vaccine trails.

2. Procurement of nonhuman primates as required by the USAID MVDP; decisions regarding species, sex and number of animals required will be made annually in consultation with the MVDP Project Officer or his/her designee.

3. Assistance in the coordination and early planning of trails. Specifically, CDC personnel shall:

    a. work with MVDP Project Officer, or his/her designee to formulate plans for vaccine trials in primates; and
    b. refer potential suppliers of experimental vaccines (e.g.investigator or industry representatives who make initial contact with CDC) to the MVDP Project Officer, or his/her designee for the purpose of direct discussions between the vaccine supplier and USAID.

4. Oversight of all aspects of implementation of studies performed at the facility. Specifically, CDC personnel shall, in consultation with the MVDP Project Officer or his/her designee:

a. develop specific protocols for all studies (including vaccine trials and other related studies such as those to refine the parasite/primates model); protocols will be submitted to the USAID MVDP for approval; and
b. report to the USAID MVDP Project Officer preliminary results of all vaccine trails in writing within one month of completions of each trail. In addition, informal reports shall be made on an interim basis as needed to keep the Project Officer informed of developments. Unusual or unexpected results, including unexpected results or toxicity in animals should be communicated to the Project Officer immediately.

5. Maintenance of a staff of investigators and technicians designated to carry out the work.

FINANCIAL PLAN AND BUDGET

Category	**FY 2006 request**
Technical Assistance	$ 39,000.00
OGH overhead @ 4%	$ 1,560.00
DPD overhead @ 10%	$ 3,900.00
CDC overhead @ 9%	$ 3,510.00
Sub-total direct and indirect costs	$ 47,970.00
Animal Costs	$112,000.00
Data Entry contract	$ 7,500.00
Supplies	$ 23,492.00
Shipping	$ 2,000.00
Travel	$ 3,000.00
OGH overhead @ 4%	$ 5,920.00
DPD overhead @ 10%	$ 14,799.00
CDC overhead @ 9%	$ 13,319.00
Sub-total direct and indirect costs	$182,030.00
Total Direct Costs	$186,992.00
Total Indirect Costs	$ 43,008.00
Total Requested	**$230,000.00**

Country/Region: Africa (Ghana, Kenya, Uganda, Zimbabwe)
Title Describing the Activity: AFENET Immunization Grants
Center/Division and Project Officer at CDC the activity was negotiated with: COGH/DESCD, Peter Nsubuga
Bureau or Mission contact following the activity: Angela Weaver, GH/HIDN/MCH
Amount, type and year of funds to be obligated: $100,000
Time Frame if appropriate: 1 year

AFENET Immunization Grants

Background
Epidemiologic information and the ability to interpret and utilize data appropriately are essential to identifying health problems and priorities and making and implementing informed decisions in all aspects of health policies and disease control programs. Accordingly, there is a need for all countries to strengthen their public health capacity by developing and supporting expertise in applied epidemiology and public health practice.

In response to this need, over thirty Field Epidemiology Training Programs (FETPs) have been developed throughout the world. Africa, however, lags far behind the rest of the world in this effort. Presently, there are only four FETPs in Africa (Ghana, Kenya, Uganda and Zimbabwe). These programs foster the professional development of field-trained epidemiologist by offering two-year training to qualified candidates in field epidemiology. The Kenyan program also offers joint training for applied epidemiologists and public health laboratorians and has extended its reach in the region by training several trainees from Tanzania. FETP trainees develop their skills through the supervised practical application of epidemiology to real public health issues. While in the field, they are required to carry out research projects in areas of priority for the districts where they are attached, often under direct supervision of the Ministry of Health staff.

In 2005, the four African programs formed a regional network called the African Field Epidemiology Network (AFENET). This network represents a formal alliance between the programs. In addition to strengthening capacity in field epidemiology and laboratory training and practice, one of the objectives of AFENET is to promote and support applied public health research activities of field-based training programs in response to public health problems in Africa.

Despite significant increases in routine immunization coverage worldwide since the launch of the Expanded Programme on Immunization (EPI) in 1974, low immunization coverage persists in sub-Saharan Africa. It is estimated that only about 50% of African children are immunized during their first year of life and close to one-fifth of children who begin the vaccination schedule do not complete it. As a result, there is an urgent need to develop new and innovative strategies to fully immunize more children, especially those in hard- to-reach and vulnerable areas. Given that the reasons for low coverage may differ from place to place, utilization of local data to identify local problems and develop and implement different strategies for improving routine

immunization coverage is essential. This requires a cadre of workers trained with the skills to appropriately collect, interpret, and utilize data to inform decisions about immunization policies and programs.

The structure of the FETPs in Africa creates a unique opportunity for USAID to both contribute to indigenous capacity building in applied epidemiology and to promote the application of newly created capacity to one of the routine practices of the health sector-immunization. The Immunization Grants Program will create an opportunity for field epidemiologists in training to focus their required projects on improving routine immunization coverage. The program will reinforce the use of epidemiological data as a tool to design, evaluate, and improve strategies to increase immunization coverage. Most importantly, it will go beyond the goals of a traditional research grant program by requiring recipients to share their results with local and national level policy makers and advocate for broader adoption of their proven intervention or strategy through changes in immunization policy and programming.

It is expected that trainees will use the results of their project to: 1) Advocate among immunization stakeholders in the recipient countries to support, promote, and implement their proven interventions, to inform policies and implementation strategies; and 2) advocate with local and national governments, the broader donor and global community, including the Global Alliance for Vaccines and Immunization (GAVI), regarding how best to channel efforts to promote and sustain acceptable routine immunization coverage in Africa.

Activities

Funds allocated in this grant may provide support for the following:

- grant awards to current FETP trainees
- personnel salary support to AFENET Africa Project Coordinator (40% FTE)
- project monitoring (including field visits) by AFENET Project Coordinator
- administrative and operational support to AFENET for the grants program

The coordinator of AFENET, located in Kampala, Uganda, will devote 40% FTE to the general management and oversight of the immunization grants program. AFENET will solicit and collect proposals from trainees in the four FETPs. USAID, CDC, and AFENET will review proposals and make the final selection of grantees. Grants will be made by AFENET directly to the FETPs for selected grant recipients. The AFENET Coordinator will oversee grant recipients through project completion, including:

- administration of grants
- regular communication with grant recipients, including reporting requirements and deadline reminders, and general support and guidance, as needed
- collecting and disseminating to USAID and CDC required plans and reports from each grant recipient
- conducting two site visits per year to each funded project
- providing updates to USAID and CDC regarding the status of each project
- additional tasks, as required

AFENET will submit the following reports, specific to the immunization grants program, on a quarterly basis to USAID and CDC:

3) Financial reports (including expenditures and accruals over the past quarter)
4) Program reports (including activities during the previous quarter, status of indicators identified in the plan of action, identification of problems and obstacles, and proposed activities for the next quarter)

Budget

Country	**Amount**
Grant Awards (maximum $6,000 each)	$42,000
AFENET Personnel costs	$11,500
AFENET Project Monitoring	$21,500
AFENET Administrative/Operational Support	$9,000
AFENET Sub-total	$84,000
CDC overhead (20%)	$16,000
Total	**$100,000**

Section II:

REGIONAL BUREAU AND MISSION FUNDS (FIELD SUPPORT)

AFRICA REGION

Country/Region: Africa
Title Describing the Activity: Integrated Disease Surveillance and Response
Center/Division and Project Officer at CDC the activity was negotiated with: NCPDCID/DEISS, Helen Perry/Rob Pinner
Bureau or Mission contact following the activity: Mary Harvey, Africa Bureau
Amount, type and year of funds to be obligated: $ 550,000
Time Frame if appropriate:

USAID Proposal: 2006-2007
CDC Support to WHO-AFRO Integrated Disease Surveillance and Response

Spending category	Africa Bureau	Global Bureau
Salaries and benefits	230,000	0
Travel	80,000	0
Miscellaneous (shipping, printing, etc.)	3,000	0
Supplies	1000	0
Contracts	130,000	0
In-country support	40,000	0
Outbreak response	50,000	0
Total:	534,000	0
Gross funds:	550,000	0

1.0 Integration of IDSR into other programs and strategies

Cost requirements: Travel, Contracts, In-country Support

Contracts: specific skills for developing costing data, graphic support, and production of materials, translation and dissemination of jointly produced IDSR materials and tools.

Travel funds: CDC participation in meetings with potential partners and field activities for gathering data to inform products and identifying best practices and stories for advocacy materials.

1.1 Document IDSR laboratory network to show how vertical disease programs in a country can work together to develop an integrated laboratory network. Collaborate with partners in CDC GAP, CDC

FELTP, CDC GID and WHO-AFRO in reviewing the information and developing a model for countries to use in integrating their own networks.

Outcome Indicator: Report of a documentation consultation describing the process by which the country established and maintained a national laboratory program.

Outcome indicator: A model that demonstrates functional laboratory system that is supporting IDSR in at least one country.

1.2 Analyze costing data gathered from at least 3 countries in order to make concrete the costs or budget proportions for strengthening surveillance systems. This information is intended for advocacy materials and for countries to refer to when developing national budgets. This information is intended to be supportive to capacity building efforts in a country, and also helps to answer the question, "What is the cost of surveillance?"

Outcome Indicator: Costing data available in presentation and briefing formats for use by technical partners in talking about IDSR with potential funding partners, Ministries of Health and other international agencies.

1.3 Develop surveillance costing product that can support advocacy materials.

Outcome Indicator: Costing guideline based on data collected during cost evaluations conducted with WHO-AFRO and partners.

1.4 Use data from exercises looking at use of IDSR data by national disease-specific programs in briefing and advocacy packages. This can include, for example, how pneumonia data from IDSR is useful to pneumonia vaccine development program, routine hospital data to malaria program, and so forth. This activity is a follow up to an activity from 2005-2006 to collect data. In 2006-2007, the data can be prepared for presentation.

Outcome Indicator: Analyzed surveillance data linking IDSR and the needs of vertical disease programs available for use in presentation and briefing packages.

2.0 Training and capacity building

Cost requirements: Travel, contracts.

Contracts: writer/developer, graphic support, translation services

2.1 Develop training module for implementing IDSR indicators that can be adapted by national and other training programs for inclusion in their curricula.

Outcome Indicator: A training module with instructional goals, examples, and exercises to support practical steps for implementing IDSR indicators.

2.2 Develop framework and tools for supportive supervision.

Outcome Indicator: A document describing the implementation of supervisory strategies for IDSR in African countries.

2.3 Based on analysis of feedback data, conduct a qualitative evaluation of how feedback is used at local levels to improve surveillance.

Outcome Indicator: Report of the qualitative evaluation with recommendations about improving feedback for IDSR.

2.4 Consult on development of regional capacity building strategies and integrated surveillance curricula as requested.

Outcome Indicator: Reports of surveillance and training consultations adopted and used by partner agencies.

2.5 Update IDSR Indicator Guide as requested.

Outcome Indicator: Updated WHO-AFRO IDSR Indicator Guide

To consider depending on available funding and time:

2.6 Finalize guidelines for community surveillance including field testing and revision.

Outcome Indicator: A practical guide for developing community surveillance based on IDSR guidelines.

2.7 Develop training guide for community surveillance.

Outcome Indicator: A guide for inclusion in the IDSR training package that includes instructional goals, examples, and exercises to support the practical steps in strengthening community links to surveillance.

3.0 Laboratory strengthening

Cost requirements: Travel, contracts

Contracts: graphic support for materials development

Travel funds: CDC participation in providing technical assistance to national partners in implementation of laboratory networks in specific countries as agreed upon with WHO-AFRO.

3.1 Finalize the IDSR Laboratory Indicators and develop guidance for implementing the indicators for monitoring and evaluating laboratory performance in support of IDSR in the African region.

Outcome indicator: Finalized IDSR Laboratory Indicators and Guidance for implementing them.

3.2 Provide technical assistance as requested to national programs.

Outcome indicator: Report of requests for technical assistance

Outcome indicator: Number of technical assistance requests for reagents, transport media and training received and responded to during the funding period.

4.0 Epidemic response

Cost requirements: Travel, specimen transport

Travel funds: CDC participation in responding to requests from WHO-AFRO to collaborate with WHO-AFRO in systematic response to outbreaks of epidemic prone diseases.

4.1 In collaboration with WHO-AFRO, provide technical support to Epidemic Preparedness and Response (EPR) officers in national IDSR programs.

Outcome indicator: Reports from outbreak response with data analyzed. (Note: sample report format is in IDSR Technical Guidelines.)

4.2 Participate in revising and updating guidelines for systematic approaches to response for epidemic-prone diseases. This guidance is disseminated throughout WHO system, USAID missions and U.S. Embassies and serves to provide a common framework for what is needed to undertake response to confirmed outbreaks of priority diseases such as meningococcal meningitis, yellow fever, and cholera.

Outcome indicator: Updated response guideline for IDSR with systematic approach for responding to confirmed outbreaks that include expertise required, standard response, treatment, and so forth.

5.0 Advocacy and tools

5.1 Establish coordination of collaborators who are working on surveillance capacity building, including laboratory, in the African region for purpose of streamlining resources and aligning objectives and strategies with IDSR.

Outcome indicator: Report of coordination meeting and document for describing overall mapping of partners' contributions to surveillance and laboratory capacity in Africa region.

5.2 Develop a publication agenda and work with AFRO to submit at least 3 joint manuscripts for publication.

Outcome indicator: number of manuscripts submitted for publication

Country/Region: Madagascar/Africa
Title Describing the Activity: CDC Technical Assistance to the Madagascar STI Laboratory System
Center/Division and Project officer at CDC the activity was negotiated with: NCHHSTP/DSTDP/LRRB, Ron Ballard
Bureau or Mission contact following the activity: Jocelyne Andriamiadana, USAID/Madagascar
Amount, type and year of funds to be obligated: $ 75,000
Time Frame: one year period

SCOPE OF WORK INTERAGENCY AGREEMENT
Between USAID/Madagascar and Centers for Disease Control and Prevention

This scope of work is for technical assistance from CDC as a part of a joint assessment team that will include the Ministry of Health and Family Planning (MOHFP) through the IST/HIV/AIDS Program, the Direction of Family Health/Safemotherhood Unit, the Direction of Laboratory, the National AIDS Committee, the WHO Geneva Department of Reproductive Health and Research, the CDC Laboratory Reference and Research Branch in DSTDP, and other partners such as UNAIDS and the WB MAP project.

I. BACKGROUND

The National AIDS Control Program requested assistance from partners in conducting an assessment of the national STI program. A joint consultation team, composed by MOHFP, UNAIDS, USAID and the CDC Division of STD prevention, conducted this assessment of the STI program in October 2005. The assessment identified a number of areas that need strengthening including STI surveillance, STI clinical services, program management and quality, provider training, community education, national leadership and updating the policy . On the laboratory component, findings from the review include:

- the need to establish a national STI laboratory system to support syphilis control activities for antenatal screening to prevent congenital syphilis
- the need to support a national syphilis reference laboratory and quality control program.

Rationale
Congenital syphilis is a public health crisis in Madagascar. Although universal antenatal syphilis screening policies exist, only 25% of mothers received such screening, and rates of effective treatment are unknown. WHO has established a global program to eliminate congenital syphilis. Madagascar could take advantage of this global initiative. The local WHO office is planning to work with GOM on a pilot “Safemotherhood” program that incorporates syphilis screening, and will pilot test this in at least one province in the near future.
Since the CDC Laboratory Reference and Research Branch is a WHO Collaborating Center, CDC technical support would be useful in assisting WHO and the GOM to

develop strategy to eliminate congenital syphilis. Syphilis screening and treatment is an inexpensive and effective intervention. CDC support would respond to the STI lab recoomendations of the assessment and contribute to the WHO congenital syphilis elimination program.

II. OBJECTIVE

The objective of this InterAgency Agreement with CDC is to provide technical assistance to Madagascar's MOHFP and CNLS for: (i) establishing a national STI laboratory system and (ii) institutionalizing a syphilis testing quality assurance and quality control system.

The establishment of a strong STI/syphilis laboratory system will contribute to better control the STIs burden through the provision of quality and rapid STIs testing, treatment and surveillance and to eliminate congenital syphilis as a public health problem.

CDC technical assistance through the IAA will be provided through a series of consultancies.

III. TASKS

The CDC assistance to MOHFP and CNLS will include:

1) conduct a formal assessment of STI laboratory systems (with a focus on syphilis control system for antenatal screening), including STI testing and surveillance

2) propose a syphilis quality control program

3) identify short term assistance needs: i) monitoring of Neisseria gonorrheae antimicrobial susceptibility, ii) evaluating GUD etiology, iii) development of sentinel surveillance for syphilis serology as it relates to the prevention of congenital syphilis, iiii) use of rapid non-treponemal tests for syphilis screening in remote areas including antenatal services.

IV. REPORTS AND DELIVERABLES

Reports
After each TA visit to Madagascar, the CDC consultants will submit a trip report in English to USAID/Madagascar, which shall include: (a) discussions/accomplishments during TA visit and recommendations; (b) problems encountered that may effect the quality or timeliness of the outputs; (c) actions that need to accomplish before the next TA visit; (d) modifications, if any, to be made to the remaining schedule of TA; and (e) next steps future activities.

Deliverable
The CDC consultants will submit a final STI lab system assessment report. This will include an analysis of the strengths and weaknesses of the system; recommendations to strengthen the system and short-mid and long term technical assistance needs.

V. ROLES AND RESPONSIBILITIES

The consultants shall work in close collaboration with the GOM through the National AIDS Committee; Ministry of Health and Family Planning and partners; HPN Office and the HPN Reproductive Health Program Management Specialist. The consultants will report directly to the USAID/Madagascar HPN Team Leader.

VI. LOGISTICS

USAID/Madagascar will provide office space and office equipment to the CDC. The CDC shall be responsible for all other logistics.

VII. PERIOD OF PERFORMANCE

The period of performance will start on or about June 01, 2006 and be completed by June 01, 2007. The services will compose of a number trips to Madagascar to be agreed upon by CDC, GOM and USAID as the needs and budget allow.

Country/Region: Sudan
Title Describing the Activity: Sudan Health Transformation Program: County Strengthening and HIV/AIDS Focus Components
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/GAP and COGH/DESCD
Bureau or Mission contact following the activity: Gary E. Leinen, USAID/Sudan
Amount, type and year of funds to be obligated:

Total $1,700,000 includes:
NCHHSTP/GAP - $1,000,000
COGH/DESCD - $700,000

Time Frame if appropriate:

Sudan Health Transformation Program: County Strengthening and HIV/AIDS Focus Components

Background

The tragic civil war that has engulfed Sudan for the past 20 years has left the health status of the population among the worst in the world. UNICEF reports that under-five mortality rates range from 65 to 170 per thousand live births. WHO estimates that maternal mortality ratios in SPLM areas may be as high as 865 per 100,000 live births. The total fertility rate is estimated at 5.9 live births per woman (UNICEF). Malaria is the number one cause of under-five mortality. UNICEF estimates that 65% of children visiting health facilities are diagnosed as malaria. Several studies suggest that resistance is fast emerging to both chloroquine and sulphadoxine-pyrimethamine (SP) although more drug sensitivity testing is needed. The UNICEF Sentinel Surveillance Survey (2001) found that one-third of children surveyed in southern Sudan suffered from diarrhea within two weeks prior to the survey. The UNICEF Multiple Indicator Cluster Survey (MICS) (1999) showed that 17% of children throughout Sudan reported recent respiratory infections. Outbreaks of measles are reported annually and neonatal tetanus is endemic in many counties. 94% of births take place at home (UNICEF). In addition, antenatal care coverage is low and usually lacks tetanus toxoid immunization and other services. There is a near absence of family planning and child spacing information and services.

The nutritional status of children and adults is poor. Bahr El Ghazal suffers from recurrent drought and under-five wasting rates are at emergency levels. 30 – 40% of babies are reported to have low birth weights. Exclusive breastfeeding rates are low. Sub-clinical vitamin A deficiency affects one of seven children in Sudan and goiter is common in areas such as the Nuba Mountains. Only 30% of the population use water from a protected source and only 20% reported having received any hygiene/sanitation information. Southern Sudan is a low prevalence area for HIV/AIDS (available data indicate a HIV prevalence rate below 3%), but is at risk of a rapidly escalating epidemic. Southern Sudan also suffers from other infectious diseases such as guinea worm (the largest remaining reservoir of the disease), onchocerciasis, trypanosomiasis, schistosomiasis, and visceral leishmaniasis. Given the above statistics, health transformation is a daunting task.

To help southern Sudanese communities transform their health and rebuild the health infrastructure, **USAID/Sudan Field Office's Sudan Health Transformation Program** will increase use of Health, Water, and Sanitation Services and Practices. This five year, $34 million program will focus on:

- Improved population coverage and utilization of primary health care complexes,
- Technical support to the National Health Secretariat and County Health Departments (CHDs) to assist CHDs to develop annual work plans, improve supervision, and develop functioning disease surveillance and response system,
- Expanded and effective training program for key PHC cadres including updated curricula and well qualified teachers.
- Focus on the private sector through the strengthening of local NGOs, and training for registered private drug sellers, and traditional birth attendants (TBAs),
- Focus on HIV/AIDS with support for vulnerable high risk groups, VCT in selected sites.

All program components will work in five regions of southern Sudan (Bahr el Ghazal, Equatoria (Eastern and Western), Upper Nile, Southern Blue Nile, and the Nuba Mountains). At the full complement of funding the program will:

- Expand PHC coverage from 30% to 60% coverage in USAID focus areas
- Rehabilitate/develop up to five CHW Training institutes,
- Train up to 2000 CHWs, with 40% women using scholarships and incentives such as childcare to increase participation of women
- Basic public health systems in 20 County Health Departments established
- Increase immunization coverage from less than 10% DPT3 to 40% DPT
- Provide 300,000 insecticide treated nets (ITNs) targeted for pregnant women and children under five,
- Support HIV/AIDS sentinel serosurveillance of ANC attendees, STI patients, soldiers and CSWs
- Provide 2 million free or subsidized condom distributions through public health facilities, the military and other outlets.

The Sudan Health Transformation Program (SHTP), approved by the Sudan Field Office (SFO) on November 7, 2003, is composed of three components: a) Primary Health Care expansion, b) Strengthening the County Health Departments, and; c) Focus on HIV/AIDS. The Sudan mission requests CDC technical expertise in the implementation of the latter two components.

FY2005 Child Survival and Infectious Disease and HIV/AIDS funds are available for the second year of this program. A Comprehensive Peace Agreement was signed on January 9, 2005; at an April 11-12 meeting in Oslo, bilateral and multilateral donors pledged significant support to rebuilding southern Sudan. The US government pledged a total of $1.6B over a two year period (including $800M already programmed).

In 1994, the Sudan People's Liberation Movement (SPLM) began to establish a civil administration in southern Sudan. The development of this structure has been hindered primarily by donor policies preventing capacity building efforts to shift the management of health programs from a UN/NGO-dominated emergency health system (delivered via Sudan Relief and Rehabilitation Commission--a relief wing of the SPLM) to the new health administration. Thus, the capacities of the emergency structure (SRRC) to coordinate, manage and deliver services is quite strong, as compared to the weak civil administration body (SPLM Secretariat of Health).

Strengthening the County Health Departments

CDC has agreed under this InterAgency Agreement to provide a long term epidemiologist to work with the SPLM Secretariat of Health (SOH). The priority is to train a group of up to 20 physician/epidemiologists to make functional simple integrated disease surveillance and response system with an emphasis on epidemic preparedness and response. CDC will collaborate with SPLM Secretariat of Health (headquartered in Rumbek, Bahr el Ghazal region, southern Sudan); John Snow International (JSI), a for-profit PVO responsible for implementation of the Primary Health Care Expansion Component; sub-grantees of JSI; UNICEF and WHO.

Scope of work, 2nd year:

In response to the initial scope of work and the need to develop greater epidemiologic and surveillance capacity, CDC identified and recruited a Resident Advisor to work with the SPLM Secretariat of Health, USAID, JSI, and the South Sudan GAP Resident Advisor (RA) with the goal of providing training to 20 County Medical Officers. The new RA met with Secretariat of Health officials, USAID, JSI, and the CDC/Kenya in early March 2005 and flew to Atlanta to meet with the CDC project team, partner organizations working in South Sudan, the RAs of other applied epidemiology training programs and potential instructors in early April 2005. The contract for the Resident Advisor was in effect in May 2005.

The initial activities for the RA will include: travel to Nairobi and S. Sudan to begin an in-depth assessment of the current surveillance activities and the partners who contribute to this system, meetings with the Secretariat of Health to further describe the target audience (County Medical Officers and other public health workers) for the training activities and to work with an instructional designer from Atlanta to begin development of the training materials for the initial courses, and to begin participating in outbreak investigations with the public health workers in Southern Sudan.

To develop further support for the program, the RA and project staff from Atlanta will conduct additional meetings with the CDC/Kenya Office, the Emerging Infections Program (IEIP) and the Field Epidemiology and Laboratory Training Program (FELTP) to determine the support these established activities may provide in the way of epidemiology training, laboratory analysis, and logistics. Agreement was reached with

the FELTP to provide space in future training courses for Sudan trainees where traveling the instructors for specific areas into Southern Sudan is not possible or practical. Further discussions will be held with the IEIP and CDC/Kenya to determine the level of support anticipated for the receipt and processing of specimens for analysis collected during outbreak investigations, as well as cost sharing for the use of facilities, vehicles, office space, and other support functions.

Funding:

In FY03, $25,000 was awarded to CDC for an initial feasibility assessment and was followed in FY04 by a commitment of $400,000 to begin the first year of the project. The bulk of these dollars will be consumed in the RA's annual contract which is approximately $290,000 per year. An increase to $700,000 in year two of the project will cover, in addition to the RA's contract, the travel and per diem of instructors who will assist the RA in delivering the first three training courses (1 at 3 weeks and 2 at 1 week each). These funds will also provide for the development and production of the course materials and the procurement of books, supplies, software and other items necessary for the trainees. Funds will be set aside to support outbreak investigations, including any travel, supplies, or equipment that may be needed in the field as well as funds to support the transportation and analysis of samples at CDC/Kenya or other laboratory facilities.

Focus on HIV/AIDS

CDC has fielded a long term epidemiologist to provide technical expertise to the New Sudan National AIDS Council. He is currently based in both Nairobi and in Rumbek, mirroring the NSNAC's location in these two cities. The objective is to develop, design, and implement a HIV/AIDS sentinel surveillance system strategy for select target groups, and conduct behavioral change communication surveys. The epidemiologist currently works with the Executive Director of the NSNAC, and will work with additional counterparts as they are hired.

Scope of work, 2nd year:

USAID is supporting CDC Global AIDS Program activities in South Sudan through an interagency agreement signed in 2004, providing approximately half of the funds available to GAP for HIV impact reduction in South Sudan. This is a very dynamic period in South Sudan, with changes occurring at all levels and in every sector of society. As in all sectors of society, the need for health services including HIV control programs is acute in South Sudan. CDC and USAID will continue to work in collaboration with the SPLM government health officials and other donors and stakeholders to build health and social services related to HIV.

CDC proposes to continue to work to develop HIV surveillance mechanisms, focusing primarily on antenatal care. Surveillance activities will also be supported by the Global Fund against AIDS, Tuberculosis and Malaria (GFATM). CDC will provide technical

assistance and laboratory supplies and perform or support the performance of laboratory testing for surveillance, as well as for quality assessment for HIV testing programs in South Sudan. CDC proposes to hire one full-time laboratory staff person (with funds outside of this interagency agreement) to support HIV program activities in South Sudan, and to procure supplies directly and through partners. Surveillance should be conducted in settings where decent antenatal services are offered to the population under surveillance, including HIV services such as counseling and testing and prevention of mother to child transmission interventions. CDC proposes to support implementing partner agencies through different mechanisms, including cooperative agreements with implementing partners and also through cooperative agreement with another partner for capacity building and grants management. Some funding for such cooperative agreements will come from each of CDC's funding sources.

In addition to program support, the capacity building cooperative agreement is intended to provide a mechanism for supporting and strengthening the National AIDS Council and/or other government management entities that may be developed. CDC proposes that the capacity building CoAg will be used for training, purchase of essential equipment, invitational travel, and essential, program related infrastructure modification.

HIV program services for the SPLM/A uniformed services have been identified as a priority by the government, and CDC will continue to support prevention and testing services for the SPLA. CDC proposes this year to establish cooperative agreements directly with implementing partners, although a cooperative agreement with a managing organization is also possible. The budget allocates $250,000 for these activities.

New CDC staff for program support will be hired with funds from the IAA. CDC proposes to hire one experienced health program manager and one finance staff. Costs of these positions may be shared between GAP and the Division of International Health, CDC, which will also be establishing operations in South Sudan that are supported by this IAA. The new positions are likely to be Kenya-based foreign-service nationals.

CDC will also support Care and Treatment for HIV, including anti-retroviral treatment. In addition to $200,000 allocated in GHAI budget, an additional $50,000 will be allocated from the IAA.

Counseling and testing services are an essential part of HIV control, and as the entry point for other services. CDC proposes to fund the development of the first permanent training program in South Sudan for different models of counseling and testing, as well as counseling related to care and treatment. Such a program may be jointly funded by other donors, such as UNICEF.

CDC Kenya will continue to provide technical assistance in different areas of HIV control, and most of the funding for such activities will come from the GHAI funds, including the funding for the CDC medical officer position.

In its activities, CDC collaborates with: SPLM Secretariat of Health; New Sudan

National AIDS Council (NSNAC); GTZ; UNDP (in particular Global Fund for AIDS, Tuberculosis and Malaria Principal Recipient representative); UNICEF; WHO, and PVOs/NGOs integrating HIV/AIDS activities in cross-sectoral programs.

CDC Participation: development of a unified USG strategy for HIV/AIDS in South Sudan; finalization of Performance Management Plan (PMP) for Sudan Strategic Objective 7

Unified HIV/AIDS strategy

As a non-focus country in the Presidential Emergency Plan for AIDS Relief, South Sudan is not required to produce a lengthy unified USG strategy. However, both CDC and USAID have expressed their commitment to developing such a strategy, and to incorporate the ideas of other USG agencies as they begin implementation of activities in Sudan. USAID and CDC expect to finalize a draft strategy prior to September 2005.

Finalizing the SO7 Performance Monitoring Plan

The PMP aims to guide the USG Sudan Team and partners in assessing and improving the performance of its humanitarian and development programs by: 1) providing a valuable tool to assess progress toward results; 2) stating the results the USG Sudan program is willing to hold itself accountable for achieving; 3) identifying responsibility within the team (and of partners) for gathering and reporting data, and 4) assessing critical assumptions and causal relationships defined in USAID's results framework.

CDC program staff will be expected to participate in the finalization of appropriate performance indicators for the HTP program and the PMP for SO7. This should be completed by June 2005.

Other Program Requirements

USAID/SFO has been granted a "negative determination with conditions" by the Africa Bureau Environmental Officer (AF/BEO) requiring special procedures to be followed for activities which may entail generation of healthcare waste.

The conditions are that the SO 7 Team will work with its implementing partners, to the extent possible, to ensure that for all USAID-supported activities entailing service delivery, including blood testing and laboratory support, USAID/Sudan's SO 7 team must work with its implementing partners to assure, to the extent possible, that the medical facilities and operations involved have adequate procedures and capacities in place to properly handle, label, treat, store, transport and properly dispose of blood, sharps and other medical waste. Appropriate guidance is articulated in Part II, Chapter 9 of the USAID Bureau for Africa's Environmental Guidelines for Small Scale Activities in Africa, titled, 'Healthcare Waste: Generation, Handling, Treatment and Disposal.' It contains guidance which should inform the SO Team's activities to promote proper handling and disposal of medical waste, particularly for small facilities. See in the section

titled, “Minimum elements of a complete waste management program.” The URL to consult is: http://www.encapafrica.org/SmallScaleGuidelines.htm. The ability of the Team to assure such procedures and capacity is understood to be limited by its level of control over the management of the facilities and operations that USAID/Sudan is supporting, as well as available funding.

Country/Region: Uganda
Title Describing the Activity: President's Malaria Initiative Activities
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DPD/MB
Bureau or Mission contact following the activity: David Bruns/Jessica Kafuko
Amount, type and year of funds to be obligated: $760,000
Time Frame if appropriate:

CDC activities during 2006 in Uganda under the President's Malaria Initiative include monitoring and evaluation of the implementation of PMI related activities, operations research on the distribution and use of artemisinin-based combination therapy at the community level, and support for an in-country CDC PMI advisor to serve as part of the PMI team. Specifically, as part of their Monitoring and Evaluation function, CDC will provide support to one demographic surveillance site, evaluation of verbal autopsy as a follow-up to the 2006 Demographic and Health Survey and entomological support to the indoor residual spray campaign.

Country/Region: Angola
Title Describing the Activity: President's Malaria Initiative Activities
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DPD/MB
Bureau or Mission contact following the activity: Alonzo Wind
Amount, type and year of funds to be obligated: $432,000
Time Frame if appropriate:

The scope of CDC activities during 2006 in Angola under the PMI as part of a broader interagency agreement with the CDC include:

- a combined epidemiological/ entomological assessment of malaria risk in the four southern provinces and the greater Luanda area in order to better target large-scale prevention activities involving insecticide-treated bednets and indoor-residual spraying
- technical assistance to the National Malaria Control Program (NMCP) to improve local capacity in the diagnosis and case management of malaria.
- a technical advisor within the National Malaria Control Program offices in Luanda to provide technical oversight for these activities and for reporting, monitoring and evaluation of results achieved.
- strengthening laboratory diagnosis of malaria; training and quality control.

EUROPE AND EURASIA REGION

Country/Region: Russian Federation
Title Describing the Activity: Technical Assistance in Tuberculosis Control and TB/HIV co-infection
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells and Peter Cegielski
Bureau or Mission contact following the activity: Nikita Afanasiev, USAID/Russia
Amount, type and year of funds to be obligated: $700,000

TB Control - $600,000
TB/HIV - $100,000

Time Frame: On-going activity: 1998-2008

Technical Assistance in Tuberculosis Control and TB/HIV co-infection

Activity Description

CDC will provide technical assistance to USAID Russia TB Control Program. The components of the program are managed by the World Health Organization (WHO) and the International Federation of Red Cross and Red Crescent Societies (IFRC). Technical assistance will be provided in such areas as multi-drug resistant tuberculosis control (DOTS-Plus), improvement of infection control at TB facilities, prevention of TB/HIV co-infection and provision of health care to PWLHA with TB, training of Russian TB professionals and capacity building of Russian TB institutions, quality assurance of TB laboratories performance, including drug susceptibility testing.

ASIA AND THE NEAR EAST REGION

Country/Region: India
Title Describing the Activity: Technical support to the Government of India for the National Tuberculosis Control Program (TB Advisor)
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells
Bureau or Mission contact following the activity: Sanjay Kapur, USAID/India
Amount, type and year of funds to be obligated: $57,000
Time Frame if appropriate:

Terms of Reference for CDC Secundee to WHO, South East Asia Regional Office (SEARO), Tuberculosis Unit

1. Assist Central Tuberculosis Division, Government of India, in planning and conduction of operational research projects, including the measurement of the impact of the Indian tuberculosis control program on TB incidence, prevalence and mortality.

2. Support Central Tuberculosis Division, Government of India, in strengthening TB/HIV collaborative activities

3. Assist Central Tuberculosis Division, Government of India, in starting community based drug resistance surveillance and a treatment program for multi-drug resistant tuberculosis, that is consistent with international guidelines

4. Assist Central Tuberculosis Division, Government of India, in improving the operational quality of tuberculosis control services

5. Assist national tuberculosis control programmes in the WHO South East Asia Region in the implementation of TB-HIV interventions in collaboration with national HIV/AIDS control programmes.

6. Assist national tuberculosis control programmes in the WHO South East Asia Region in undertaking interventions, including surveillance, to address anti-TB drug resistance

7. Assist national tuberculosis control programmes in the WHO South East Asia Region in identifying operational research priorities and developing and undertaking operational research to enhance the reach and acceptance of DOTS and of additional interventions to address TB-HIV and anti-TB drug resistance.

Country/Region: RDM Asia-Bangkok Regional Office
Title Describing the Activity: Leishmaniasis Surveillance Network
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DPD, Caryn Bern
Bureau or Mission contact following the activity: John MacArthur/RDM Asia
Amount, type and year of funds to be obligated: $150,000
Time Frame if appropriate:

Background

The parasitic disease kala-azar (visceral leishmaniasis) was first described in 1824 in Jessore District (now Bangladesh). Epidemic peaks were recorded in Bengal in the 1820s, 1860s, 1920s, and 1940s. After achieving good control of the disease during the intensive vector control efforts for malaria in the 1950s-1960s, Bangladesh experienced a VL resurgence that has lasted to the present. Leishmaniasis is responsible for 2 million cases per year (500,000 visceral leishmaniasis (VL) plus 1.5 million cutaneous leishmaniasis (CL)) resulting in 60,000 deaths/year. Sixty percent of the global VL burden is in South Asia with India accounting for 40% and Bangladesh adding an additional 20% of the cases.

Shortages of first-line antileishmanial drugs and insecticide for indoor spraying programs have hindered VL treatment and vector control efforts. Effective control of VL will require activities to improve availability and access to diagnostic testing and antileishmanial drugs, enhanced surveillance for kala-azar, post-kala-azar dermal leishmaniasis and VL treatment failures, and increased coverage and efficacy of vector control programs. There are increasing levels of drug resistance in the region with 65% resistance to first-line drug (antimonials) in India with the 2nd line therapy being considerably more expensive. There are no resistance data from Bangladesh

Proposal

In collaboration with ICDDR,B and the Bangladesh MoH, to work with one or two subdistrict government health complexes with high reported incidence rates of visceral leishmaniasis (>500 cases per year in carchment populations of 300,000 to 400,000) in Bangladesh. Current surveillance data are thought to represent approximately a 5-fold underestimate of the true incidence. The health complexes would serve as sentinel surveillance sites in which we will institute enhanced surveillance including improved data collection and management system (in other words computerization), ascertainment of kala-azar cases and follow-up for treatment failure, and introduce ascertainment of post-kala-azar dermal leishmaniasis (PKDL). We will include community-level evaluations of the surveillance system based on active case ascertainment.

Discussions will ensue with USAID RDM/A to determine whether this project will initially begin only in Bangladesh or in both Bangladesh and India.

Summary Budget

(Note: More detailed budget available upon request)

Activity	**Description**	**Budget**
1	Enhanced Leishmaniasis Surveillance Network	$150K
Total		$150K

Country/Region: RDM Asia-Bangkok Regional Office
Title Describing the Activity: Regional TB Program
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Jay Varma
Bureau or Mission contact following the activity: John MacArthur/RDM Asia
Amount, type and year of funds to be obligated: $700,000
Time Frame if appropriate:

Concept Sheet for CDC/TB Funding from USAID/RDMA Oct 06 – Sep 07

Background

In January 2006, the World Health Organization (WHO) released "The Global Plan 2 to Stop TB 2006-2015." Major components of this plan include expanding the DOTS strategy from first global plan to address HIV-associated TB, multi-drug resistant TB (MDR-TB), and private sector TB care and to foster operational research. Three years before this plan was announced, CDC formed a partnership with the Thailand Ministry of Public Health (MOPH) to pilot new approaches to TB control in four Thai provinces, using a model similar to what the Global Plan is now advocating. This partnership, known as the Thailand TB Active Surveillance Network, expands the foundation of DOTS to include: enhanced surveillance, monitoring, and evaluation of TB cases treated in the public and private sector; closer integration of TB and HIV services; increased laboratory capacity for TB culture and susceptibility testing; and electronic recording and reporting of TB cases to permit rapid analysis and dissemination of data for policy change. Network activities were launched in October 2004. In 2005, USAID/RDM-A began investing in the Active Surveillance Network, and, as a result, the network will now expand to Tak province, the province with the largest number of Burmese refugees and migrants in Thailand and a worrisome focus of MDR-TB transmission. Training, lab capacity expansion, and procurement have begun, and the full complement of Active Surveillance Network activities is scheduled to begin across all nine districts of Tak province in June 2006.

The Active Surveillance Network has resulted in reduced mortality, increased sputum conversion rates, increased case finding, and enhanced laboratory services in project sites.**(Appendix A)** A major goal of this system is to develop models of and evidence for sustainable interventions that can be exported nationally, regionally, and globally. In a short time, we have begun achieving this goal. Lessons learned from HIV counseling and testing of TB patients have led to Thai national policy changes, revision of the national recording and reporting system, and government mobilization of resources for expanding TB/HIV collaborative activities in other provinces in Thailand. Lessons learned have also been exported to other countries; officials from nine different Ministries of Health in Asia have received training in TB/HIV collaboration at the Active Surveillance Network sites. WHO headquarters and regional staff have visited the Bangkok network site twice to learn about the experiences of public-private partnerships in Bangkok and whether these can be applied to other countries.

The Active Surveillance Network has served as a platform for research into important public health questions about TB and HIV in Thailand. In 2004, USAID/RDM-A invested in an observational study to determine risk factors and causes of death in HIV-infected TB patients who are ascertained through the Active Surveillance Network. Patient enrollment began in May 2005 and, as of December 2005, 397 HIV-infected TB patients have been enrolled. The most important finding to date is that TB appears to be a late complication of HIV disease in Thailand, occurring almost exclusively in patients with AIDS, in marked contrast to what is seen in sub-Saharan Africa, where TB occurs across a wide-spectrum of immune-deficiency. Data on the first 49 deaths is currently being analyzed and, over the next 3-6 months, we anticipate having powerful epidemiologic data about what social or medical interventions might reduce the high, early mortality rate in HIV-infected TB patients.

Because delayed diagnosis of TB may be an important cause of mortality in HIV-infected TB patients, WHO recommends that all HIV-infected persons be screened for TB; the best method to screen for TB, however, has not yet been determined. In 2005, USAID/RDM-A invested in CDC designing a clinical algorithm to screen for and diagnose TB in HIV-infected patients. To date, a comprehensive scientific protocol has been developed and agreements made with national TB programs, laboratories, and non-governmental organizations to enroll 2000 patients in Thailand (Bangkok), Cambodia (Banteay Meanchey, Battambang), and Viet Nam (Hanoi, Ho Chi Minh City). USAID RDM-A funding is supporting technical assistance for the Thailand and Viet Nam sites, as well as the costs of all diagnostic testing for patients in Viet Nam.

<u>Proposal</u>
In October 2006 – September 2007, CDC proposes to have USAID invest in continuing the three activities described above, including:

Activity #1: Thailand TB Active Surveillance Network
CDC's Global AIDS Program (GAP) funded the Active Surveillance Network from 2003 – 2005 in the four original provinces, and USAID supported the fifth province, Tak. New U.S. government rules, however, restrict the use of HIV-specific funds for TB activities that are not directly targeted at HIV-infected patients. We propose to increase USAID's investment in the Active Surveillance Network beyond Tak province. Of the approximately $660K required to fund the Active Surveillance Network, including all program management and service delivery costs, we propose to have ~58% ($384K) supported by USAID and ~42% ($276K) supported by CDC's Global AIDS Program. Of the $384K invested by USAID, $240K (63%) would directly fund service delivery, including case finding in the public and private sectors, laboratory diagnostic testing, nursing care, and local TB program monitoring for all five sites in the Active Surveillance Network (Chiang Rai, Ubon-ratchathani, Bangkok, Phuket, and Tak). CDC's Global AIDS Program will continue to fund the HIV-associated components of the Active Surveillance Network.

Activity #2: Thailand TB/HIV Observational Research Study

Patient enrollment in the observational study will end in August 2006, but follow-up of patients and close-out of data will need to last through December 2007. Additionally, we anticipate the need to disseminate findings from this study to healthcare workers through training sessions and to assist policy makers with revising national strategies based on these findings. We propose to have $198K invested from USAID in this activity.

Activity #3: Improving Diagnosis of TB in HIV-infected Persons in Southeast Asia (ID-TB/HIV Study)

Patient enrollment in this study will begin in May 2006, and the study is anticipated to last between 12 – 18 months (6 months of enrollment, 6 – 12 months to complete testing, data collection, and analysis). Technical assistance for implementing and monitoring this study is needed during this time. Because of the importance of this study to global health policy, the CDC principal investigator (Dr. Jay Varma) has been selected by WHO to participate in an expert WHO technical committee to formulate recommendations for improving diagnosis of TB in HIV-infected persons, including ultimately translating findings from this study into international policy. We propose to have $118K invested from USAID in support of activities related to this study.

Summary Budget

(Note: More detailed budget available upon request)

Activity	**Description**	**Budget**
1	Thailand TB Active Surveillance Network	$384K
2	Thailand TB/HIV Observational Study	$198K
3	Improving Diagnosis of TB in HIV-infected Persons in Southeast Asia (ID-TB/HIV Study)	$118K
Total		$700K

Appendix A. Contributions of Thailand TB Active Surveillance Network to public health in Thailand and Asia.

Type of Impact	Specific Accomplishment	CDC Contribution
Policy Change	National policy adopted to perform HIV counseling and testing on TB patients, with development of work plan for implementation of this policy	Built evidence base; lobbied for change; tested strategy; financial support for planning workshop held in Viet Nam; technical assistance in writing national policy and plan
	National TB recording and reporting system revised to include HIV-related data and additional important TB-related data	Built evidence base; lobbied for change; revised national forms based largely on forms developed as part of Ubon network
	Expanded TB/HIV partnerships in Northeastern Thailand	Lessons learned in Ubon network applied; "Seed" money from CDC project used to mobilize resources from GFATM
	Restricted policies on prescribing of anti-tuberculosis drugs at Bamrasnaradura Institute	Built evidence base (about problem of diverse providers managing TB); supported implementation of new policy
Better Public Health Outcomes	Decreased death rate during TB treatment and increased TB cure rate among HIV-infected TB patients in Ubon	Provided infrastructure and technical guidance for enhanced TB/HIV collaboration, TB program monitoring, and HIV testing in TB clinics
	Increased TB case finding in Bangkok, Phuket, Chiang Rai	Provided infrastructure and technical guidance for partnerships with private sector
	Increased sputum conversion rate in Phuket	Provided infrastructure and technical guidance
	Increased proportion of patients receiving HIV counseling and testing in Bangkok, Chiang Rai, Phuket, and Ubon	Provided infrastructure and technical guidance
Enhanced Capacity	More rapid, sensitive diagnostic methods for TB implemented in Bangkok. Chiang Rai, Phuket, and Ubon	Provided infrastructure and technical guidance
	Access to routine drug-susceptibility testing available in Bangkok, Chiang Rai, Phuket, and Ubon	Provided infrastructure and technical guidance
	Electronic recording and reporting software implemented in Bangkok, Chiang Rai, Phuket, Ubon, and Bamrasnaradura Institute	Provided infrastructure and technical guidance

Type of Impact	Specific Accomplishment	CDC Contribution
	Infrastructure for measuring outcomes of public health interventions and conducting operational research	Provided infrastructure and technical guidance; Observational study launched to understand causes of high, early mortality rate in TB/HIV patients
	Training of public health staff in TB and TB/HIV management	Provided infrastructure and technical guidance
	Enhanced capacity for TB outbreak response	Outbreaks investigated at Phuket Vachira Hospital and Wat Tham Krabok with laboratory, IT, epidemiologic, statistical support from CDC and CDC-funded infrastructure and personnel
Exporting of Models	On-site training of public health personnel from Bangladesh, Cambodia, China, Burma, Indonesia, Laos, Malaysia, Nepal, Viet Nam, and multiple Thai provinces about TB/HIV collaborative activities	Activities funded; technical support during training
	WHO TB/HIV training course for SEARO and WPRO countries	Curriculum development; organization; hosting of site visits at project sites
	WHO headquarters and regional office visits to public-private partnership site in Bangkok	Activities at network site funded; technical support for presenting findings to visitors

Country/Region: RDM Asia-Bangkok Regional Office
Title Describing the Activity: Regional Technical Advisor
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DPD/MB, Richard Kahn
Bureau or Mission contact following the activity: Lois Bradshaw, RDM Asia
Amount, type and year of funds to be obligated: $207,000
Time Frame if appropriate:

Project Description
In April 2002, USAID adopted a plan to realign resources, accelerate systems, and manage a worldwide HIV/AIDS strategy that is scientifically guided, carefully monitored and well coordinated with the strategies of host country partners, international organizations, and other donors. Part of this plan involved the creation of a Regional Development Mission in Thailand to design and manage regional initiatives in Asia and assist neighboring countries in developing high-impact programs and strengthening human capacity. The primary focus for the HIV/AIDS-Health Office (HHO) of the Regional Development Mission-Asia (RDM-A) will be the six Mekong countries -- Burma, Cambodia, China, Laos, Thailand and Vietnam -- and, in partnership with USAID Missions, some areas of South Asia. Additionally, HHO may provide assistance in "non-presence" countries in Southeast Asia outside of the Mekong region.

While HHO will concentrate its efforts on HIV/AIDS, it will also have responsibility for designing, managing, and overseeing Infectious Disease (ID) programs (e.g. tuberculosis, malaria, disease surveillance, antimicrobial drug resistance) throughout the Mekong Region (and possibly other parts of Asia).

An ID technical advisor is needed for the RDM-A office to provide technical, management, and policy advisory services to the HHO Office and to the countries in the region. In addition, the advisor will work with USAID's missions, ID staff in Washington, implementing partners, and other donors to develop programs and leverage resources to address the most important ID needs in the region.

The detailing of a CDC malaria staff person to USAID/RDM-A would serve several purposes: (1) providing USAID with a highly-qualified regional ID advisor with malaria expertise; (2) expanding U. S. Government (USG) expertise in Thailand to assist in the expansion and scaling-up of programs throughout Asia to address all three of the major infectious diseases of public health importance; (3) strengthening USAID/CDC collaboration in the region, especially with and between the IEIP program; and (4) saving USG funds since a more-expensive, non-direct hire contracting mechanism would not be needed.

The specific objectives of this detail are as follows:

- To participate in the designing of an analytically sound and focused Greater Mekong ID Strategic Plan and of an operations plan for RDM-A/HHO and manage this ID portfolio;
- In collaboration with USAID/Washington (USAID/W), to provide planning, programming and budgetary advice to RDM-A/HHO, US Embassies, USAID missions, and implementing partners in all aspects of the USAID ID program;
- To follow ID trends in Asia, analyze information, and communicate needs and opportunities to RDM-A/HHO and USAID/W;
- To establish and maintain close and collaborative working relationships with CDC and other USG agencies; WHO; Global Fund for AIDS, Tuberculosis (TB), and Malaria; Roll Back Malaria; Stop TB; and other ID partners in the region;
- To assure that all USAID legal and reporting requirements for the program are met, and assist implementing partners in setting up reporting and tracking systems to provide correct and complete information in an efficient and timely manner;
- To keep abreast of the state-of-the-art methods in ID research, prevention, diagnosis and treatment, as well as social developments in the region, host country policies and programs, and overall donor assistance to the region;
- To regularly review and analyze data on ID activities to provide up-to-date information on the effectiveness and impact of program strategies and inputs;
- To identify opportunities and propose additional ID activities which are of regional interest and complementary to on-going country and regional programs;
- To work closely with the HIV/AIDS technical staff in RDM-A/HHO and USAID/W to develop strong linkages between the ID and HIV/AIDS program efforts; and
- To represent RDM-A and/or USAID/W at selected international and regional meetings on ID topics.

Summary Budget

Activity	**Description**	**Budget**
1	RDM/A ID Advisor (Malaria)	$107K
2	RDM/A ID Advisor (Other ID)	$100K
3	RDM/A ID Advisor (Avian Influenza)*	$82K*
Total		$289K

* $82,000 for Avian Influenza shown in this table was obligated in Amendment 20 of the 1999 USAID/CDC Interagency Agreement and is therefore not included in the $207,000 obligated under this Agreement for this scope of work.

Country/Region: RDM Asia-Bangkok Regional Office
Title Describing the Activity: Antiretroviral Resistance Surveillance in Thailand
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Jay Varma
Bureau or Mission contact following the activity: Matt Friedman, RDM Asia
Amount, type and year of funds to be obligated: $200,000
Time Frame if appropriate: third year of a 5-year activity

Background

More than 50,000 HIV-infected persons in Thailand have begun treatment with antiretroviral drugs (ARVs), most in the last three years. WHO has set a goal of 3 million persons on ARV therapy worldwide by the end of 2005. With the rapid expansion of treatment programs, a major risk exists for the development of resistance to the most commonly used and accessible ARVs, and subsequent treatment failure. When ARV resistance reaches a significant prevalence, initial treatment regimens need to be altered and clinical resistance testing may be instituted. However, these measures are costly. Surveillance for ARV resistance is critical to provide the data for making appropriate decisions on alteration of first-line ARV regimens.

The initial $100,000 provided by USAID in FY04 for ARV resistance surveillance in Thailand was used, together with some GAP funds, to support expert consultation with the co-chair of the CDC/WHO Working Group on ARV Resistance Surveillance in January 2005 to design ARV resistance surveillance for Thailand, and subsequently for initial implementation of two priority approaches. These are:

(1) implementation of the WHO-recommended threshold survey in two populations: pregnant women and commercial sex workers, beginning in June 2005; and
(2) retrospective measurement of resistance prevalence during 2003-2004 in newly-infected injecting drug users in Bangkok, to be done in summer 2006.

In FY05, USAID provided an additional $200,000 to CDC to expand ARV resistance surveillance with an additional priority approach: monitoring the incidence of resistance over time in a cohort initiating treatment. With this first year of funding, we initiated a cohort at a 4 hospitals in northern Thailand (Lampang, Lamphun, Chiang Rai, and Chiang Mai) with testing at 4 timepoints over 2 years (0, 6, 12, and 24 months).

Proposal

We propose to expand and continue ARV resistance surveillance activities by:

(1) Continuing annual threshold surveys in two populations (pregnant women and sex workers) and adding a threshold survey in men who have sex with men;

(2) Continuing to support completion of enrollment and follow-up of the cohort over 2 years
(3) Expansion of the cohort to add another geographic region in Thailand (probably Bangkok)
(4) Supporting the Thailand National Institute of Health to become a WHO-accredited laboratory for ARV resistance surveillance testing

This resistance incidence study is critical to determine the durability of Thailand's existing first-line regimen, GPOvir, so that ARV program improvements can be made where needed and strategies for regimen changes can be developed. There are also regional and global implications to this study. The three drugs comprising GPOvir (D4T, 3TC, and nevirapine), are the most commonly used ARV regimen worldwide, and GPOvir itself is now being used in some neighboring countries. In addition, GPOvir will be reviewed by the U.S. FDA for purchase by agencies implementing the President's Emergency Plan for AIDS Relief (PEPFAR). It is likely that the data from this resistance incidence study will be required to document the durability of GPOvir before it can be made available to 25 countries through PEPFAR. This study must continue to provide timely data as global ARV treatment scale-up proceeds.

Summary Budget

(Note: More detailed budget available upon request)

Activity	**Description**	**Budget**
1	ARV resistance testing reagents and supplies	$120,000
2	Training, personnel time, data entry, analysis, and workshops for interpretation and dissemination	$70,000
3	Technical assistance and inspection visits for laboratory accreditation	$10,000
Total		**$200,000**

LATIN AMERICA AND THE CARIBBEAN REGION

Country/Region: Dominican Republic
Title Describing the Activity: Assessment of the national HIV/AIDS surveillance system
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/GAP, Theresa Diaz and Keith Sabin
Bureau or Mission contact following the activity: Estelle Quain, GH/OHA/SPER
Amount, type and year of funds to be obligated: $75,000
Time Frame if appropriate: 1 year

BACKGROUND

Since the beginning of the AIDS epidemic in the Dominican Republic in 1984, USAID/DR and partners had provided significant technical and financial support for the development and strengthening of the National HIV/AIDS Surveillance System, which has been the responsibility of the National AIDS Program (DIGECITSS) (formerly know as PROCETS). However, in 1998 USAID/DR considered that DIGECITSS had the necessary capacity to continue with limited technical assistance. In 2004, because of staff turnover at all levels of the Ministry due to political reasons and limited financial resources, surveillance became sporadic and in some cases, information was not collected, or collected and not processed (i.e. sentinel surveillance for 2002). Also, case reporting is not done consistently, and most experts consider that the country has a 50% underreporting.

In addition, collected surveillance information is not shared, disseminated or used for analysis/decision making within the MOH and with other stakeholders. The HIV/AIDS laboratory network is not efficient: often test kits are expired, no refrigeration is available for samples, no confirmation tests are performed, and results frequently take over a week or longer. The laboratory staff have been unable to adopt new laboratory techniques to improve efficiency and timeliness.

USAID/DR, PAHO, UNICEF, UNAIDS, and other donor agencies formed a support group in order to strengthen the deteriorated surveillance system. As a result, for the last two years and in coordination with PAHO, UNICEF and UNAIDS, USAID/DR has provided technical assistance and support to strengthen the DIGECITSS surveillance system, including sentinel surveillance, passive surveillance (case reporting) and service statistics (PMTC, VCT, and STIs). One additional problem is that sentinel surveillance has only focused on ANC clinics and STI services for sex workers, and only in the last two years have we been able to obtain data, segregated by age groups, in order to measure HIV infections among young pregnant women in the age group of 19 – 24.

Other vulnerable populations, including people living in Bateyes communities, MSM, IDU, or prisoners, have not been the focus of a national surveillance system.

SCOPE OF WORK

USAID requests that the Center for Disease Control (CDC) conduct an initial needs assessment on the National HIV/AIDS surveillance system of the Dominican Republic. The analysis would examine strengths and weakness of the laboratory network and the speed at which data and information flow through the system.

OBJECTIVES

The objectives of the assessment are:
(1) To assess the surveillance situation and the extent and needs of the country to strengthen the surveillance system.
(2) To identify gaps and opportunities for the implementation of a coordinated approach, including assessment of role of partners (e.g. PAHO, UN agencies, and CAREC).
(3) To develop a three-year action plan and budget, based on the assessment findings.
(4) To present this action plan to MOH, DIGECITSS, COPRESIDA, USAID/DR and other stakeholders, for discussion and approval.

ACTIVITIES

1. Meet with PAHO, interested UN Agencies, and other local partners (including MOH/DIGECITSS and COPRESIDA).
2. Present a time table of the assessment to be provided.
3. Assess HIV laboratory network, surveillance data and field data.
4. Prepare a draft report and present it to USAID and partners for discussion.
5. Prepare a three-year development plan and budget.

TIME

The assessment is requested for mid-July 2005.

COMPOSITION OF THE TEAM

The CDC will provide Spanish speaking people from both CDC/Atlanta and CDC/Central America. A PAHO representative should be part of the team. CDC has identified Amalia De Riego as their PAHO counterpart.

ESTIMATED BUDGET

Assessment	$50,000.00
Initial follow-on work	$25,000.00
Total	$75,000.00

Country/Region: Bolivia
Title Describing the Activity: Strengthening STI /HIVAIDS Activities in Bolivia
Project Officer at CDC the activity was negotiated with: NCHHSTP/GAP**,** Gabriela Paz/MERTU
Bureau or Mission contact following the activity: Stanley Blanco
Amount, type and year of funds to be obligated: $50,000
Time Frame: 1 year activity

Strengthening STI /HIVAIDS Activities in Bolivia

I. INTRODUCTION

For FY06, USAID/Bolivia is providing funds for an Inter-Agency Agreement (IAA) with CDC to continue technical assistance in STIs/HIV/AIDS.

Through this IAA USAID/Bolivia will continue to strengthen selected capacities of the Bolivian Ministry of Health (MoH) and Non-Governmental organizations (NGOs) in HIV/AIDS, with emphasis on working with high-risk populations. The technical assistance provided through the IAA will focus on the MOH's National Program and local NGOs that receive financial/technical support from USAID/Bolivia driven primarily by three factors: (1) areas in Bolivia with higher HIV/AIDS prevalence levels, particularly among high-risk groups; (2) continuity in the Departmental Health Services and municipalities where CDC, USAID/Bolivia and the National Program have been working to strengthen surveillance and access to voluntary testing and counseling (VCT); and, (3) the need of continuous quality control of the laboratory network.

II. BACKGROUND

A. BASIC EPIDEMIOLOGY[1]

- **HIV in Bolivia is often diagnosed late in the course of infection**. Between 1984 and 2004, 1549 people have been registered as HIV positive in Bolivia. Forty-eight percent (743 individuals) are currently classified as having AIDS.
- **Nine out of ten of the reported HIV/AIDS cases in Bolivia are in the departments of Santa Cruz, Cochabamba, and La Paz**. 54% of reported HIV/AIDS cases are in Santa Cruz, 21% in La Paz, and 14.5% in Cochabamba.
- **Most HIV/AIDS cases occur in men**. The male/female ratio for HIV/AIDS is approximately 2:1.
- **The largest percentage (39%) of HIV/AIDS cases occur in adults age 25 – 34**.

[1] Source: STI/HIV/AIDS National Program/ PROSIN II/ Socios en Desarrollo TA to surveillance system.

- **The vast majority of HIV infections in Bolivia are transmitted through sexual activity**. In 2005, over 90% of the documented HIV infections (n = 242) were acquired through sexual transmission. About 1.7% of cases were acquired through mother-to-child transmission and 0.8% through blood or blood products. The mode of transmission for the remaining 6.6% of the cases was undocumented/unknown.

B. HIV in high risk groups[2]

- Men Who Have Sex with Men (MSM): A handful of small, targeted studies conducted among populations of MSM have consistently shown seroprevalence rates in excess of 10%.
- Commercial Sex Workers (CSWs): Although CSWs are a high-risk group in many countries, the evidence in Bolivia is different. CSWs registered at the 12 MOH specialty clinics (known as CDVIRs – Centros de Vigilancia y Referencia) have low rates of HIV seroprevalence in Bolivia (less than 1%). Data on sexually transmitted infections (STIs) in this population groups show declining levels of syphilis and gonorrhea. Concerns remain, however, that unregistered, clandestine sex workers who have not benefited from prevention and treatment services provided through the CDVIRs are likely to have higher STI prevalence rates and a correspondingly increased risk for HIV transmission.

C. The National STI/HIV/AIDS Program

The National AIDS Program is part of the Infectious Disease Prevention and Control Unit of the Ministry of Health. Five years ago, the National Program, with technical assistance from USAID (channeled through CDC), established four sentinel surveillance sites in the cities of Cochabamba, El Alto, La Paz, and Santa Cruz. Three additional sites were established in 2002-03 along the borders with Brazil and Argentina. At each site, the HIV prevalence rate for 2005 (and the preceding years since their establishment) was less than 1 percent.

The National Program has mobilized support from the international community, with a large proportion of its funding derived from external sources where USAID is a major donor (see III.A. below). The Government of Brazil is currently donating antiretroviral (ARV) drugs to treat HIV/AIDS, and people living with HIV/AIDS receive the drugs at no cost.

D. The Global Fund

The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) initiated activities in Bolivia in September, 2004, and has an approved budget of $6 million budget for the first

[2] Source: STI/HIV/AIDS National Program

two years of the HIV/AIDS component. The focus of the HIV/AIDS Component of the program is to: (a) supply ARVs for all eligible people living with HIV/AIDS (PLWHAs); (b) provide information, education and communication (IEC) for high risk groups and general population; (c) prevent mother-to-child transmission (MTCT); (d) and provide integrated support for persons living with HIV/AIDS (PLWHAs), including some medications for opportunistic infections. To date not all proposed and funded activities have been carried out and a reformulation for a second phase is being prepared for approval.

III. USAID SUPPORT IN STIs/ HIV/AIDS

A. History and Accomplishments

Since the inception of the National Program on HIV/AIDS, USAID has been a major donor. The principle vehicles for providing technical and financial support have included:

(1) The bilateral project with the Ministry of Health. Beginning in 1999, USAID and the MOH created the Integrated Health Project (PROSIN). In September, 2004, USAID and the MOH signed a new bilateral agreement, extending the project (as PROSIN II) through FY09. Through PROSIN, USAID and the MOH have worked together to establish nine departmental and three border town STI/HIV/AIDS clinics (CDVIRs) which provide diagnosis and treatment, promote behavior change for risk reduction, and conduct epidemiological surveillance. PROSIN II provides technical assistance and support for updating epidemiological information and clinical records (in consultation with the CDC), training for health providers in syndromic management of STIs, and purchasing essential equipment for the laboratory network (including a flow cytometer for the Bolivian National Reference Laboratory). The majority of the clients at these clinics are registered commercial sex workers.

(2) PASA with the CDC to strengthen epidemiological/sentinel surveillance. This PASA began in 1992 and ended in February 2006. CDC technical assistance will continue under an Inter-Agency Agreement for FY06, as described in this SOW

(3) USAID also supports local NGOs. Through the end of FY05, this support has been channeled especially through our Cooperative Agreement with PROCOSI, a consortium of 36 local nongovernmental organizations (NGOs). Three PROCOSI members (PROSALUD, CIES and SEXSALUD) received two-year sub-grants (November 2003 through September 2005) to develop programs to increase access to VCT services for high-risk groups and the general population in the cities of La Paz, Cochabamba and Santa Cruz, and to three border towns with Argentina and Brazil. USAID/Bolivia continues supporting local NGOs to enhance their VCT capacities under another Cooperative Agreement with the PROSALUD/Partners in Development Project.

(4) IMPACT project. This Global Health Project, implemented by Family Health International (FHI), provided technical assistance from April 2004 through September 2005. Their main activities were: (1) strengthening counseling services offered by CDVIRS and NGOs by producing a counselors' training manual and related materials, conducting training workshops for over 50 counselors, and establishing a master trainer program as a mechanism for providing ongoing support to the counselors already trained and (2) conducting an assessment of existing capacity to offer integrated VCT, and producing recommendations to strengthen VCT services through local NGOs and the public sector.

(5) The Bolivian NGO PROSALUD implements a comprehensive social marketing program, which includes condom social marketing. The program targets low-income urban populations, with a new component to reach rural communities.

(6) The Bolivian NGO Centro de Programas en Comunicación (CPC) provides technical assistance to local organizations (including the member NGOs of PROCOSI) in a variety of aspects of IEC materials development and communications strategies. CPC has worked closely with PROSIN II, the National Program and local NGOs on HIV/AIDS prevention activities. CPC also runs a confidential hotline on STIs and HIV/AIDS.

B. NEXT STEPS

During the current FY05-FY09 strategy period, USAID/Bolivia will strengthen its focus on priority high-risk populations. We will: (a) continue to work in prevention and quality of care, (b) continue to expand access to VCT activities, (b) strengthen epidemiological/sentinel surveillance, (c) continue to support the CDVIR clinics, (d) continue to support IEC and the confidential telephone hot line.

IV. SCOPE OF WORK

The primary objective of USAID/Bolivia's program is to contribute to the prevention of new infections by reaching high-risk groups with prevention programs as the most cost-effective way of slowing the spread of HIV/AIDS in the country. USAID's program is in line with the activities of the MoH, the Global Fund, and other donors.
Since 1992 CDC has provided technical consultation to the national STI/AIDS Control Program in the areas of clinical services, epidemiology, laboratory services, behavioral interventions, and information systems.

This scope of work and activity description focuses on the following objectives and results for one-year implementation period:

Objective 1. HIV Sentinel Surveillance among MSM

To initiate surveillance for HIV and high risk behaviors among MSM, and other most at risk population groups through formative research.

Plan/Activities

HIV prevalence among most at risk groups
As part of second generation HIV surveillance, HIV prevalence should be assessed among groups at risk that are not evaluated through routine HIV sentinel surveillance. Reports from epidemiologists and other health workers suggest that HIV risk and prevalence is higher among MSM and street children.

- Develop a survey among MSM, using new techniques for participant recruitment such as respondent driven sampling, and assess HIV prevalence with biological specimens.
- Technical assistance to Partners in Health Project for protocol development, data collection and data analysis. A surveillance consultant will be identified through the CDC Central American office for this purpose.
- Partners in Health Project will be in charge of developing operational research among most at risk populations in Bolivia.

Objective 2. STI sentinel and behavioral surveillance and HIV surveillance through VCT sites

To continue to strengthen the STD sentinel surveillance system including behavioral surveillance.

Plan/Activities
The sentinel STI/HIV surveillance system that has been developed with USAID and CDC support remains the best ongoing source of data on STI/HIV for any population in Bolivia. This system provides clinic based prevalence data on syphilis, gonorrhea, trichomoniasis,genital ulcer and HIV among women attending these clinics in Bolivia. This system also provides data on antimicrobial resistance in *Neisseria gonorrhoeae*. Data that exist on prevalence of STI and condom use suggest that the program is continuing to have substantial impact on preventing disease.

- Technical assistance to strengthen the STI/HIV sentinel surveillance system, the plan is to continue supporting the TA to the epidemiology and to the information technology process.
- A CDC epidemiologist will assist the Bolivia program on interpretation and data analysis.

- An IT consultant will identify any problems with variable coding that might have changed during the 12 years of the project, and further reporting requirements that might not be addressed by the current software.
- Recently, Partners in Health Project is operating several VCT sites around the country. CDC will provide support to analyze HIV positivity and epidemiological data collected through these sites.

Objective 3. Strengthening CDVIR and VCT laboratories

To assess laboratory needs on bio-safety, equipment and reagents in order to strengthen the laboratory role on surveillance and patient management.

To assist the CDVIR and VCT laboratories to strengthen quality control.

Plan/Activities

- A consultant will conduct an evaluation of CDVIR and VCT laboratories and assess the needs in equipment and reagents.
- The consultant will make recommendations to establish a system for internal and external quality control.

V. ACTIVITIES AND DELIVERABLES

The following deliverables will be measured to respond to the three objectives.

(1) Assistance in formative research to develop a protocol to evaluate HIV risk and HIV prevalence among MSM

(2) Assistance to conduct data collection for the HIV survey among MSM

(3) Visit of a CDC technical team to provide technical assistance for the STD sentinel and behavioral surveillance among sex workers and provide recommendations to strengthen the program

(4) Conduct an assessment of laboratory needs, and support the continuation of quality control

VI BUDGET

CDC/GAP Support to Bolivia				Program Period 9/30/05-9/29/06 12 months	
		Rate	Unit	Units	Amount
1. CONSULTANTS					
Surveillance Consultant	TBD	$4,000	month	1	$4,000
Laboratory Consultant	TBD	$4,000	month	1	$4,000
IT consultant	CDC	$0	month		$0
TOTAL CONSULTANTS					**$8,000**
3. TRAVEL AND TRANSPORTATION					
International Airfare (US - Bolivia)		$1,800	rt	3	$5,400
Per Diem		$140	day	60	$8,400
Airport Transfers, Visas		$100	trip	3	$300
Ground Transportation		$10	day	60	$600
International Airfare (Guatemala-Bolivia)		$1,500	rt	2	$3,000
Per Diem		$170	day	44	$7,480
Airport Transfers, Visas		$100	trip	2	$200
Ground Transportation		$10	day	44	$440
TOTAL TRAVEL AND TRANSPORTATION					**$25,820**
4. OFFICE COSTS AND OTHER					
Communications (Phone, Fax, Internet)		$50	month	12	$600
Laboratory and medical supplies					$4,280
TOTAL OTHER					**$4,880**
5. ADMINISTRATIVE FEE					
Universidad del Valle de Guatemala			year	10%	4300
CDC Atlanta			year	14%	$7,000
					$11,300
TOTAL BUDGET					**$50,000**

Country/Region: Brazil
Title Describing the Activity: Expansion of the Tuberculosis Directly Observed Therapy Short-Course (Dots) Strategy in Rio De Janeiro and Sao Paulo, Brazil
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells
Bureau or Mission contact following the activity: Patricia Paine, USAID/Brazil
Amount, type and year of funds to be obligated: $30,000
Time Frame if appropriate:

EXPANSION OF THE TUBERCULOSIS DIRECTLY OBSERVED THERAPY SHORT-COURSE (DOTS) STRATEGY IN RIO DE JANEIRO, BRAZIL

Introduction

In Brazil, tuberculosis remains an important public health problem. It is estimated that more than 50 million people in the country are infected with *Mycobacterium tuberculosis*. Brazil is one of 22 countries responsible for 80% of all TB cases worldwide; further, Brazil is one of the two countries responsible for 50% of all TB cases reported in Latin America. According to WHO, the estimated number of annual cases of TB in Brazil is between 100,000 and 130,000; the number officially notified from Brazil is between 90,000-95,000 cases. Furthermore, the rate of TB-HIV coinfection is growing in Brazil, suggesting that management of TB in Brazil is an urgent need.

In the state of Rio de Janeiro, with 15 million inhabitants, there are approximately 16,000 cases of TB notified per year (incidence rate: 87.5/100,000, twice the national rate), representing 20% of the notified cases in Brazil. Approximately 20% of the cases need to be hospitalized and about 900 TB patients die each year. With respect to treatment outcomes, the state of Rio de Janeiro reported a treatment default rate of 15.4% in 2003. Almost 20% of TB cases in Rio state are diagnosed in hospitals/ emergency rooms. In 2005, the state TB program in Rio de Janeiro implemented a TB suspect registry, with the objeective to monitor the progress in case detection.

In 2004, tuberculosis was declared a national priority for the period 2004-2007, and the NTP priortized the implementation and expansion of the DOTS strategy to 315 municipalities in the country where 70% of the TB cases occur; of these 32 are in the state of Rio de Janeiro. These 32 municipalities comprise 95% of the TB cases in the metropolitan region and 85% of the notified cases from the state. Currently in Rio de Janeiro, the DOTS strategy covers about 22.8% of the population. The network of health centers in Rio de Janeiro is composed of 4409 ambulatory centers, 24% of which are in the metropolitan region, and 392 hospitals, 58% of which are in the metropolitan region. All of these municipalities have a TB program; however, the the exact TB control actions in each municipality have not been evaluated. The Family Health program (PSF) covers

24% of the state; however in metropolitan region 1, where 76% of the TB cases are concentrated, only 8% of the population is covered by the PSF. The laboratory network is made up of 496 public and private laboratories; of these 186 (104 public and 82 private) perform smear microscopy.

The implementation and expansion of the DOTS strategy, with emphasis on treatment observation, is a critical need for Rio de Janeiro to improve TB control in the state.

The Ministry of Health in Brazil, and the health authorities in Rio de Janeiro in particular, require technical assistance to diagnose, treat, control, and monitor tuberculosis through a plan of DOTS expansion, and to develop and implement activities related to TB/HIV co-infection. New activities will build upon and enhance current DOTS expansion and TB/HIV activities.

Aim

The aim of the USAID support detailed in this proposal is to improve the National Tuberculosis Program (NTP) management and laboratory capacity in the state of Rio de Janeiro, in 12 priority municipalities in the metropolitan region, in order to help the state-level NTP reach the WHO targets of 70% case detection and 85% treatment success among new smear-positive TB cases.

Objectives

1. Improve TB control by implementing and expanding the implementation of the 5 components of the global TB control strategy DOTS in 6 priority municipalities in the metropolitan region of Rio de Janeiro (Nova Iguacu, Duque de Caixas, Sao Joao do Meriti, Belfort Roxo, Itaborai, Sao Goncalo, Itaguai, Japeri, Mege, Mesquita, Nilopolis, Queimados). The five components of DOTS include: 1) political commitment to TB control; 2) passive diagnosis of TB using sputum smear microscopy or sputum cultures; 3) standardized short-course treatment with direct observation for at least the first two months; 4) stable supply of good quality anti-TB medications for the full course of treatment; and 5) a standardized recording and reporting system;
2. Improve case detection in emergency rooms and in congregate settings;
3. Increase the treatment success rate and reduce the treatment default rate;
4. Improve the knowledge, awareness, and management of TB among TB control staff and patients by conducting trainings and developing educational materials for both patients and staff.

Activities

The table below provides a summary of planned activities, indicators, outputs, and time frame for the project.

Major activities	Specific activities	Indicators	Output	Time
Stregnthen State TB Program in Rio de Janiero	Sensitize TB managers and health care professionals of the necessity of the DOTS strategy in general and direct observation of therapy in particular; monthly meetings with the municipality coordinators	Number of meetings held; number of program managers and health care professionals trained; materials made and distributed	Increased awareness and acceptance of the importance of the DOTS strategy; increased commitment to the implementation of the DOTS strategy; increased quality of the information gathered and disseminated with respect to TB	6-12 months
Strengthen State TB Program in Rio de Janeiro	Train the NTP teams (including separate trainings for team members [doctors, nurses, laboratory technicians, community workers, and health center teams] and supervisors) in each municipality in the 5 elements of the DOTS strategy	Number of individuals and teams trained in each municipality; materials made and distributed; types of training designed and implemented	Increased awareness and acceptance of the importance of the DOTS strategy; increased commitment t the implementation of the DOTS strategy	6-12 months
Strengthen State TB Program in Rio de Janeiro	Produce educational materials for the general population and for health care workers (including material to be used/consulted for active case finding); hire a consultant who is an expert in education and communication strategies	Number and type of materials made and distributed; types of training designed and implemented by consultant; rates of case detection over time	Increased awareness and acceptance of the importance of the DOTS strategy; increased commitment to the implementation of the DOTS strategy; increased case detection	6-12 months

Strengthen State TB Program in Rio de Janeiro	Support strategies/ create education materials for active case finding-in hospitals, jails, shelters, etc	Number of TB suspects found through active case detection; number of TB cases/number of TB suspects examined; number of sites conducting active case finding	Increased TB case detection	6-12 months
Strengthen State TB Program in Rio de Janeiro	Facilitate opportunities for municipality TB program teams to contribute to and participate in national and international scientific conferences	Number of teams/ individuals presenting data from the municipality TB programs at national and international scientific meetings	Increased investment by health professionals in the success of the Expansion of the DOTS strategy in the state	6-12 months

Strengthen State TB Program in Rio de Janiero	Support and facilitate monitoring and evaluation activities at the municipal TB program level, including active case finding; contract supervisors; augment availability of transport for patient outreach and assistance with needs for/from the laboratory; improve the quality of the information	Number of supervisors performing monitoring and evaluation activities; number of supervisions conducted; evaluation of treatment outcomes/trends in treatment outcomes; evaluation of impact of active case finding (number of TB cases found/number of TB suspects evaluated); number of patients visited at their homes; number of labs which can send materials more easily due to the transport; time for follow-up of bacteriological results; patient default rate	Strengthening of each municipality DOTS program; increased knowledge and capacity among program managers in implementing the DOTS strategy; reduced default rate; decreased turn-around time in the laboratories; improved quality of information	6-12 months
Strengthen State TB Program in Rio de Janeiro	Create a social mobilization effort; conduct an annual social mobilization workshop; design and implement activities for World TB Day	Number of NGO's involved in TB control; number of workshops planned and given; number of NGOs participating in the workshops	Increased visibility of the DOTS strategy and increased involvement of civil society institutions; Increased coverage of DOTS, Improved TB treatment outcomes for patients being treated under the DOTS strategy	6-12 months

Strengthen State TB Program in Rio de Janiero	Create a semestral epidemiological bulletin to disseminate information on USAID-sponsored DOTS expansion activities to all 92 municipalities in Rio de Janeiro	Number of materials created and disseminated; distribution of trimester bulletin	Increased knowledge about TB and DOTS expansion activities in both patients and providers	6-12 months

EXPANSION OF THE TUBERCULOSIS DIRECTLY OBSERVED THERAPY SHORT-COURSE (DOTS) STRATEGY IN SAO PAULO, BRAZIL

Introduction

In Brazil, tuberculosis remains an important public health problem. It is estimated that more than 50 million people in the country are infected with *Mycobacterium tuberculosis*. Brazil is one of 22 countries responsible for 80% of all TB cases worldwide; further, Brazil is one of the two countries responsible for 50% of all TB cases reported in Latin America. According to WHO, the estimated number of annual cases of TB in Brazil is between 100,000 and 130,000; the number officially notified from Brazil is between 90,000-95,000 cases. Furthermore, the rate of TB-HIV coinfection is growing in Brazil, suggesting that management of TB in Brazil is an urgent need.

In the state of Sao Paulo, with 41 million inhabitants, there are an estimated 21,000 cases of TB per year, or approximately 45 cases/100,000 per year. The distribution of TB in the state is not homogeneous; indeed, some areas have a TB incidence as high as 100/100,000. In 2004, 15% of the 68% of TB cases which were tested were co-infected with HIV. Similar to the distribution of TB, coinfected cases are also not homogeneously distributed throughout the state. With respect to treatment outcomes, 74% of TB cases were cured in 2004, with a treatment default rate of 9%. The implementation of the DOTS strategy, with emphasis on treatment observation, is a critical need for Sao Paulo to improve these treatment outcomes and reduce the default rate. The health authorities in Sao Paulo have priortized 73 municipalities for the expansion of the DOTS strategy. These municipalities comprise 80% of the state's TB cases.

The Ministry of Health in Brazil, and the health authorities in Sao Paulo in particular, require technical assistance to diagnose, treat, control, and monitor tuberculosis through a plan of DOTS expansion, and to develop and implement activities related to TB/HIV co-infection. New activities will build upon and enhance current DOTS expansion and TB/HIV activities.

Aim

The aim of the USAID support detailed in this proposal is to improve the National Tuberculosis Program (NTP) management and laboratory capacity in the state of Sao Paulo in order to help the central-level NTP reach the WHO targets of 70% case detection and 85% treatment success among new smear-positive TB cases.

Objectives

1. Improve TB control by continuing to implement the 5 components of the global TB control strategy DOTS in the 73 priority municipalities in Sao Paulo, with particular focus on Guarulhos and Carapicuiba. The five

components of DOTS include: 1) political commitment to TB control; 2) passive diagnosis of TB using sputum smear microscopy or sputum cultures; 3) standardized short-course treatment with direct observation for at least the first two months; 4) stable supply of good quality anti-TB medications for the full course of treatment; and 5) a standardized recording and reporting system.

2. Improve the knowledge, awareness, and management of TB among TB control staff and patients by conducting trainings and developing educational materials for both patients and staff.

Activities

The table below provides a summary of planned activities, indicators, outputs, and time frame for the project.

Major activities	Specific activities	Indicators	Output	Time
Strengthen State TB Program in Sao Paulo	Strengthen the new EPI-INFO-based information system, "TB WEB"; implementation, training, and supervision of system in 9 hospitals/outpt settings: Hospital das Clinicas, Santa Casa, Hospital Emelio Ribas, Complexo Hospitalar do Mandaqui, Instituto Clemente Ferreira, Centro de Referencia em DST/AIDS, and 3 sanatorios em Campos do Jordao; conduct supervision of the information system in 20 other sites with a high burden of TB	Number of people trained and using this system; Number of sites using this system; number of supervisions conducted at these sites	Increased use and more accurate use of the information system	6-12 months
Strengthen State TB Program in Sao Paulo	Monitor and evaluate followup and outcomes of TB patients after hospital discharges	Number of patient discharges monitored/ total number of discharges; number of patients who continued treatment in ambulatory care/ all discharges who needed to have ambulatory care	Increased capacity to track outpatient patient care; increased knowledge of outpatient treatment sites which need technical assistance to improve TB outpatient care	6-12 months
Strengthen State TB Program in Sao Paulo	Monitor drug susceptibility testing results; conduct drug resistance surveillance	Percentage of cases with anti-TB drug resistance/ total number of TB cases assessed; percentage of resistant TB cases receiving appropriate TB treatment (including with DOT); percentage of each type of resistance pattern	Increased knowledge about drug resistance and provision of data for design of appropriate treatment regimens	6-12 months

Strengthen State TB Program in Sao Paulo	Facilitate a management course for 35 TB program managers each year; conduct an operations research course for 35 priority municipality leaders	Number of persons trained in both courses	Increased capacity of TB program managers to effectively implement the 5 components of DOTS in the priority municipalities, and to conduct operations research	6-12 months
Strengthen State TB Program in Sao Paulo	Strengthen DOTS in Sao Paulo- train 3000 HCW in the DOTS strategy; Create a social mobilization effort; create a "Sao Paulo Social Network of TB Control" and involve at least 50% of the civil society organizations; implement the respiratory symptoms registry ("TB suspect registry") in all primary health care facilities; perform active case finding in 6 hospitals/emergency rooms and 3 prisons in Guarulhos and 1 hospital/ER and 1 prison in Carapicuiba	Increase the visibility of the DOTS strategy and increasingly involve civil society institutions; Percentage of HCW trained in DOTS—including increasing suspicion of TB and management of TB information; Percentage of patients on DOT/ total number of cases; percentage of patients with smears done at the end/ total patients; number of activities which involve active case finding in primary health care facilities (screen 1% of the population); number of suspected TB cases examined and TB cases found (including contacts); recording and reporting of these TB suspects using the TB suspect registry; number and type of venues where active case finding successfully performed (eg jails, hospitals,	Increased coverage of DOTS, Improved TB treatment outcomes for patients being treated under the DOTS strategy	6-12 months

		emergency rooms) besides primary health care facilities/total able to perform active case finding; number and type of patient incentives planned/distributed; frequency and length of delays between diagnosis and treatment initiation; evaluate deaths from TB-reporting and accuracy of data-reported vs notified		
Strengthen State TB Program in Sao Paulo	Expand activities to offer directly oberved treatment, including home visits	Number of patients receiving directly oberved treatment; number of patients successfully treated by address of residence and address of treatment center	Increased number of patients receiving directly observed treatment	6-12 months
Strengthen State TB Program in Sao Paulo	Expand distribution of incentives to assist patients in completing treatment	Number of patients receiving incentives, number of patients successfully completing treatment stratified by receipt of incentives, evaluation of the use and impact of incentives	Increased number of individuals successfully completing treatment; evaluation of the impact of incentives	6-12 months
Strengthen State TB Program in Sao Paulo	Create and disseminate TB educational materials-for general public, persons at high risk for TB, and health professionals-particularly in municipalities with new leaders who need to know the importance of the DOTS strategy; create a trimester bulletin to disseminate information on USAID-sponsored DOTS expansion activities	Number of materials created and disseminated; distribution of trimester bulletin	Increased knowledge about TB and DOTS expansion activities in both patients and providers	6-12 months
Strengthen laboratory	Perform quality control (QC) laboratory activities; perform	Number of QC activities performed; Number of	Improved microbiology	6-12 months

activities/ laboratory-related activities in Sao Paulo	sputum cultures to diagnosis TB/detect smear-negative TB; Perform DST on all cultures; Install smear capacity in the emergency rooms, with ability to detect AFB+ in 4 hours	smears/cultures being done with good quality/total number of smears and cultures; Number of cultures done/ total number of suspected TB cases; Percent concordance between smears at peripheral lab and QC lab; Number and results of DSTs done; frequency and duration of delays of smear and culture result availability and reporting from all sites (including emergency rooms); evaluation of time between smear and culture results and treatment initiation.	activities for TB; improved diagnostic capacity for TB	
Strengthen State TB Program in Sao Paulo	Identify and examine all TB contacts according to the NTP norms	Number and results of all contacts identified; proportion of contacts examined/total number of possible contacts	Improved case detection through identification of contacts	6-12 months
Implement infection control activities in Sao Paulo	Implement the three internationally accepted categories of infection control to prevent TB: 1) administrative controls; 2) environmental controls (such as UV lights, HEPA filters); and 3) personal respiratory protection programs (suchas use of N95 masks)	Description and number of infection control actions implemented (such as writing an infection control plan, triaging patients with cough to be evaluated first, number of HCW using being fit-tested and using masks, etc); number of sites implementing complete/incomplete infection control activities	Improved infection control and therefore less TB transmission in congregate settings	6-12 months

Country/Region: Honduras
Title Describing the Activity: Technical Assistance to strengthen second generation epidemiologic surveillance and monitoring and evaluation for the National HIV/AIDS Program in Honduras
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/GAP/CAP, Edgar Monterroso
Bureau or Mission contact following the activity: Kellie Stewart, USAID/Honduras
Amount, type and year of funds to be obligated: $800,000
Time Frame:

Description

CDC will continue implementation of mechanisms for ongoing collection, analysis, and diffusion of quality information about HIV/AIDS prevalence in Honduras. The work plan for FY06 has been conceptualized as the second phase of a long term plan to design effective and automated surveillance and monitoring & evaluation systems for the National HIV/AIDS program.

In FY06, CDC will implement three specific activities:

1. Provide TA to the Ministry of Health's HIV/AIDS Department in establishing a national second generation epidemiologic surveillance system
2. Provide TA to the Ministry of Health's HIV/AIDS Department in establishing a national monitoring and evaluation system for the HIV/AIDS program
3. Complete implementation of a Behavior Surveillance Survey with biomarkers within most-at-risk populations.
4. Complete implementation of STI Sentinel Surveillance focused on Commercial Sex Workers in highest risk geographical areas.

Specific objectives include:

1. Provide information about the prevalence of HIV and STIs as well as information about behavioral tendencies of vulnerable and high risk groups in Honduras.
2. Redesign an epidemiologic surveillance system for the network of epidemiologists, laboratories, blood banks, and centers of integrated attention that operate in the national health system. This will contribute to the effective integration of epidemiologic information in the detection, diagnosis, follow-up and treatment of HIV/AIDS cases.
3. Elaborate and implement activities for monitoring and evaluation that will facilitate the development a National HIV/AIDS/STI Monitoring and Evaluation Program, including development of national level indicators.

4. Develop strategies for analysis and diffusion of epidemiologic and M&E information to be directed at decision makers, service providers, and civil society at all levels to gain a better comprehension of the characteristics of the epidemic and to achieve an organized national response.

Country/Region: Honduras
Title Describing the Activity: Monitoring and Evaluation Strategy for the Reduction of Maternal and Child Mortality in Sub-Sectors of Honduras
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/GAP/CAP, Nivaldo Linares
Bureau or Mission contact following the activity: Emma Iriarte, USAID/Honduras
Amount, type and year of funds to be obligated: $373,000
Time Frame: 1.5 years

Monitoring and Evaluation Strategy for the Reduction of Maternal and Child Mortality in Sub-Sectors of Honduras

Project Description

Studies conducted during the last few years have demonstrated that the maternal and child mortality indicators show a decrease. From more than 182 x 100,000 live births in 1990, to 108 x 100,00 live births in the year 997 for maternal mortality; and from 80 x 1000 live births, to 34 x 1000 for children during the same years. The decrease however, is too slow and it shows significant differences between departments, thus, the national levels are considered insufficient.

The institutional response that took place between 2002 and 2003 through an "Initiative for Reduction of Maternal Mortality and Mortality of Children under 5 Years of Age with Emphasis on Child Mortality" defined the problem. Maternal mortality is directly associated with reproductive risk, including complications and poor health care during pregnancy, childbirth and post-partum. Child mortality includes poor health determined by premature births, congenital abnormalities, respiratory and diarrheal infections, as well as intervention levels at: home, community and institutions integrating the network of health care services for the sectors.

Based on this analysis, during 2004 the Honduran Health Secretariat redefined its focus and conducted an intervention project on maternal and child mortality with a new strategy entitled "Reduction of Maternal Mortality and Child Mortality of Children under Five Years of Age Strategy for Sub-Sectors". The strategy recognizes the decentralization of health care services taking place at a sectoral framework and identifies the effort as a priority to decrease maternal and child morbidity and mortality in selected departments: Copan, Lempira, Intibuca and La Paz. These departments that are affected with extreme poverty, lack access to health care services due to economical factors and geographic location.

Project Objectives

1. Design and implement a strategy to monitor and evaluate (M&E) a reduction of maternal and child mortality (ESRMN) at a sub-sectoral level in 4 selected departments of Honduras.

2. Develop and implement an M&E Unit for Health in 4 selected departments of Honduras for the development of the M&E strategy of ESRMN.

3. Provide training for health personnel at the 4 selected departments in Honduras on M&E methodologies, programs and intervention initiatives related to health.

4. Provide a methodological framework for the Honduran Health Secretariat on M&E general public health programs to be applied to other health programs in the country.

Project Activities

Product 1. Redesign M&E for ESRMN

Activities:

1. Conduct a comprehensive analysis of context and conceptual framework to guide the operational activities of ESRMN toward the advancement of the design of the M&E strategy.

2. Reconstruct a framework plan of the objectives (goals, objectives and expected outcomes) for ESRMN based on institutional initiatives of SSH and the technical cooperation of USAID, BD and BM in Honduras.

3. Provide better understanding by outlining each one of the intervention strategies to be incorporated into ESRMN and the planning of activities to be developed in the 4 selected departments between 2005 and 2006 (Matrix of activities).

4. Redesign the ESRMN's document and incorporate a definite plan for goals, objectives and expected results and strategies of the activities proposed in the intervention to provide orientation in the design and development of the M&E process.

Product 2. M&E Protocol for ESRMN in Honduras

Activities:

1. Methodological design of the M&E strategy for ESRMN: Development of the protocol

2. Validation of the M&E methodology (protocol) at the department (includes implementation of the methodology and adjustments of the indicators model, instruments, processing of information tools and procedures for logistics.

3. Development of a tool for informatics that will allow an automated management and integration of all useful M&E information for analysis at departmental levels

4. Implementation of the M&E strategy for ESRMN in the 4 selected departments.

Product 3. Develop M&E Units in the 4 Selected Departments.

Activities:

1. Contract a resident consultant in Honduras, specialized in M&E to coordinate the project locally under the technical supervision of the Regional Office of CDC-CAP

2. Contract 4 workers for the M&E Units established on each of the selected departments.

3. Develop an organizational and operational model for the M&E Units on health at departmental levels.

4. Institutionalization of the M&E Units on Health at departmental levels with the application of the M&E strategy for ESRMN in its departments.

Product 4. Training of health personnel on M&E

Activities:

1. Conduct 2 training workshops on M&E concepts and methodologies for a public health program addressed to facilitators and personnel of the M&E Units on Health for the 4 selected departments and at a central level.

2. Conduct at least 4 workshops (1 for each department) for training on M&E concepts and methodologies (a duplicate of the national workshop) addressed to health personnel in the 4 selected departments.

3. Edit and print training material on concepts and methodologies of M&E for public health programs to be delivered to UPEG inside a folder so that the material may serve as learning material for replication of courses in the rest of the county.

4. Define, acquire, and deliver to the 4 M&E Units of Health in the selected Departments, a bibliographic kit on M&E topics and on health activities for use as reference working material for each Unit.

5. Develop an integrate analytical workshop on the results obtained after the application of the M&E strategy for ESRMN, focused on decision-making and with the participation of health officials at departmental levels (4 departments) and at a national level (UPEG and other General Offices).

Product 5. Folder containing the general methodological framework of M&E

Activities:

1. Integration and presentation of the lessons learned in the application of the M&E strategy for ESRMN in the 4 departments.

2. Comprehensive integration of a conceptual and methodological model on M&E public health programs.

3. Operational planning of an integration model containing objectives, users, questions, methodologies, indicators, sources and instruments used for the collection of information and an M&E plan applicable to public health problems.

4. Develop operational manuals detailing procedures for the development of strategies on monitoring and the conduction of evaluation studies for the public health program.

5. Provision of a training module on "Concepts and methodologies for M&E of public health programs" as an integral component of the M&E strategy for public health programs.

6. Provide a manual on organization and functioning of the M&E Units at the departmental level.

Budget

Personnel	$174,920.00
Travel and Per Diem	$50,371.00
Equipment	$17,400.00
Supplies	$5,000.00
Other	$10,200.00
Administrative expenses	$115,109.00
TOTAL	**$373,000.00**

Country/Region: Honduras
Title Describing the Activity: Strengthening Public Health Surveillance Capacities in Honduras
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/GAP/CAP, Nivaldo Linares
Bureau or Mission contact following the activity: Emma Iriarte, USAID/Honduras
Amount, type and year of funds to be obligated: $466,000
Time Frame: 4 years

Strengthening Public Health Surveillance Capacities in Honduras

Project Description

Epidemiological surveillance constitutes the central element for health care delivery. In essence, it provides basic information for the design and application of intervention measures that will be vital for health preservation and protection. Under this conception, health surveillance serves as the frame for control activities providing supportive elements for decision-making within the objectives established by the National Health Surveillance Strategic Plan 2004-2009 developed by the General Office of Health Surveillance (DGVS) of the Honduras Health Secretariat (SSH).

This project will develop a group of activities intended to support and implement the National Strategy for Health Surveillance in Honduras. It will provide assistance on the technical-normative and strategic-operative fields intended to articulate and integrate the process of surveillance within different internal and external actors in the health sector. Between the years 2005 and 2009, it will also strengthen the response capacity proposed by the National Health Surveillance Network for the country.

Objectives of this project

1. Prepare, update and implement norms for health surveillance that regulate the conceptual and methodological aspects and processes concerning Health Surveillance in Honduras.

2. Strengthen the operations of the Surveillance Analysis Units (UDA) at all levels, central, departmental, hospital and health services network as well as the Health Surveillance Information Services in the country.

3. Create and strengthen a Health Surveillance Network (RVS) through the Departments and Surveillance Laboratories for an effective articulation and integration of all the participants in health surveillance.

4. Amplify and institutionalize the field epidemiological training program at different levels of complexity, particularly oriented to the development of activities promoting decision-making in all the health related levels.

5. Develop and implement new surveillance sub-systems with emphasis on: A) epidemiology; B) water quality control for human consumption, C) entomology; D) maternal mortality and mortality if children under five years of age; E) birth defects, and, F) lesions caused by external causes.

Expected Result and activities bay second year of project

Expected Result 1. Management of health surveillance

Activities

1. Coordination and development of a work plan for the National Health Surveillance
    - First year project results presentation to new government health authorities.
    - Coordination meetings with local health authorities from the 4 participating departments in order to prepare the implementation of the second year project activities
    - Strengthening transportation infrastructure to support Project field work in the 4 participating departments.

2. Develop a national health surveillance norm for application of health care providers within the national health system including the public and private health care sector in the country.
    - Final draft writing of the National Health Surveillance Guidelines.

3. Develop and review surveillance protocols for the following systems:
    - maternal mortality and mortality of children under five years of age
    - birth defects
    - lesions caused by external causes
    - Entomological surveillance
    - Quality of the water of human consumption

4. Develop a work strategy for interrelationships between the General Office of Health Surveillance, Regional Surveillance Departments, Laboratory Surveillance Network, National Programs for Disease Prevention and Control and other public or private institutions within the health system.
    - Technical meetings among Surveillance General Directorate, Health Promotion General Directorate (Prevention and Control Programs) and Strategic Planning from the Honduran Health Secretariat.

- Update training workshop on Epidemiology with emphasis in surveillance and Health Services Management, for intermediate and central level of the Honduran Health Secretariat.

Expected Result 2. Information Sub-System for Surveillance and Units of Analysis

1. Organization, structuring and equipping the Surveillance Department (DGVS, central level) and the Regional Surveillance Departments.
   - Computer equipment purchase to improve information infrastructure of the Health Surveillance General Directorate and 4 participating departments in the project.

2. Conceptual and operative re-planning of the surveillance information sub-system according to new norms for national health surveillance.

3. Automation (unique platform) for surveillance information management by the UDA at the central, departmental, and health services networks.

4. Publish daily epidemiological information through the Health Surveillance Bulletin (alert-response system) and on a weekly basis (notification of cases and surveillance analysis) through printed and electronic means.

5. Strengthen the reorganization of the national laboratories network including the functions of the Central Laboratory.

6. Design and operate a Unique System of Laboratory Information for both clinical and public health components.
   - Software development for the Surveillance Information System at the Central Laboratory.

Expected Result 3. Field epidemiology training program

1. Design a Field Epidemiology Training National Program for human resources.
   - Honduras Field Epidemiology Training Program presentation and approval.
   - Setting up FETP Unit at the Health Surveillance General Directorate
   - Training and building-up mentors team for the Honduras FETP

2. Design and implement the Field Epidemiology Training Program at three levels: basic, intermediate and advanced, under the Office of General Surveillance.
   - Workshop on planning epidemiology basic course for health workers at the hospital and local levels
   - Train of trainer workshop on methods for teaching Basic Epidemiology for trainers from the 4 participating departments

- Basic Epidemiology Courses in 4 participating departments (FETP basic level)

3. Develop a specialization program on Advanced Epidemiology (EEA), at a diploma granting level, through a cooperative agreement with the Health Secretariat and the National University.
   - Writing, presentation and signature of the accreditation agreement by the selected university
   - Academic and operational Program elaboration for the first Diploma Program on Applied Epidemiology Specialization
   - Development of the first Diploma Program on Applied Epidemiology Specialization (FETP Intermediate level)

4. Design and develop a Program on Specialized Continuous Epidemiological Education with the objective of establishing permanent reinforcement of dexterities for epidemiologists at all health levels.
   - Workshop on Surveillance Information System operation
   - Basic Hospital Epidemiology Course for the Epidemiology Departments personnel in the hospital network in Honduras.

Expected Result 5 Development of specific component of surveillance systems

A. Alert-response sub-system for epidemiological emergencies

1. Develop a surveillance protocol for the timely detection and response at occurrences of outbreaks and other important epidemiological situations.
   - Setting-up Epidemic Intelligence Department (Warning-Response) in the Health Surveillance General Directorate of the Honduras Health Secretariat
   - Validate warning-response component protocol in the 4 participating departments of the project.

2. Preliminary Workshop for the implementation of Warning-Response protocols for personnel in charge of surveillance in the 4 participating departments of the project

3. Warning-Response protocol implementation in the 4 designated departments

4. Strengthen the initiative of DGVS in the organization and functioning of teams during disease outbreaks at all different levels, under the leadership of one epidemiologist.
5. Acquisition of the minimum equipment needed by the central and departmental teams for response to outbreaks and other epidemiological emergencies.

B. *Surveillance on maternal mortality and mortality of children under five years of age*

1. Validation of the Surveillance Protocol of the maternal mortality and children under 5 years old in the 4 participating departments of the project

2. Preliminary Workshop for the implementation of the Surveillance Protocol of the maternal mortality and children under 5 years old, with the personnel in charge of surveillance and maternal and infant Program in the 4 participating departments of the project

3. Implementation of the Surveillance Protocol of the maternal mortality and children under 5 years old in the 4 participating departments of the project

C. *Surveillance sub-system for environmental risks (water and entomology)*

1. Re-planning of the strengthening strategy for surveillance units on environmental risks (water quality and entomology) at DGVS and at the surveillance units of for sanitary and environmental risks located in the departments.

2. Implementation of the entomological surveillance and the quality of the water for human consumption protocols in the 4 participating departments of the project.

D. *Birth defects surveillance sub-system*

1. On the part of the Ministry of Health, implement a sentinel epidemiological surveillance system for neural tube defects in the main hospital centers under the Ministry of Health and the IHSS from 2005-2006.

2. Expand the epidemiological sentinel surveillance system on Defects and Birth Problems (DTN) to s sentinel system on congenital malformations in all public hospitals of the Ministry of Health and the Honduras Social Security Institute (IHSS) in the 4 participating departments of the project.

Budget

Personnel	$130,620.00
Travel and Per Diem	$24,666.00
Equipment	$30,800.00
Supplies	$10,600.00
Other	$100,366.00
Administrative expenses	$168,948.00
TOTAL	**$466,000.00**

Country/Region: Guatemala
Title Describing the Activity: Maternal and Child Health National Survey 2007
Center/Division and Project Officer at CDC the activity was negotiated with:
CDC/MERTU – Robert Klein
Bureau or Mission contact following the activity: Baudilio López, USAID/Guatemala
Amount, type and year of funds to be obligated: $430,000
Time Frame: September 2006-December 2008

Scope of Work

MATERNAL AND CHILD HEALTH NATIONAL SURVEY 2007 (ENSMI 2007)

I. Background

The Maternal and Child Health National Survey 2007 (ENSMI 2007) will follow-up previous ENSMI´s conducted in 1987, 1995, 1998/99 and 2002. Conducting these national surveys using the same methodology for data collection, processing, and analysis makes the ENSMI-series the most relevant statistical tool in the health sector, and it has become an exceptional source of comparison on the most important health, nutrition and demographic indicators. ENSMI provides relevant information of the most pressing issues affecting the health of women and children at a national level, as well as by regions and by ethnic groups. It also provides information on relevant indicators related with women and men in reproductive age, and, for the first time, this information will be representative at a departmental level.

The Maternal and Child Health National Survey 2007 will provide updated information to analyze changes, tendencies, determinants and consequences of maternal and child health, levels of mortality (neonatal, post-neonatal, infancy, post-infancy and childhood), fecundity and reproductive patterns.

It is important to underline that this new version of ENSMI, will provide a wider overview of maternal and child health with respect to important issues such as:

- Patients' search of healthcare services
- Healthcare received
- Food intake (purchased and consumption)

- Intra-family violence

- Anemia and anthropometry for children under five years of age and pregnant women.

The results described in this scope of work (SOW) are those related with the work to be undertaken by CDC/CESCAP under the inter-agency agreement (USAID-CDC). The government estimate projected details the local costs of carrying out the survey. This SOW complements the Scope of Work to be performed by CDC/MEASURES.

II. Purpose and Objectives

The Maternal and Child Health National Survey 2007 has a threefold purpose:

1. Provide authorities at all levels: government, international institutions and non-governmental agencies, information related to demography and demographic analysis, health and nutrition indicators needed for decision-making.

2. Make available internationally information related to demographic, health and nutrition characteristics of the participating countries, in order to conduct comparative health and population studies.

3. Broaden the information related to the reproductive health of men and women during their reproductive age.

Objectives:

1. Provide information at a national, urban/rural and regional level; and, for the first time, at a departmental level.

2. Provide information on factors that influence fertility levels in the Guatemalan population that will permit comparisons with international statistics.

3. Make available updated health data for vulnerable groups such as women between 15-49 years of age, and children under five years of age.

4. Provide information on men between 15-59 years old in order to, for the first time; be able to analyze tendencies and changes on reproductive health occurring within this segment of the population during a four- or five-year period.

III. Expected Results

Result 1: A statistical sample defined to allow statistical inferences at the national, regional and departmental levels

A. The universe

The universe for the Maternal and Child Health National Survey 2007 is the national population comprised in the 22 departments of the country; demographic and health data will be obtained from:

a. Private households including all regular residents living there at the moment of the survey.

b. Women/men of reproductive age (15-49 years old) identified as eligible at each of the households during the survey.

c. Children under sixty months of age (5 years old) living at each of the selected households.

B. The sample

The sample design shall be probabilistic, stratified, multi-staged and independent for each department. The Guatemalan National Institute of Statistics (INE) has developed a master sample frame that is advisable to use it for ENSMI 2007. The sample shall allow estimates at the national, regional and, departmental levels, as well as urban/rural level and estimates on the indigenous and ladino populations. Gross estimates done in Guatemala indicate that in order to have good statistical estimates at the departmental level some 22,500 households shall be selected for the questionnaire for women and 11,250 for the questionnaire for men, making the 2007 survey the largest of the ENSMI's series in Guatemala to date.

Result 2. Vital sections/analysis are included in the 2007 study to allow for comparisons with previous ENSMI's

Sections that were included in past surveys and are required to be included in ENSMI 2007 in order to perform multi-year comparisons, shall include, but not be limited to, the following:

1. Household characterization
2. Socioeconomic characteristics of the household
3. General characteristics of the members of the family
4. General characteristics of women between 15 to 49 years of age and men between 15 and 59 years old.
5. Marital status, reproduction, histories of births, family planning, fertility preferences, background of the partner, STI and AIDS, health risks, intra-familiar violence (for women between 15 to 49 years old and men from 15 to 59 years).
6. History of pregnancies, medical attention during pregnancy, childbirth and post-partum, lactation, anthropometry (for women between 15 to 49 years of age).
7. Immunizations, diarrheal episodes, ARI, oral rehydration, anthropometry (for children under 5 years of age).
8. Specific modules for persons between 15 to 24 years of age.

Result 3. Ample participation, and acceptance of the 2007 survey as official and endorsed by INE, the MOH and other public and international organizations

A. Preparation

With technical assistance of the Centers for Disease Control and Prevention – CDC Atlanta, a Technical Support Group shall be comprised by governmental and non-governmental institutions as well as international cooperation agencies and modules for the development of questionnaires for men and for women in reproductive age shall be elaborated.

For each of the questionnaires to be used in the surveys, a respective manual of operations shall be developed and validated, including among others: manuals for supervisors, survey-takers, anthropometry technicians, cartographers and sample collectors.

B. Pilot testing

When questionnaires have been drafted, a pilot testing shall be conducted immediately to evaluate, modify and verify their contents. Modifications will be made as appropriate.

The pilot testing shall be conducted in locations with similar cartographic characteristics as the sectors selected for the ENSMI. The pilot testing shall be conducted by expert personnel with previous survey experience who afterwards will become field supervisors and editors.

C. Translation of questionnaires

The final version of the questionnaires written in Spanish should be translated into at least the four major Mayan languages; the translations shall not be literal but would focus on contents so that they can be readily understood.

The translations for men aged 15 to 59 years of age shall be done by men and the translations for women aged 15 to 49 years old shall be done by women.

All translations shall be validated with a selected sample of men and women who are native speakers of each of the major Mayan languages.

D. Training

The training for field personnel should take into account the national diversity so it is advisable to include personnel not only from the department of Guatemala but also others who represent the rural segment of the Guatemalan population. Selected personnel for anthropometry and sample collection for micronutrient analysis shall receive specialized training from experts on each of these fields.

E. Fieldwork

Prior experience indicates that fieldwork should take about an eight-month period; during this period, information from about 750 sectors shall be collected to ensure representation for each of the 22 departments of the country. Field staff should include one field director, three assistants and a number of field teams whose number-composition shall be defined by CDC/CESCAP based on a thoughtful thorough analysis. Personnel for the CDC/CESCAP central office shall conduct visits during the data collection process to ensure that the work is done following rigorous procedures to ensure data quality.

F. Data processing

The data collected shall be entered into network linked computers using applications designed and developed for this specific purpose. The totality of the questionnaire contents shall be entered twice in order to have 100% verification. The director shall ensure that digitalization error is decreased to a minimum. Special effort shall be deployed for detection and correction of data inconsistencies to diminish master errors.

G. Map development

Taking advantage of the platform of maps in existence at CDC/CESCAP, thematic maps shall be developed at a regional level for comparison with the results of previous ENSMIs. In addition, CDC/CESCAP should have the unique opportunity to develop departmental thematic maps. This will help underscore the status of each locality for each of the indicators.

Result No. 4. In a joint effort with the GOG, fund raising carried out to complete the full amount required to cover local costs

The MOH has already initiated a series of fund raising activities to ensure that the full amount of resources required to implement the 2007 survey is available. CDC/CESCAP shall work collaboratively with the MOH to ensure that other donor and GOG entities contribute with their own monies to finance the survey. USAID/GUATEMALA will provide about one third of the total funds required to pay local costs of the survey; therefore, CDC/CESCAP must work closely with the MOH to raise the additional two thirds needed to complete the full amount of funding required.

Result 5. Close coordination between CDC/CESCAP and CDC/MEASURES is secured to guarantee high quality of 2007 survey

A. Technical Assistance

As on the past ENSMI (2002), CDC Atlanta will provide technical assistance to assure the quality of the information collected, processed and analyzed.

This support will mainly be provided for the following:

- Planning and pretest questionnaires
- Data entry/cleaning programs and standardization of field staff
- Data cleaning/analysis file definition and data analysis
- Report writing & printing
- Databases preparation

IV. Period of Performance

The performance period extends from July 2006 to December 2008 to ensure wide dissemination and in depth analysis of the data. Mission expects a preliminary report by September 30, 2007. The suggested timeline is included as Annex 1 to the current SOW.

V. Deliverables

The final results of the ENSMI will be presented in stages to ensure that most of data generated is shown and properly analyzed in the reports:

- Preliminary Report
- Summary of the Report
- Final Report for Women
- Final Report for Men
- Executive Report

The presentation of results will be made to the highest authorities from the Ministry of Public Health and the National Institute of Statistics, non-governmental organizations and financing agencies. USAID/GUATEMALA shall receive at least 100 hard copies of each of the aforementioned reports.

In addition, USAID/GUATEMALA expects the following reports:

- The data base
- The aforementioned reports on electronic format
- One electronic copy of the power point or any other presentations related with the 2007 ENSMI
- A press release
- Any other information/reports deemed necessary

VI. Logistic Support

All the logistic support will be provided by CDC/CESCAP, including but not limited to the following: office space, vehicles, equipment and office supplies

VII. Government Estimate

The total cost of the ENSMI 2007 is much higher than the amount that the USAID/GUATEMALA Mission has available for this purpose US $1,155,000.00. Therefore, CDC/CESCAP is expected to work closely with the MOH authorities and USAID/GUATEMALA staff to advocate for additional funding in order to get the exact amount of resources required to pay local costs related to the ENSMI 2007 survey.

DESCRIPTION	USAID/GUATEMALA CONTRIBUTION	OTHERS CONTRIBUTION	TOTAL (US$)
A. TECH. PERSONNEL	160,150	251,510	411,660
B. MATERIALS & COMMUNICATIONS	138,600	268,950	407,550
C. CARTOGRAPHIC ACTUALIZATION	111,700	155,336	267,036
D. TRANSLATION OF QUESTIONNAIRES	15,000	8,900	23,900
E. PILOT TESTING	10,000	2,450	12,450
F. TRAINING	15,000	10,500	25,500
G. FIELDWORK	438,900	772,976	1,211,876
H. DATA PROCESSING	57,750	95,250	153,000
I. DEVELOPMENT & REPORT REPRODUCTION	103,950	171,050	275,000
J. SOCIALIZATION & REPORT DIFFUSION	11,550	17,950	29,500
K. THEMATIC IN-DEPTH ANALYSIS	80,850	131,150	212,000
J. GENERAL EXPENSES	11,550	24,000	35,500
TOTAL	**1,155,000**	**1,910,022**	**3,065,022**

Annex I

TIMETABLE

Nº	OBJETIVE	ACTIVITIES	PERIOD
1.	Official approval of ENSMI	• Call a meeting with institutions that might support ENSMI 2006 • Develop agreements through which the survey may be institutionalized	June 2006
2.	Formation of the Technical Support Group (TSG)	• Contact the institutions that might form the TSG group of ENSMI 2006 • Establish working conditions (periodicity of meetings, formation of groups, etc.) • Identify the persons responsible by institution and by theme of the questionnaire	July 2006
3.	Search of financial sources with international agencies.	• Contact institutions that might financially support the ENSMI 2006 • Develop through agreements and letters of understanding commitments to support the survey • Establish the financing of the survey by products (fieldwork, reproduction of reports, digitalization, etc.)	July 2006
4.	Contents analysis and questionnaires	• Conduct specific meetings with special institutions to determine the theme of the questionnaire. • E-mail base sections of the questionnaires to institutions by theme or specialty • Analyze questionnaires for women and for men by comparing with the results obtained in 2002. • Analyze the contents of the sections with highest demand for modification and/or broadening	July-September 2006

Nº	OBJETIVE	ACTIVITIES	PERIOD
5.	Design and selection of the sample	• Design of the sample framework • Selection of the sample	June - July 2006
6.	Fieldwork planning	• Establish field work methodology • Establish work load distribution for each post • Establish field work logistics with respect to the transportation of samples	September 2006
7.	Pilot testing	• Review questionnaire (different modules and sections) • Classroom practice for modules and sections of questionnaires for men, women, and special groups. • Field practice in places similar to final work sites	October 2006
8.	Cartographic actualization	• Identification of selected sectors • Fieldwork for actualization • Processing of updated information • Reproduction of updated material	September 2006- January 2007
9.	Translation of questionnaires	• Contact institutions and persons with the ability to translate --not literally but by content-- different modules and sections of the questionnaires • Establish translating methodologies	October 2006- January 2007
10.	Fieldwork	• Collect data at a national level for 30,000 women between the ages of 15 to 49 years and 20,000 men from 15 to 59 years of age. • Conduct the necessary surveys to obtain data for the modules addressed to special ENSMI 2006 groups	February – August 2007
11.	Data input	• Code and edit 50,000 questionnaires • Input and verification of 100% of the 50,000 questionnaires • Establish and detect inconsistencies on the data of the questionnaires	February - September 2007

Nº	OBJETIVE	ACTIVITIES	PERIOD
12.	Tabulation of data	• Develop the necessary applications for data tabulation • Generate initial tabulators for an overall revision on data consistency • Generate specific tabulations by theme (PF, fecundity, nutrition, etc)	August – September 2007
13.	Preparation and presentation of the Preliminary Report	• Design the report (contents, size – number of pages) material • Establish the methodology for the elaboration of the report • Write up the report and its contents • Design and elaboration of charts and graphs • Official presentation of the report to the institutions	September - October 2007
14.	Preparation and presentation of the Final Reports	• Design the report (content, size, number of pages, material) • Establish elaboration methodology for the report • Write up contents for the report • Design and elaboration of charts and graphs • Official presentation of the report to the institutions	January - August 2008
15.	Preparation and presentation of Executive Reports	• Design reports (contents, size, number of pages, material) • Establish the methodology for the elaboration of the reports • Write up contents for the report • Design and elaboration of charts and graphs • Official presentation of reports for the institutions • Workshops for diffusion of results at a national level (regional and departmental)	September 2008 - December 2008

Section III:

MAARDS

Indonesia and Mexico

Country/Region: Indonesia
Title Describing the Activity: Technical Assistance to the UNICEF Integrated MNCH/Malaria Control Program & MOH National Malaria Program (non-PMI)
Center/Division and Project Officer at CDC the activity was negotiated with: NCZVED/DPD/Malaria
Bureau or Mission contact following the activity: USAID/Indonesia
Amount, type and year of funds to be obligated: $50,000
Time Frame: Second year activity of a three-year activity

The Ministry of Health for the Government of Indonesia, USAID/Indonesia and UNICEF consider malaria control an important factor in promoting the health of the most vulnerable in Indonesia, particularly pregnant women and children. Malaria is endemic in eastern Indonesia and is a contributor to high rates of anemia and maternal and infant mortality. To promote the health of women and children and to reduce the incidence of malaria in Indonesia, USAID/Indonesia is supporting the integration of malaria control into UNICEF's community based maternal and new born child health program in eastern Indonesia. USAID/Indonesia also supports John Snow Inc. (JSI) to implement our maternal and new born child health program with a malaria control component in six provinces in Java and Sumatra. The GOI has received funds from the Global Fund for AIDS, TB and Malaria for malaria control activities. Technical assistance would aid the GOI, USAID and UNICEF in evidence based program planning, implementation, surveillance and evaluation and would contribute to coordinated programming efforts.

USAID/Indonesia is providing funding for CDC to provide technical assistance to the Government of Indonesia and UNICEF through a series of temporary duty assignments over a year. Additionally CDC will work closely with UNICEF to determine the possibility of arranging a malaria sedondment staff. The specific details and timing of the technical assistance package remains to be negotiated between USAID/Indonesia and CDC.

AGENCY FOR INTERNATIONAL DEVELOPMENT

MODIFIED ACQUISITION AND ASSISTANCE REQUEST DOCUMENT

		Status: Page: 1 of 5
1. Benefiting Country Indonesia	2. Managing Request No. Org: 497-0019-06-047 Req:	3. Amend No Original
4. Authorized Agent USAID/Washington	5. Request Title Malaria – Technical Assistance	6. Date Award Needed By: June 15, 2006
7. Type of Action [X] New Award [ ] Mod to Existing Award [X] Inc Funding [ ] Acquisition [X] Assistance [ ] Inter-Agency [X] Unilateral Agreement [ ] Sub-obligation Under a Bilateral Agreement		8. Contract/Grant/Cooperative Agreement Reference Number (If this is for an order or a modification to an award) TBD-GH-06-2006

ACTION TYPE

9. USAID Funding (attach a detailed budget in support of line items as Attachment A)

Activity:	Malaria	Fund Account:	HCD5-05-23497-KG13	Amount Committed: (Original)	$50,000.00
Activity:	Malaria	Fund Account:		Amount Committed:	
Activity:		Fund Account:		Amount Committed:	
Activity:		Fund Account:		Amount Committed:	
Activity:		Fund Account:		Total Commitment:	$50,000.00

Organization/Activity Chaining to the Lowest level: SO19

10. Instructions to Authorized Agent:
USAID/Washington's Office of Procurement is requested to add funds to CDC/IAA No. TBD-GH-06-2006 for the US CDC/HHE to provide technical assistance to malaria control program in Indonesia. This MAARD provides $50,000.00 for the technical assistance as initially budgeted in USAID/Indonesia – BHS OYB 2005. The source of funds for this MAARD is HCD5-05-23497-KG13.

11. Address of Voucher Paying Office Contact: USAID/Washington

Addressee:	USAID/M/FM/CMP	Office and Room:	RRB 7.07-108 or 134
Address (line one):	1300 Pennsylvania Ave	Address (line two):	Washington, DC 20523-7700
Location:	Washington, DC	Phone:	

12. Participants

Requestor	Ratna Kurniawati, BHS	Signature:	Date:
Program Manager	Lynn Adrian, BHS	Signature:	Date:
Office Team Leader	Herbert Smith, BHS	Signature:	Date:
Program Office	Richard Hough, PRO	Signature:	Date:
Contracting Office	Gloria Steele, AID/W	Signature:	Date:
Controller (Mission funded)	Linda Tarpeh-Doe, OFM	Signature:	Date:
FM/A (AID/W funded)		Signature:	Date:

13. The Program Manager is responsible for recording the commitment as soon as the issue that prevented this from being recorded in A&A is resolved.

Program Manager Signature:	Lynn Adrian, BHS	Date:

14. Line Items

#	PSC	DESCRIPTION	RC	Unit of Measure	QUANTITY	UNIT COST/ PRICE	TOTAL COST
1		Malaria Technical Assistance					$50,000.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
						GRAND TOTAL	$50,000.00

MAARDREV (Cont)

15. Delivery and Shipping Schedule

#	Description	Delivery Qty	Delivery Date	Location Type	Location Address
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	

MAARDREV (Cont)

Request No.: 497-0019-06-047

16. Special Provisions

A. Language Requirements (Include funds in budget or training as required.) N/A

B. Access to classified information No	Access Type: N/A
C. Duty post(s) and duration of technical specialists(s) services at post(s) (months): Indonesia for period 12 months	D. Dependents' travel and support N/A

E. Geographic code applicable to procurement waiver(s)
☒1. 000 ☐ 2. 935 ☐ 3. 941 ☐ 4. 899 ☐ 5. Other (specify)

F. Salary approval(s) to exceed FS-1 salary are:	G. Cooperating country acceptance
☐ 1. attached ☐ 2. in process ☒ 3. N/A	☒ 1. has been obtained ☐ 2. is in process ☐ 3. is not applicable to services required

H. Clearance for procurement of IRT equipment, software, and services is:
☐ 1. attached ☐ 2. is in process ☒ 3. N/A

I. OMB approval of any report to be completed by ten or more members of the general public under the statement of work. ☐ 1. attached ☐ 2. in process ☒ 3. N/A

J. Participant Training ☐ is ☒ is not being funded.

K. Requirement (contracts only) is recommended for:
☐ SB Set-Aside ☐ SDB Set Aside ☐ SBA 8(a) Program ☒ No Recommendation

L. Other (specify)

17. PROVISIONS FOR LOGISTIC SUPPORT	IN KIND SUPPLIED BY		FROM LOCAL CURRENCY SUPPLIED BY		TO BE PROVIDED OR ARRANGED BY SUPPLIER	NA
	USAID	COOPERATING COUNTRY	USAID	COOPERATING COUNTRY		
Office Space and Equip.	☐	☐	☐	☐		X
Housing & Utilities	☐	☐	☐	☐		X
Travel arrangement	☐	☐	☐	☐		X
Vehicles (official)	☐	☐	☐	☐		X
Adm. & Secretarial Support	☐	☐	☐	☐		X
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		
	☐	☐	☐	☐		

Commissary use: ☐ YES ☐ NO Pouch Use: ☒ YES ☐ NO Embassy Health Room Privileges: ☐ YES ☒ NO

MAARDREV (Cont)

Request No: 497-0019-06-047

18. Relationship of Contractor, Recipient, or Participating Agency to Cooperating Country and to USAID:
Relationship and Responsibilities:

USAID/Indonesia supports the integration of malaria control into UNICEF's community based maternal child health program in eastern Indonesia. USAID/Indonesia is providing funding to CDC to provide technical assistance to Government of Indonesia and UNICEF through a series of temporary duty assignments over the 12 months

CDC will be responsible for providing technical assistance to program development, implementation, surveillance, assessment of the burden of malaria in pregnancy in collaboration with local universities, and monitoring &evaluation of malaria control activities in eastern Indonesia managed by UNICEF. CDC will also be responsible for providing technical assistance to the Government of Indonesia /MOH for planning and disbursing funds in support of effective, evidence based malaria control programs supported by GFATM.

19. Government furnished property/Government furnished equipment

No office space will be made available in the US Embassy compound.

20. Summary of attachments that accompany the request (check applicable boxes)

- ☒ A. Detailed budget estimate in support of line items
- ☐ B. Evaluation criteria for competitive procurement
- ☐ C. Justification for procurement by other than full and open competition or noncompetitive assistance
- ☒ D. Statement of work or program description
- ☐ E. Waiver(s), justification(s), clearance(s), approval(s)

Country/Region: Mexico
Title Describing the Activity: Tuberculosis Prevention and Control Program
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells and Peter Cegielski
Bureau or Mission contact following the activity: Molly Lindner, USAID/Mexico
Amount, type and year of funds to be obligated: $ 454,731

It is expected that CDC will continue to provide support to the USAID/Mexico Tuberculosis Prevention and Control Program in conjunction with the National TB Program (NTP) of the Ministry of Health of Mexico in the following areas:

Research ($22,200 USD):
The CDC will continue to provide technical assistance in support of the national TB drug resistant study in Mexico in its pilot and operational phase, as well as provide technical leadership in the area of operations research training and mentoring.

Information Systems ($215,500 USD):
The CDC will support the improvement of TB surveillance and NTP administration through the development and adaptation of an integrated data and information management and reporting system.

DOTS MDR ($132,000 USD):
CDC will support Mexico's DOTS MDR efforts to improve case management and successful MDR treatment by augmenting the capacity of the national referral center for drug resistant tuberculosis.

*Detailed involvement in each activity, including objective of visit, dates, and funding necessary, will be provided to USAID/Mexico prior to travel, as well as periodic expense and trip reports as appropriate.

*All activities involve close collaboration with USAID/Mexico and national partners.

AGENCY FOR INTERNATIONAL DEVELOPMENT

MODIFIED ACQUISITION AND ASSISTANCE REQUEST DOCUMENT

		Status: Funded Page: 1 of 5
1. Benefiting Country Mexico	2. Managing Request No. Org USAID/Mexico Req: 523-4018-06-003	3. Amend No. Original
4. Authorized Agent USAID/Washington/OP	5. Request Title Tech Support CDC IAA TB SOAG Mex	6. Date Award Needed By: 6/30/2006

7. Type of Action ☐New Award ☒Mod to Existing Award ☐Inc Funding ☐Acquisition ☐Assistance ☒Inter-Agency ☐Unilateral Agreement ☒ Subobligation Under a Bilateral Agreement	8. Contract/Grant/Cooperative Agreement Reference Number (If this is for an order or a modification to an award) CDC IAA No. 936-3100.04 TBD-GH-06-2006

ACTION TYPE - CA- Cooperative Agreement

9. USAID Funding (attach a detailed budget in support of line items as Attachment A

Activity :	72X1095 5234018.01 EL 18 TB	Fund Account:	LCDX-02-25523-CG13	Amount Committed :	$162,360.00
Activity :	72X1095 5234018.01 EL 19 TB	Fund Account:	LCDX-02-25523-CG13	Amount Committed :	$265,065.00
Activity :	72X1095 5234018.01 EL 21 TB	Fund Account:	LCDX-02-25523-CG13	Amount Committed :	$27,306.00
Activity :		Fund Account:		Amount Committed :	
Activity :		Fund Account:		Total Commitment:	
Activity :		Fund Account:		Total Commitment:	
				Total Commitment:	$454,731.00

Organization/Activity Chaining to the Lowest level:
USAID/MEXICO SO 523-008 Sustainable and effective institutional capacity developed Activity 5234018.01 Tuberculosis

10. Instructions to Authorized Agent:
The autorized agent is requested to put funds available in the amount of $454,731 USD to USAID/Washington Project CDC IAA No. 936-3100.04, under temporary agreement No. TBD-GH-06-2006 to provide assistance to Mexico. Agreement end date is September 2009. Project No.: 936-3100.24. Funds are available under the TB SOAG mechanism.

11. Address of Voucher Paying Office Contact: USAID/Washington

Addressee:	USAID/Washington, DC	Office and Room:	
Address (line one):	1300 Pennsylvania Ave. NW	Address (line two):	Washington, DC 20523-3800
Location:	U.S.A.	Phone:	(202) 712-4569

12. Participants

Requestor	Molly Lindner, TB Program Coordinator	Signature:
Program Manager	Nancy Alvey, Health Team Leader	Signature:
Contracting Officer	Gloria Steele, USAID/Washigton	Signature:
Negotiator		Signature:
Controller (Mission funded)	Amy Fawcett, CONT, USAID/ES	Signature:
FM/A (AID/W funded)		Signature:

13. The Program Manager is responsible for recording the commitment as soon as the issue that prevented this from being recorded in A&A is resolved.

Program Manager Signature:	

MAARDREV

14. Line Items

#	PSC	DESCRIPTION	RC	Unit of Measure	QUANTITY	UNIT COST/ PRICE	TOTAL COST
1		See attached description		each	1	454,731.00	454,731.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
							0.00
						GRAND TOTAL	454,731.00

MAARDREV (Cont)

15. Delivery and Shipping Schedule

#	Description	Delivery Qty	Delivery Date	Location Type	Location Address
1	Technical Support			Ship To	USAID/MEXICO P.O. Box 9000 Brownsville, TX 78520-0900
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	
				Ship To	

Request No.: 523-4018-06-003

16. Special Provisions

B. Language Requirements (Include funds in budget or training as required.) N/A

B. Access to classified information No	Access Type: N/A
C. Duty post(s) and duration of technical specialists(s) services at post(s) (months): 5 days per trip per traveller	D. Dependents' travel and support N/A

E. Geographic code applicable to procurement waiver(s)
☒ 1. 000 ☐ 2. 935 ☐ 3. 941 ☐ 4. 899 ☐ 5. Other (specify)

F. Salary approval(s) to exceed FS-1 salary are:	G. Cooperating country acceptance
☐ 1. attached ☐ 2. in process ☒ 3. N/A	☒ 1. has been obtained ☐ 2. is in process ☐ 3. is not applicable to services required

H. Clearance for procurement of IRT equipment, software, and services is:
☐ 1. attached ☐ 2. is in process ☒ 3. N/A

I. OMB approval of any report to be completed by ten or more members of the general public under the statement of work. ☐ 1. attached ☐ 2. in process ☒ 3. N/A

J. Participant Training ☐ is ☒ is not being funded.

K. Requirement (contracts only) is recommended for:
☐ SB Set-Aside ☐ SDB Set Aside ☐ SBA 8(a) Program ☒ No Recommendation

L. Other (specify)
N/A

17. PROVISIONS FOR LOGISTIC SUPPORT	IN KIND SUPPLIED BY		FROM LOCAL CURRENCY SUPPLIED BY		TO BE PROVIDED OR ARRANGED BY SUPPLIER
	USAID	COOPERATING COUNTRY	USAID	COOPERATING COUNTRY	
OFFICE SPACE	☐	☐	☐	☐	X
OFFICE SUPPLIES	☐	☐	☐	☐	X
OFFICE EQUIPMENT	☐	☐	☐	☐	X
TRAVEL ARRANGEMENTS	☐	☐	☐	☐	X
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	
	☐	☐	☐	☐	

Commissary use: ☒ YES ☐ NO Pouch Use: ☐ YES ☒ NO Embassy Health Room Privileges: ☒ YES ☐ NO

MAARDREV (Cont)

Request No: 523-4018-06-003

18. Relationship of Contractor, Recipient, or Participating Agency to Cooperating Country and to USAID:
Relationship and Responsibilities:

Visit will be coordinated with and technical reports submitted to Tuberculosis Program Coordinator, Molly Lindner, USAID/Mexico.

19. Government furnished property/Government furnished equipment

N/A

20. Summary of attachments that accompany the request (check applicable boxes)

- ☐ A. Detailed budget estimate in support of line items
- ☐ B. Evaluation criteria for competitive procurement
- ☐ C. Justification for procurement by other than full and open competition or noncompetitive assistance
- ☒ D. Statement of work or program description
- ☐ E. Waiver(s), justification(s), clearance(s), approval(s)

ANNEX B
REVISED FINANCIAL PLAN AND BUDGET
Umbrella IAA between USAID and CDC

Below is a summary of the budget for each component by directive and implementing unit within CDC to be funded under this agreement in FY 06.

Component (by funding source)	**Implementing Unit**	**Budget**
I. *Global Bureau*		
Tuberculosis		
1. MDR-TB Component	NCHHSTP/DTBE	$300,000
2. TB/HIV Component	NCHHSTP/DTBE	$200,000
3. DOTS Component	NCHHSTP/DTBE	$500,000
Antimicrobial Resistance	NCIRD/DBD/RDB	$300,000
Surveillance	COGH/DESCD	$900,000
Environmental Health	NCZVED/DFBMD	$350,000
Malaria Vaccine Development (non-PMI)	NCZVED/DPD/MB	$230,000
Immunization	COGH/DESCD	$100,000
	Global Bureau Total:	**$2,880,000**
II. *Regional Bureau and Mission Funds (Field Support)*		
AFRICA		
AFR/SD – IDSR	NCPDCID/DEISS	$550,000
Madagascar	NCHHSTP/DSTDP/LRRB	$75,000
Sudan	NCHHSTP/GAP	$1,000,000
Sudan	COGH/DESCD	$700,000
Uganda (PMI)	NCZVED/DPD/MB	$760,000
Angola (PMI)	NCZVED/DPD/MB	$432,000
E&E		
Russia	NCHHSTP/DTBE	$700,000
ANE		
India	NCHHSTP/DTBE	$57,000
RDM/Asia - Bangkok	NCZVED/DPD	$150,000
RDM/Asia - Bangkok	NCHHSTP/DTBE	$700,000
RDM/Asia - Bangkok	NCZVED/DPD/MB	$207,000
RDM/Asia - Bangkok	NCHHSTP/DTBE	$200,000

LAC

LAC Bureau - Dominican Republic	NCHHSTP/GAP	$75,000
Bolivia	NCHHSTP/GAP-MERTU	$50,000
Brazil	NCHHSTP/DTBE	$30,000
Honduras:		
1. HIV/AIDS	NCHHSTP/GAP/CAP	$800,000
2. M&E Strategy	NCHHSTP/GAP/CAP	$373,000
3. Public Health Surveillance	NCHHSTP/GAP/CAP	$466,000
Guatemala	CDC/MERTU	$430,000
	Field Support Total:	**$7,755,000**

III. *Mission Funds (MAARDS)*

Indonesia	NCZVED/DPD/MB	$50,000
Mexico	NCHHSTP/DTBE	$454,731
	MAARD Total:	**$504,731**
	TOTAL:	**$11,139,731**

Annex C:
Standard Provisions

A. GENERAL

1. CDC will use the funds made available to it under this Agreement to cover costs incurred in carrying out the Program under the terms and conditions of this Agreement. CDC will be accountable for all funds made available to it under this Agreement. Funds not expended by CDC by the Completion Date of the Program (as defined below) and funds expended for purposes or activities not authorized by this Agreement will be promptly refunded to USAID.

2. The Completion Date for the Program will be the date stated in Block 7 of the face sheet of this Agreement, or such other date as the parties may agree to by amendment of this Agreement. "Completion Date" for this purpose means the estimated date by which all USAID-financed services will have been performed and all USAID-financed goods will have been furnished for the Program as contemplated in this Agreement. Except as USAID may otherwise agree in writing, funds transferred under this Agreement may not be used to finance services performed after the Completion Date or goods furnished after the Completion Date.

3. USAID will begin to formally close out the Program after the physical completion of the Program or the Completion Date, whichever occurs first. CDC will cooperate with USAID to expeditiously and properly document the close-out of the Program. Except as USAID may otherwise agree in writing, CDC must, not later than nine months following the Completion Date, submit to USAID requests for reimbursement or liquidation of outstanding advances under the Program. Funds which have not been disbursed and for which reimbursement requests, with supporting documentation, have not been received by USAID as of nine months following the Completion Date of the Program may be unilaterally deobligated by USAID.

4. CDC must ensure that all statutory or other restrictions on expenditures of the funds transferred by this agreement are fully complied with.

B. PERSONNEL

1. Agency Responsibilities - CDC has full responsibility for performing the technical services required under this Agreement, including staffing, supervision, backstopping, promotion, and reporting, subject to general guidance from USAID.

CDC personnel remain on CDC's employment rolls and are subject to CDC's position ceilings and regular promotion procedures. CDC personnel assigned in the United States operate under the rules and regulations of CDC unless otherwise required by law. Certain Department of State and USAID regulations (for example, regulations relating to use of USAID premises and equipment) will apply to CDC personnel depending upon the nature and location of their assignments. USAID and CDC will cooperate in resolving any

issues that may arise under these regulations. CDC shall be responsible, through the Center at CDC that receives funds under the terms of this Agreement, for performing all administrative and supervisory duties required for its employees, including negotiating and managing all personnel agreements.

USAID Automated Directive System (ADS) Chapter 306 applies to CDC personnel serving under this Agreement. Before CDC personnel may undertake an overseas assignment, CDC must make the necessary administrative arrangements, including all predeparture clearances (e.g., health (including medical waivers), security, language training and testing, and orientation).

2. Limitations - Except as specifically provided in writing by USAID, CDC personnel may not officially represent USAID at any function; approve policy documents; supervise USAID employees; negotiate, review, or sign contracts on behalf of USAID; certify vouchers; select or recruit USAID employees; or prepare USAID funding or budget documents.

3. Time and Attendance Records – Unless USAID agrees otherwise, Participating Agency personnel serving overseas are responsible for forwarding their time and attendance records to the Participating Agency for recordkeeping and for the processing of salary payments. At the request of the USAID Agreement Officer or the USAID Cognizant Technical Officer, the Participating Agency must provide a copy of the time and attendance records for personnel named in the request.

4. Standards of Conduct - Participating Agency personnel and their dependents are required to maintain high standards of personal conduct expected of United States Government officials representing the United States overseas. Failure to do so can lead to disciplinary action.

5. Special provisions governing long-term advisors

a. Post of Assignment - All CDC United States citizen direct-hire employees stationed overseas and funded under this Agreement are entitled to the same types of support and privileges and immunities as equivalent USAID United States citizen direct-hire employees at the same post. However, in some cases, support for such Participating Agency employees may not come from the same source as support for USAID direct-hire staff. For example, in some instances, housing for Participating Agency employees may be provided by a host-country institution rather than by USAID or the Embassy as for USAID employees. In any event, Participating Agency employees' housing and facilities are to be equivalent to those provided to comparable USAID United States citizen direct-hire employees.

Participating Agency employees stationed overseas under this Agreement will receive the same APO, Commissary, PX, and club privileges as USAID United States citizen direct-hire employees when allowed by the regulations of

the organization to which the facility is attached. Participating Agency employees and their dependents are entitled to the same health benefits as USAID direct-hire employees.

b. Termination – If, for any reason, USAID curtails, revises, or terminates programs or strategic objectives under which activities required under this Agreement are performed, USAID may unilaterally determine which categories of Participating Agency personnel are to be retained. If USAID plans to terminate the services of Participating Agency personnel under this Agreement, USAID will notify the Participating Agency in writing at least 45 days in advance.

C. BILLING AND FINANCIAL REPORTS

1. CDC must bill USAID as provided in the Schedule. The amount billed will be determined by CDC and will be billed for an expenditure transfer into an account administered by CDC and for which CDC provides fiscal reports to OMB and/or the Department of Treasury. This amount will be treated by USAID as an advance and will be expended based on the periodic financial reports, described below, detailing the implementation of the Program.

2. The financial reports submitted for liquidation of advances or requests for reimbursement must, as provided in the Schedule, contain current period and cumulative amounts as follows:

Budget Line Item	Budget Amount	Current Period Disbursements	Cumulative Disbursements	Remaining Budget Balance

3. CDC must use the categories of obligations and expenditures set forth in Annex B of this Agreement. CDC must provide this information both in summary form for the entire Program and separately by Cooperating Country, if appropriate.

4. The financial reports will be used to liquidate the advance authorized by this Agreement. CDC must submit its periodic financial report within 30 days after the end of the applicable reporting period. The report must be signed in the original by an authorized official of CDC billing office.

D. ELIGIBLE COUNTRIES

1. Except as USAID may otherwise agree in writing, funds provided under this Agreement will only be expended for assistance to countries eligible for assistance under the Foreign Assistance Act of 1961, as amended, or under acts appropriating funds for foreign assistance.

E. PROCUREMENT

1. CDC will administer the funds (including procurement and monitoring actions) in accordance with its own procedures, except as provided in this Agreement or as USAID may otherwise agree in writing.

F. BOOKS AND RECORDS

1. CDC must keep full and complete records and accounts with respect to the funds made available to it under this Agreement in accordance with generally accepted U.S. Government accounting principles. CDC must require that all contractors or grantees financed under this Agreement maintain books and records related to the Program in accordance with generally accepted accounting principles as formally prescribed by the United States, the Cooperating Country, or the International Accounting Standards Committee (an affiliate of the International Federation of Accountants). CDC must ensure that all such books and records of all contractors and grantees financed under this Agreement may be audited by CDC, USAID, or other authorized U.S. Government official for a period of three (3) years from the expiration of the contract or grant.

G. IMPLEMENTATION AND MONITORING

1. CDC is responsible for overall supervision of the Program.

2. If the Schedule of this Agreement specifies that CDC will prepare and submit periodic progress reports to USAID, CDC must submit each such report within 30 days after the end of the interval covered by the report. The report must identify any grants funded under this Agreement to non-U.S., nongovernmental organizations in the amount of $300,000 or more per year. CDC must provide an audit schedule for all such grants. The schedule must conform with the requirements set forth in Section H of the Standard Provisions of this Agreement.

3. CDC must submit to USAID such other information as USAID may reasonably request regarding the implementation, impact, or success of the Program of the Program and the expenditure of funds under this Agreement.

4. CDC hereby agrees to provide USAID with copies of all evaluation or other reports generated by federal or outside sources.

H. AUDIT AND INSPECTION RIGHTS

1. Audit and inspection requirements as set forth in the Inspector General Act of 1978, as amended, (the "Act") apply with respect to the funds transferred hereby, and to the books and records of any contractor or grantee financed with such funds. The Office of the Inspector General for USAID must ensure full compliance with all applicable provisions of the Act in coordination with the Office of the Inspector General

for CDC, or other appropriate office, which will provide all appropriate assistance or other support.

2. CDC must ensure that grants with non-U.S., nongovernmental organizations include an audit clause that requires that if a grantee receives $300,000 or more per year in grant awards, the grantee agrees that it will have an independent financial audit of the funds provided under such grants. The financial audit of the funds disbursed to the grantee will determine whether the receipt and expenditure of the funds provided under the grant are in accordance with generally accepted accounting principles and whether the grantee has complied with the terms of the agreement. An audit must be conducted for each fiscal year of the grantee. The audits must usually be performed annually, but not less frequently than every two years. The audits must be performed in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Non-U.S., nongovernmental organizations receiving less than $300,000 per year are exempt from the financial audit requirements, but are subject to the requirement to make records available upon request for review by authorized U.S. Government officials.

3. CDC must ensure that contracts with non-U.S. contractors include the appropriate audit and examination of records clauses as specified in the Federal Acquisition Regulation.

4. CDC must ensure, by appropriate written arrangements with recipients of USAID-financed assistance under this Agreement, that such assistance will be subject to audit and inspection by authorized U.S. Government officials.

I. OTHER AGREEMENTS

1. In each Cooperating Country in which a framework economic assistance bilateral agreement governing privileges, immunities, and tax exemptions of USAID-financed personnel, entities, and commodities is not in effect, CDC, with the assistance of USAID and, if necessary, the United States Embassy in the Cooperating Country, will seek to obtain for its personnel, contractors, and grantees as well as for any commodities financed under this agreement, exemptions from taxes, duties, and fees that may be imposed by the Cooperating Country with respect to activities or transactions financed under this Agreement.

2. CDC must ensure, with the assistance of USAID, and if necessary, the United States Embassy in the Cooperating Country, through written arrangements which CDC and/or grantees or contractors financed under this Agreement must enter into with recipients of USAID-financed assistance that (1) such assistance must only be used for the purposes stated therein and, (2) that if such assistance is no longer needed for such purposes, that such assistance may be used for other purposes as may be agreed upon by CDC in consultation with USAID.

J. AMENDMENTS AND MODIFICATIONS

1. Implementation letters may be used to record mutually agreed upon adjustments to Annex A (Program Description) or to Annex B (Financial Plan and Budget) without formal amendment of this Agreement. In addition, USAID, from time to time may issue implementation letters to furnish additional information about matters addressed in this Agreement. Implementation letters must not be used, however, to modify the Completion Date, the Schedule, or Annex C (Standard Provisions) of this Agreement or to increase the total amount of USAID funds obligated under this Agreement (block 9C of the Face Sheet). Such changes must only be accomplished through formal amendment of this Agreement.

2. This Agreement may be amended, modified or canceled upon the mutual, written agreement of both parties.

K. AUTHORIZED REPRESENTATIVES.

1. For all purposes relevant to this Agreement, CDC and USAID will be represented by the individuals identified in block 12A and block 12B, respectively, of the face sheet of this Agreement. Each party may, by written notice to the other party, designate additional representatives, who will serve as representatives for all purposes specified in such notice. CDC and USAID hereby designate as Additional Representatives the persons named in blocks 12A and 12B, respectively, who may exercise all powers under this Agreement other than amending, modifying or canceling this Agreement. A person holding or acting in the same office as an individual named in this Agreement must have the authority to exercise all powers of such individual under this Agreement, unless the party concerned advises the other party in writing to the contrary. USAID may accept as duly authorized any instrument signed by representatives of CDC until receipt of written notice of revocation of their authority.

L. INTERNATIONAL TRAVEL

1. Except as USAID may otherwise agree in writing, all travel financed under this Agreement is subject to the Federal Travel Regulation.

2. Except as USAID may otherwise agree in writing, travel financed under this Agreement to all international destinations will be subject to United States Embassy or USAID Mission clearance in accordance with guidance issued from time to time by USAID. CDC is hereby advised that in some instances, several weeks' advance notice may be required in order to obtain the necessary approvals for certain international destinations.

M. INVESTMENT PROMOTION

1. No funds or other support provided under this agreement may be used in a project or activity reasonably likely to involve the relocation or expansion outside of the United States of an enterprise located in the United States if non-U.S. production in such

relocation or expansion replaces some or all of the production of, and reduces the number of employees at, said enterprise in the United States.

2. No funds or other support provided under this agreement may be used in a project or activity the purpose of which is the establishment or development in a foreign country of any export processing zone or designated area where the labor, environmental, tax, tariff, and safety laws of the country would not apply, without the prior written approval of USAID.

3. No funds or other support provided under this agreement may be used in an activity that contributes to the violation of internationally recognized rights of workers in the cooperating country, including those in any designated zone or area in that country.

N. COMMERCE AND TRADE

1. No funds or other support provided under this agreement may be used for any testing or breeding feasibility study, variety improvement or introduction, publication, conference, or training in connection with the growth or production in a foreign country of an agricultural commodity for export which would compete with a similar commodity grown or produced in the United States: provided that this shall not prohibit (a) activities designed to increase food security in developing countries where such activities will not have a significant impact in the export of agricultural commodities of the United States; or (b) research activities intended primarily to benefit United States producers.

2. No funds or other support provided under this agreement may be used to

(a) Procure directly feasibility studies or prefeasibility studies for, or project profiles of potential investment in, the manufacture, for export to the United States or to third country markets in direct competition with United States exports, of import-sensitive articles as defined by 19 U.S.C. 2463 (b) (1) (A) and (E)); or

(b) Assist directly in the establishment of facilities specifically designed for the manufacture, for export to the United States or to third-country markets in direct competition with United States exports, of import-sensitive articles as defined by 19 U.S.C. 2463 (b) (1) (A) and (E)).

O. COMMUNICATIONS PRODUCTS

Unless the Schedule of this Agreement specifically provides otherwise or USAID approves otherwise in writing, the following requirements apply to any printed material (other than noncolor photocopy material), photographic services or video production services (“Communications Products”) prepared under this Agreement:

1. CDC must follow USAID-established standards for Communications Products financed by USAID. A copy of the USAID standards may be obtained from the USAID Authorized Representative on request.

2. The following Communications Products are eligible for USAID financing under this Agreement only if they are approved in writing by the USAID Bureau for Legislative and Public Affairs (LPA):

a. Any Communications Products costing over $25,000, including the costs of both preparation and execution. (For example, in the case of a publication, the costs will include research, writing, and other editorial services (including any associated overhead), design, layout, and production costs.)

b. Any Communications Products that will be sent directly to, or are likely to be seen by, a Member of Congress or Congressional staffer.

c. Any Communications Products of which more than 50 percent of the copies will be distributed in the United States (excluding copies provided to USAID/PPC/CDIE and other USAID/Washington offices for internal use).

P. TRAINING OF COOPERATING COUNTRY PERSONNEL

Except as USAID may otherwise agree in writing, the planning and implementation of all training of personnel of cooperating countries financed under the Program must comply with USAID Automated Directives System Chapter 253.

Q. NATIONAL SECURITY

1. In accordance with National Security Decision Directive 38 of June 2, 1982,

> [A]ll agencies with staffs operating under the authority of Chiefs of Mission will ensure that, in coordination with the Department of State, the Chiefs of Missions' approval is sought on any proposed changes in the size, composition, or mandate of such staff elements. Departments and agencies wishing to initiate changes should transmit their proposals to Chiefs of Missions in consultation with the Department of State.

Accordingly, CDC is responsible for complying with all requirements of National Security Decision Directive 38, as instructed by the Department of State and the chiefs of mission in each cooperating country.

2. CDC must ensure that all of its employees assigned or hired overseas and all of its personnel (both employees and contractors) traveling overseas on temporary

duty have the requisite security clearance and otherwise comply with the requirements of 12 Foreign Affairs Manual (FAM) 443.

R. USE OF GOODS AND SERVICES

Except as USAID may otherwise agree in writing, all good and services financed under this Agreement will be used for the purposes of the Program until the completion or termination of this Agreement, and thereafter will be used as USAID may direct in implementation letters.

S. MARKING

Unless USAID agrees otherwise,

1. CDC must co-brand USAID-funded activities.

2. All USAID-financed equipment and materials must be marked with the USAID red, white, and blue emblem, and their shipping containers must be marked with the emblem and the USAID financing document number.

3. All construction sites and other locations receiving USAID financing must display signs marked with the USAID red, white, and blue emblem and indicating participation by the United States of America. These signs should be erected at an early date in the construction or implementation phase and be replaced by permanent signs, plates or plaques, marked with the USAID red, white, and blue emblem, at the end of this phase.

Attachment 1:
Workplan Format

Country/Region:
Title Describing the Activity:
Center/Division and Project Officer at CDC the activity was negotiated with:
Bureau or Mission contact following the activity:
Amount, type and year of funds to be obligated:
Time Frame (i.e., second year of a 3 year activity):

A. Background and Rationale

B. Overall Objectives

C. Activities (include components below for each discrete activity)

- **a. Description**
- **b. Timeframe**
- **c. Timeframe**
- **d. Outputs**
- **e. Expected Results**
- **f. Budget**
- **g. Project Officer**
- **h. Collaborating Partners**

D. Total Budget

Attachment 2:
Project Reporting Format

Date:

Project Title & Country/Region:
Time frame:
USAID Funding Unit:
Funding Level:
Pipeline:
CDC Contact Person:
Implementing Unit (Center/Division):

Project Description/Summary (mid-year and annual report):

[This is a brief description of the project and the goals to be achieved over the life of the project, which could ideally be taken from the original Scope of Work or work plan.]

Activities/Tasks Completed (mid-year and annual report):

[Discussion of the activities accomplished during the period. This is not intended to be an itemized list of all the tasks that were achieved, but should be something that directly relates back to the planned activities in the work plan.]

Results/Accomplishments (annual report and mid-year if appropriate):

[This should reflect the real results or impact of the project achieved over the past year and how these results contribute to achieving the long-term goals or strategy of the project. Documenting measurable results achieved is a key part of the annual report as these activities will be submitted in the annual Child Survival and Health Report to Congress. There may be less to report in the mid-year report, which might read more like a progress report.]

Challenges/Issues/Obstacles (mid-year and annual report):

[Discuss any problems/issues facing the project, how they will be addressed and if there is any role for USAID in addressing them. If necessary, this is a good place to explain why the tasks/activities defined in the work plan have not been achieved.]

Future Directions (annual report):

[This is a general and forward looking discussion regarding the next steps or future of the project (expansion, completion, modification, next logical steps). This is not a request for a work plan, but will provide information about the

activity as the agency prepares for the annual review of funded programs and starts the next fiscal planning cycle.]

Attachment 3:
CDC Project Manager Job Description

Public Health Advisor

I. INTRODUCTION

This position serves as the principle infectious diseases coordinator between United States Agency for International Development (USAID) and Centers for Disease Control and Prevention's (CDC) five centers that receive funds through an Interagency Agreement.

II. MAJOR DUTIES

Principle infectious diseases Interagency Agreement coordinator between United States Agency for International Development (USAID) and Centers for Disease Control and Prevention. 100%

- Management, consultation, and evaluation of USAID/CDC's Infectious Diseases agreement.
- Establish and maintain administrative controls, management information systems, policies and guidelines concerning the coordination with USAID Washington headquarters, USAID missions and CDC Project Officers in the effective overall management of USAID's Infectious Diseases agreement.
- Establishing policies; planning and implementing projects and program activities; participating with (USAID) Team Leaders and (CDC) Project Officers in the plans to carry out the collaborative activities in support of strategy and program development, implementation, operations research, training, monitoring and evaluation of maternal health, child health, HIV/AIDS, and infectious diseases activities undertaken by USAID.
- Facilitate and coordinate the daily management and administrative operations of USAID/CDC's Infectious Diseases agreement and serve as the principal management contact for staff on all program activities.
- Provide guidance and direction to all staff and outside program collaborators on the organization and management of the agreement that is consistent with CDC policies and guidelines.
- Coordinate all CDC reports and the annual work plans pertaining to this infectious disease agreement.