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: GHN-T-00-06-00001
3. Resource Code: 4100800	4. Activity Name: CDC IAA
5. Fund Account/Symbol (see page 2)	6. Fiscal Year: 2007
7. Completion Date: September 30, 2011	8. Original ____or Amendment No. _2_

9A. Prior Funding	9B. Funding Obligated this Document	9C. New Total Funding
$12,970,031	$3,136,676	$16,106,707

10. Authority: Section 632(b) of the Foreign Assistance Act of 1961, as amended.

11. The purpose of this amendment is to modify USAID's interagency agreement with CDC to provide field support funding for this agreement in the amount of $3,136,676.

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:	13B. Signature by Authorized Representative:
CENTERS FOR DISEASE CONTROL AND PREVENTION	U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
BY: ______________________________	BY: ______________________________
NAME: Dr. Stephen Blount, MD	NAME: Gloria D. Steele
TITLE: Director Office of Global Health Office of the Director	TITLE: Senior Deputy Assistant Administrator Bureau for Global Health
DATE: ______________________________	DATE: ______________________________

14. This Interagency Agreement consists of this face sheet and the following items (if checked):

_X_ Revised Schedule
_X_ Annex A – Program Description
_X_ Annex B - Revised Financial Plan and Budget
__ Annex C - Standard Provisions

ACCOUNTING AND APPROPRIATION DATA SHEET
IAA with the Centers for Disease Control and Prevention
Award No. GHN-T-00-06-00001-02

A. GENERAL

1.	Total Estimated Cost:	$ 100,000,000
2.	Total Amount Obligated prior to Action:	$ 12,970,031
3.	Total Amount Obligated this Action:	$ 3,136,676
4.	Total Amount Obligated	$ 16,106,707
5.	Project Number:	936-3100
6.	USAID Project Officer:	Angela Weaver GH/HIDN/MCH 3.07-027, 3rd Floor, RRB Washington, DC 20523-3700

B. SPECIFIC

1.	NMS/Phoenix Request Number:	1932
2.	Organizational Symbol:	GH/HIDN/ID
3.	Resource Category Code:	4100800
4.	Activity Name:	Umbrella CDC IAA
5.	Fund Account/ Allotment Symbols:	
6.	Total Obligation Amount:	$ 3,136,676

ACTION MEMORANDUM

TO: SDAA/GH, Gloria D. Steele

FROM: GH/HIDN, Richard Greene

SUBJECT: Amendment 1 of Interagency Agreement (IAA) No. GHN-T-00-06-00001, between USAID and the Centers for Disease Control and Prevention (CDC), under the Infectious Disease Activity Approval Document (ID AAD) 936-3100

ISSUE FOR DECISION

Your approval is needed for an amendment to the subject IAA between USAID and the CDC to:

1. Provide Mission and Core funding for this agreement in the amount of $1,830,300;
2. Clarify management of the IAA and funds release, and
3. Clarify financial accountability requirements for USG activities with host governments and NGOs funded under this agreement.

ESSENTIAL FACTORS

Background: In 2006, the Office of Health, Infectious Diseases and Nutrition (HIDN) entered into a new Interagency Agreement with the CDC to provide appropriate and responsive technical assistance in the analysis, planning, development, and evaluation of many disease control, research, and health service delivery activities that are supported by HIDN, USAID missions, and regional bureaus.

This flexible mechanism allows USAID to access to CDC's internationally recognized expertise in order to:

- Carry out collaborative activities in support of project development, monitoring, and evaluation of host country health activities, and

- Conduct studies, assessments, evaluations, and other research activities at the request of USAID to assist in planning and formulating its health programs and otherwise assist it in implementing USAID strategic objectives.

The total estimated cost of this IAA is $100,000,000. Total amount obligated to date is $11,139,731. The amount to be obligated with this action is $1,830,300. The total amount now obligated to this IAA is $12,970,031.

Discussion: USAID is providing incremental funding to CDC for the following activities:

- USAID/GH - $1,102,220 will be used to fund the President's Malaria Initiative (PMI) activities in the fifteen PMI focus countries;

- USAID/Malawi - $478,080 will be used to fund PMI activities in Malawi;

- USAID/Cambodia - $200,000 will be used for Tuberculosis and HIV prevention and control in Cambodia, and

- USAID/Philippines - $50,000 will be used to strengthen the Tuberculosis Control Program in the Philippines.

This amendment includes revisions to the Schedule of the original agreement, including:

- Addition of Section H.8 of the Schedule, which includes financial accountability requirements for USG activities with host governments funded under this agreement, and

- Amendment of Section H.4.c of the Schedule to include the definition and terms of pass through funding.

Authority: Pursuant to the GH Delegations of Authority under ADS Section 103.3.16.1, paragraph g, the Senior Deputy Assistant Administrator has the authority to negotiate, execute, and amend 632(b) interagency agreements.

RECOMMENDATION

That you approve the attached Amendment No. 1 to the CDC IAA by signing the attached IAA Face Sheets.

Attachments:

1. IAA Face Sheet (5 Originals)
2. Annex A: Program Description
3. Annex B: FY 07 Financial Plan and Budget
4. Revised Schedule

CLEARANCE PAGE FOR ACTION MEMORANDUM requesting a decision on Amendment # 1 of the CDC IAA.

GH/HIDN/ID, IKoek_______________________________Date_____________
GH/HIDN, EFox___________________________________Date_____________
GH/HIDN, JIce____________________________________Date_____________
GH/GC, CRyder___________________________________Date_____________
DAA/GH, MMiller_________________________________Date_____________
GH/SPBO, LWhite_________________________________Date_____________

P:\GH.SHARED\HIDN Program Staff docs & guidance\Scott Torres\2006 CDC IAA\Amendment 1\CDC IAA Umbrella Amendment

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 07.

Component (by funding source)	**Implementing Unit**	**Budget ($)**
USAID/GH – Malaria PMI	NCZVED/DPD/MB	1,102,220
USAID/Malawi MAARD	NCZVED/DPD/MB	371,830
USAID/Malawi MAARD	NCZVED/DPD/MB	106,250
USAID/Cambodia MAARD	NCHHSTP/DTBE	200,000
USAID/Philippines MAARD	NCHHSTP/DTBE	50,000
	TOTAL:	**$ 1,830,300**

Annex A:
Program Description

Section I: **Global Bureau Funds**
Global Health Bureau—PMI Funds……………………………page 3

Section II: **MAARDS**
Malawi………………………………………………………………page 5
Cambodia…………………………………………………………...page 18
Philippines………………………………………………………..page 24

Section I:

GLOBAL BUREAU FUNDS

Country/Region: Global Health Bureau
Title Describing the Activity: President's Malaria Initiative Activities
Center/Division and Project Officer at CDC the activity was negotiated with:
NCZVED/DPD/MB David Gittleman, Richard Kahn
Bureau or Mission contact following the activity: Irene Koek
Amount, type and year of funds to be obligated: $1,102,220
Time Frame if appropriate:

CDC is one of USAID's key partners in the President's Malaria Initiative (PMI). As part of this Initiative, USAID will fund the staffing, administration, management, and technical assistance costs associated with the implementation of the PMI in its fifteen focus countries in FY07.

USAID will specifically fund the following trips and staffing costs:

ACTIVITY	COST
Staffing costs:	
Salaries and other associated staffing costs for headquarter staff	$703,000
General HQR Travel:	
Angola Field Support visit	$10,000
Angola Field Assignee visit	$20,000
Tanzania Field Assignee visit	$12,000
PMI USAID liaison TDY	$22,000
WHO AFRO Meeting	$16,000
16 two-week TDYs for PMI assessment visits in the eight FY08 focus countries	$128,000
Overhead @20.99%	$191,200
Total	**$1,102,220**

Unless otherwise agreed, prior approval is required from the CTO for any changes or substitutions in the above line items.

Section II:

MAARDS

Malawi
Cambodia
Philippines

Country/Region: Malawi
Title Describing the Activity: Malaria Activities
Center/Division and Project Officer at CDC the activity was negotiated with (need both Center/Division and name of contact): NCZVED/DPD/MB, Richard Khan (Atlanta) and Carl H. Campbell (Malawi)
Bureau or Mission contact following the activity: USAID/Malawi, Catherine Chiphazi
Amount, type and year of funds to be obligated: $478,080
Time Frame if appropriate: One Year

CDC Malaria Malawi Programme Overview

Work-plan Activities:

1) Support policy and guideline development and revisions, and scale-up of interventions:

   Provides support for policy dialogue, guideline review, and writer-editor support – for ITN, IPT, and Case Management interventions and entomology. Includes synergy opportunities with other programs.

2) Dissemination and technical assistance including Monitoring and Evaluation activities and Technical Work Group (TWG) support.

   Provides support for indicator household survey in 6 sentinel districts and ongoing TA, dissemination, and TWG support. Follow-up survey in 6 Districts at the household level to assess ITN coverage of under 5 children and pregnant women (biomarkers are collected) – Evaluation of WHO and MERG recommendation of using anaemia as a marker for malaria.

3) Drug Quality Surveillance – through sentinel district sites

   Protocol will be developed and implemented with Ministry and PMPB to a) document quality of drugs in formal and informal channels, b) strengthen drug QA/QC system.

4) Rapid Malaria Tests Evaluation – through sentinel sites

   Provide support to the operations research priority of the NMCP. A protocol is being developed and will be implemented upon approval of review bodies. The major purpose is to assess the use of RDTs for case management activities in health centers and community case management and survey impact activities.

5) Communication Strategy Implementation Guidance and Evaluation

   The Communication Strategy for NMCP was developed with funding and TA from USAID and CDC and was implemented in 2006. This will provide support to

NMCP to assist in implementation guidance and evaluation. Drug Change Plan materials development needs are included as a priority activity.

6) Facility-based and community surveillance strengthening for measuring impact

   Data collection system strengthening in designated sentinel districts for measuring impact of the rapid, nationwide, scale-up of interventions for impact (SUFI). Includes use of village/community registries.

7) Entomology M & E Activities with MoH.

   Project activities include a) vector assessments, b) ongoing evaluation of ITNs, both conventional and long-lasting in sentinel areas, c) insecticide resistance monitoring in sentinel areas, and d) insectary development planning for Lilongwe and Blantyre.

   A protocol and plan is being developed for approval by CDC, USAID, COM/MAC, and MoH before activities are implemented

8) Participation in COM/MAC and MoH training programs (MPH, entomology, etc.)

   Includes course participation and mentoring and supervision of students.

9) Drug Change Plan Implementation – materials development and training guidance.

   Provide support to NMCP for material development for guidance and training for implementation of new first-line malaria therapy change.

10) EPI-ITN Project in four (4) Districts.

   The goals are to increase coverage of primary vaccine coverage in children and increase ITN coverage and use for children and pregnant women. Long-lasting ITNs are provided at ANC and at EPI venues at 100% subsidy.

Cooperative Agreements (CoAg):

1) Develop a Cooperative Agreement with the MoH/NMCP and have it in place by 01 October 2007 for use during PMI implementation. (see #3 below)

2) The current project period for the Cooperative Agreement with the University of Malawi/College of Medicine ends 29 September 2009. Hopefully, this partnership linking the College, the Ministry of Health, CDC and USAID will continue. See goals and objectives of this partnership in the CoAg document

3) The CoAg and the process for developing it will follow the requirements defined in the revised Section H.8 of the IAA Schedule, Financial Accountability Requirements for USG Activities with Host Governments, including:

a. The conduct of a pre-award survey or audit for any host government entity to receive grant funding under the IAA, consistent with Circular A-110 and *Guidelines For Financial Audits Contracted by Foreign Recipients*; and conducted in consultation with the USAID Regional Inspector General;

b. Based on the pre-award audit, USAID will approve the scope and nature of any grants to be made to a host government entity;

c. USAID shall review and clear all agreements (or amendments or funding increases) to be entered into between host governments and CDC involving services or funds to be provided under the IAA. (See Section H.8 for further requirements)

Country/Region: Cambodia
Title Describing the Activity: Tuberculosis and HIV Prevention and Control in Cambodia
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells
Bureau or Mission contact following the activity: USAID/Cambodia – Jonathon Ross
Amount, type and year of funds to be obligated: $200,000
Time Frame if appropriate: One Year

USAID Cambodia
SO: Increased Use of High Impact HIV/AIDS and Family Health Services and Appropriate Health Seeking Behaviors

Proposal from the Centers for Disease Control and Prevention (CDC) to Improve Tuberculosis and HIV Prevention and Control in Cambodia

Cambodia ranks among the poorest countries in the world. It has the highest infant, child and maternal mortality rates in Asia, and faces the most serious HIV/AIDS epidemic in the region. Since October 2003, CDC has collaborated with the Banteay Meanchay Provincial Health Department and Cambodia Ministry of Health to implement TB/HIV collaborative activities in Banteay Meanchay province, Cambodia.

Banteay Meanchay is a province located on the Thailand border. It has one of the highest rates of HIV in the country, with an HIV prevalence of 4.4% among pregnant women. Cambodia is also one of the 22 high-burden TB countries and has an estimated TB rate of 585/100,000 in 2001. TB is a major cause of morbidity and mortality in Banteay Meanchey, particularly among HIV-infected persons. The province has very limited HIV/AIDS care services available. HIV-infected persons can either receive care through a private clinic or through a non-governmental organization (NGO). Major limitations to the NGO-based system include: (1) significant portions of the province, are not covered; (2) no strong referral system exists so patients must know about the services available in their area in order to access home-based care; (3) no NGOs provide anti-retroviral therapy (ART).

In February and March 2005, we evaluated the TB/HIV pilot project in Banteay Meanchay to determine the current status of the project and to determine what improvements should be made. We identified 959 persons diagnosed with TB from October 2003 through February 2005 at the participating TB clinics. Of these, 216 were known to be HIV-infected either because of a prior HIV diagnosis or because of referral by the TB program to voluntary HIV counseling and testing (VCT). During TB treatment, the death rate among HIV-infected TB patients was substantially higher among HIV-infected TB patients (22%) than among HIV-uninfected TB patients (5%). One way to reduce mortality among HIV-infected patients would be diagnose TB earlier. By actively referring newly diagnosed HIV patients from VCT to the TB program, CDC and the PHD are working to overcoming the programmatic barriers to early diagnosis. From October 2003 – February 2005, 45% of persons newly diagnosed with HIV received TB screening. As a result of the programmatic evaluation, the PHD has now implemented activities which will likely

increase these referral rates substantially. Unfortunately, programmatic efforts can only address the *quantity* of TB screening performed. The *quality* of TB screening remains a major barrier that needs to be addressed. Globally, at least 50% of HIV-infected TB patients have smear-negative or extra-pulmonary TB; many sites in Banteay Meanchey, such as Poipet, have very low rates of smear-negative or extra-pulmonary TB, suggesting that there is under-diagnosis of TB in HIV-infected patients. Preliminary data from a project in Battambang reveal the extent of the problem: of 20 patients with sputum cultures positive for TB, only 6 (30%) were smear-positive; the other 14 (70%) of patients would be missed by current screening methods. Improving TB diagnostic capacity in Banteay Meanchey could identify these cases of TB missed by current screening methods, reducing TB morbidity, mortality, and transmission.

We found that one barrier to screening HIV patients for TB is that patients perceived TB testing as a service separate from HIV/AIDS care; they viewed TB screening as a distraction from the larger issue of HIV/AIDS care. Similarly, we found that TB programs need to work harder to link patients to HIV/AIDS care and to monitor the progress of such initiatives. For example, we could only verify that about 50% of HIV-infected TB patients were actually receiving HIV/AIDS care, including co-trimoxazole preventive therapy. One model for improving the linkage between TB and HIV programs for newly identified patients is to have HIV/AIDS outpatient clinics operating five days per week at several locations within the province. Patients diagnosed with HIV at a VCCT site are immediately referred to the nearest HIV/AIDS outpatient clinic where they receive counseling, OI prophylaxis, TB screening, and an evaluation for ART. One such model exists in Battambang, where 85-95% of patients diagnosed with HIV at a VCCT in Battambang province receive appropriate OI prophylaxis and TB screening because they are immediately entered into the HIV/AIDS outpatient clinic after diagnosis.

The proposed activities that will be conducted by CDC under this strategic objective will focus on strengthening and expanding Cambodia's efforts to address the country's TB and HIV epidemics. These include:

(1) <u>Training of TB and HIV clinical staff</u> – Developing a comprehensive HIV/AIDS care system in Banteay Meanchey requires building the capacity of existing clinical staff to diagnose and treat TB and other HIV-associated diseases adequately. We propose to train both TB and HIV clinical staff to increase understanding of: (a) how to diagnose TB in HIV-infected patients, including extra-pulmonary and smear-negative TB, (b) when and how to administer OI prophylaxis (e.g., cotrimoxazole preventive therapy) and anti-retroviral therapy in HIV-infected TB patients, (c) the existing TB/HIV referral network and strategies to improve it, (d) the importance of linking patients to social, behavioral, and medical services provided by NGOs. A key outcome of this training will be commitment from all clinical staff to strengthen the existing referral network and to adopt a case-management (i.e., patient-centered) approach to managing patients with HIV-infection, particularly those at highest risk of death, such as HIV-infected TB patients.

(2) Development of a case management model for newly-infected HIV patients to insure linkages to core services, such as TB screening and co-trimoxazole preventive therapy – Improving care for HIV-infected patients starts with insuring that the health system focuses on individual patients receiving the range of services essential to their health. We propose to develop weekly case management meetings attended by TB and HIV clinical and program staff, including physicians, nurses, and counselors. In these meetings, staff will review records of all newly diagnosed HIV patients to insure that these patients have been linked to core services, such as screening for TB, co-trimoxazole preventive therapy, and home-based care. For patients who did not receive these services, staff will review barriers and identify potential solutions. Staff will also review the summary TB/HIV monitoring and evaluation data from the PHD and review how their healthcare facilities are performing compared with other facilities in the province.

(3) Development of evidence-based clinical guidelines for TB screening of HIV-infected patients – Improving TB diagnostic services will be challenging. Because conventional sputum smears have limited sensitivity for the diagnosis of TB in HIV-infected patients, more sophisticated testing is needed to diagnose TB accurately. Such testing could include: fluorescent microscopy; sputum culture; urine culture; blood culture; and lymph node aspiration for smear and culture. Such tests cannot be performed in Banteay Meanchey at this time, but capacity could be developed in the future if there was sufficient evidence to justify the need for some of these tests. We propose, therefore, to conduct a short-term enhancement of TB diagnostic capacity to evaluate which diagnostic tests increase the yield of TB diagnosis in HIV-infected persons living in Banteay Meanchey. This project would build on the training and case-management components of this project. For a short-time (likely a 3-5 month period), TB and HIV clinical staff would perform a 'gold-standard' diagnostic work-up during the TB screening evaluation of newly diagnosed HIV patients. This 'gold-standard' work-up would involve collecting sputum, blood, urine, and lymph node specimens from newly diagnosed HIV patients, transporting these specimens to a reference laboratory in Phnom Penh for analysis, using the results for patient decision-making, and then evaluating the results of this process to determine which tests were timely, high-yield, feasible, clinically important, and cost-effective. The major outcome of this process would be evidence-based clinical guidelines for TB screening of HIV-infected patients. We would also use this data to make major programmatic decisions about how to improve TB diagnostic capacity in Banteay Meanchey, building local capacity for those tests found to be most useful, feasible, and cost-effective.

Overall cost estimate: $200,000

Country/Region: Philippines
Title Describing the Activity: Strengthening TB Control Program in the Philippines
Center/Division and Project Officer at CDC the activity was negotiated with: NCHHSTP/DTBE, Charles Wells
Bureau or Mission contact following the activity: USAID/Philippines, Cora Manolato
Amount, type and year of funds to be obligated: $50,000
Time Frame if appropriate: One Year

Background

The Philippines has the 9th highest burden of tuberculosis in the world and it is the sixth greatest cause of morbidity and mortality in the country. Approximately, 78 Filipinos die from the disease every day. According to the 1997 National Prevalence Survey (NPS), almost two thirds of the population is infected with the *Mycobacterium tuberculosis,* and the annual risk of TB infection was estimated to be 2.3% (Tupasi et al, 2000a).

Throughout the last decade, the Government of the Philippines has intensified their efforts to prevent and control TB. In 1996, the CRUSH TB (Collaboration in Rural and Urban Sites to Halt TB) Program was piloted in lloilo City, Antique and Batangas. This pilot was based on the DOTS strategy that resulted in its expansion nationwide. The Department of Health confirmed their commitment for DOTS by announcing the TB Control Program as the number one health priority for the decentralized Local Government Units (LGUs) in 1998. Despite the rapid decentralization process, the National TB Program (NTP) remained intact and the disease remains a priority at the lower levels. The NTP provides policy, technical guidance, and monitoring of the program to the LGUs as well as the provision of anti-TB drugs and other supplies.

The private sector's involvement in TB control has increased in the past 5 years due to a number of private initiatives on public-private mix DOTS (PPMD). Currently, the DOH/NTP, being part of Philippine Coalition Against Tuberculosis (PHILCAT), is engaging the private sector involvement in the DOTS strategy by conducting a series of training workshops for private physicians to educate them about DOTS, and to encourage referral of TB patients to public health centers and PPMD centers. All PPMDs are supported with free anti-TB drugs supply by the DOH.

USAID has been supporting TB prevention and control activities for the past seven years. In support of the National Tuberculosis Program (NTP), USAID efforts have been at the forefront of engaging the various sectors in TB-DOTS. USAID supported the Infectious Disease Surveillance and Control Program (IDSCP) which expanded DOTS in three regions, i.e. Cordillera Autonomous Region, Region VII and Region XII. Through the USAID Philippine Tuberculosis Initiatives for the Private Sector (PhilTIPS) program, 30 PPMDs clinics have been set up to demonstrate that profit-oriented private clinics can be tapped in TB control. PhilTIPS followed a multi-pronged approach to engaging the private sector in TB control. The approach includes support to TB policy reform and TB care financing; operations research; TB services expansion in the private sector through grants and technical assistance to health facilities (clinics, hospitals, HMOs, workplaces); training of physicians and those in allied health professions; certification; communications; and, support to informed decision-making. The USAID Local

communications; and, support to informed decision-making. The USAID Local Enhancement and Development (LEAD) for Health Program provided technical assistance to LGUs to enhance the governance, financing and service delivery of TB-DOTS at the 10calleveI. LEAD and the Enhanced and Rapid Improvement of Community Health (EnRICH) Project, another USAID supported program, further strengthen LGU capacity and other community-based initiatives in TB control in the ARMM. National-level partnerships and organizations involved in TB control like the Program Assistance to Control TB (PACT) and PhilCAT have also received USAID grants and technical assistance to enhance their institutional capacity.

The Philippine Department of Health has been successful in securing two TB grants from the Global Fund to fight AIDS, TB and Malaria (Global Fund or GFATM), in Round 2 in 2003 and recently approved Round 5. Private-public mixed DOTS (PPMD) became a major strategy under Round two of the GF A TM following external evaluations that stated that there was substantial additionality in case detection and satisfactory case holding. These grants have allowed the government to pilot and expand public and private TB control models.

Availability of over-the-counter anti-tuberculosis drugs and self-medication by patients has been contributing to the emergence ofMDR-TB in the Philippines. The latest published data of MDR-TB among new TB patients was 1.5% and 14.3% in previously treated patients with a combined rate of 4.3% (Rivera et al1999). Based on mathematical modeling, the estimated number of new MDR-TB cases was 7,742 with an estimated 3.2% new cases in 2000 (Dye et aI., 2002) and an estimated prevalence of MDR TB around 26,000 cases (Tupasi et aI., 2003). A nationwide drug resistance survey was undertaken in 2004 with the support of WHO and JICA by the National TB Reference Laboratory with the establishment of culture centers in five regions of the country. Preliminary results show a rate of 4.5% among new cases and 21 % in previously treated cases (Philippines Global Fund Proposal Round 5).Currently treatment of MDR- TB is only available to a limited number of patients, mostly those living in Metro-Manila.

According to the 1997 National Prevalence Survey, the prevalence ofTB infection in the 0-4 year old age group was found to be 6.9% while the 5-9 age group increased to 16%. Annually, it can be estimated that 1,500,000 children are infected with TB in the Philippines whereas 40,000 will develop the disease. In 2004, the NTP partnered with World Vision to create guidelines for administering treatment. In early 2006, the program was piloted in one city per province empowering 20-30 health professionals. Phase two is envisioned to take place in 2007 following a review of "lessons learned". DOH has enlarged the scope of TB control to include TB in children. All of these initiatives are now reflected in the updated NTP Operations Manual.

A new TB initiative funded under a USAID RFA is planned to be in place by October 2006 for a five-year cooperative agreement to assist the Philippines prevent and control TB as well as address critical issues on emerging and re-emerging infectious diseases including MDR-TB. The new intiative is a follow on project to provide technical assistance to the National TB program in promoting access to appropriate treatment

services and improving the quality and coverage of prevention and control efforts through public and private sector programs.

USAID has a longstanding history of partnership with US Centres for Disease Control (US CDC) in TB control efforts worldwide. CDC also has extensive experience in the Philippines, particularly in emerging priorities such as multi-drug resistance and laboratory services. Their expertise would be a valuable contribution to the start-up and development of the five year strategic plan of the forthcoming USAID TB project.

II. GOAL

The present scope of work is to mobilize technical expertise from the US CDC in developing USAID's TB program activities that would strengthen the GRP's National TB control program.

III. SPECIFIC OBJECTNES

Specifically, the SOW is to provide technical assistance services and advisory support for the implementation of the Mission' new TB Project and related TB initiatives. USAID would like to draw from CDC's expertise to ensure that the new TB project is well-designed and appropriately focused from inception and to make certain that implementation gets off to a good start. Approximately 8 person weeks of consultants' services will be required to assist in the development of the five year strategy work plan and year one Activity Work Plan for the new USAID-funded TB Project, to help strengthen the capacity to deliver TB DOTS, DOTS-plus, pediatric TB services, and provide periodic monitoring of project activity once the new TB project gets under way.

In addition, USAID requests assistance to refine TB activities under the Mission's new TB initiatives, including TB initiatives under the new ARMM Health Project, Health Sector Development Project, and the Health Promotion and Communications Project to ensure that the TB activities are coordinated and synchronized with the larger TB Project.

IV. REQUESTED SERVICES

The following tasks are expected:

1. In coordination with the DOH NTP, CDC will provide technical assistance to the development of the new Project's 5-year Strategic Work plan and the Year-l Activity Work plan for TB, including pediatric and MDR-TB.

2. Recommend, as needed, cost-effective TB interventions under the Mission's new projects, including the new ARMM Health, Health Sector Development Project, the Health Promotion and Communications Project within a joint implementation and coordination framework. In collaboration with the DOH/NTP, CDC will provide recommendations to fine-tune TB approaches and activities, in areas covering expansion of TB DOTS, TB/MDR-plus, and pediatric TB services.

3. Provide technical support in developing program activities on multi-drug resistant TB for the new TB project.

Two separate TDYs are envisaged. Task #1 and #2 will be conducted through the first TDY (on/about late November). This TDY will focus on the start up on the new USAID TB project. The second visit will be to fine-tune the project's plans to address multi-drug resistant TB in the Philippines and would take place in the first quarter of 2007.

V. EXPECTED OUTPUTS/DELIVERABLES

Two TDY trips are anticipated with. Expected deliverables include the following:

Trip reports for each trip which include detailed recommendations for USAID's new TB Project's 5-year Work plan and Year-l Activity Work plan will be due at USAID within 3 weeks after departure from the Philippines. These recommendations shall be formulated and shared with USAID and project partners during a debriefing prior to departing from the Philippines. In addition a draft trip report (or a briefing paper) will be shared with OPHN during the debriefing.

VI. PROJECT IMPLEMENTATION PLAN

This SOW will be implemented within approximately 12 months.

VII. PROPOSED BUDGET: Total: US$ 50,000