



**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.	<b>Total Obligation Amount:</b>	<b>\$ 11,139,731</b>
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## **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

08/18/2006

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:**

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## **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
<b>TOTAL</b>		<b>\$300,000</b>

## 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 2<sup>nd</sup> or 3<sup>rd</sup> 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
<b>Total</b>	<b>\$376,000</b>	<b>\$311,500</b>	<b>\$312,000</b>	<b>\$162,500</b>

**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.

<b>DOTS Expansion and NTP Capacity Building</b>		
1. Assignee at IUATLD	500,000	
<b>TOTAL</b>		<b>\$500,000</b>

**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:**

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**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

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## **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***

<b>Country</b>	<b>Amount</b>
Ghana	\$125,000
Kenya	\$125,000
Uganda	\$125,000
Zimbabwe	\$125,000
<b>Total</b>	<b>\$500,000</b>

**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***

	<b>Amount</b>
AFENET operational support	\$250,000
<b>Total</b>	<b>\$250,000</b>

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***

	<b>Amount</b>
AFENET	\$250,000
FETPs	\$500,000
CDC overhead (20%)	\$150,000
<b>Total</b>	<b>\$900,000</b>

**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:**

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## **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)

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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

<b>Category</b>	<b>FY 2006 request</b>
Technical Assistance	\$ 39,000.00
<i>OGH overhead @ 4%</i>	\$ 1,560.00
<i>DPD overhead @ 10%</i>	\$ 3,900.00
<i>CDC overhead @ 9%</i>	\$ 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
<i>OGH overhead @ 4%</i>	\$ 5,920.00
<i>DPD overhead @ 10%</i>	\$ 14,799.00
<i>CDC overhead @ 9%</i>	\$ 13,319.00
Sub-total direct and indirect costs	\$182,030.00
Total Direct Costs	\$186,992.00
Total Indirect Costs	\$ 43,008.00
<b>Total Requested</b>	<b>\$230,000.00</b>

**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

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## **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***

<b>Country</b>	<b>Amount</b>
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
<b>Total</b>	<b>\$100,000</b>

**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

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**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 recommendations 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 gonorrhoeae* antimicrobial susceptibility, ii) evaluating GUD etiology, iii) development of sentinel surveillance for syphilis serology as it relates to the prevention of congenital syphilis, iv) 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.





























































































































































**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.

<u>Component (by funding source)</u>	<u>Implementing Unit</u>	<u>Budget</u>
<i>I. Global Bureau</i>		
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
	<b>Global Bureau Total:</b>	<b>\$2,880,000</b>
<i>II. Regional Bureau and Mission Funds (Field Support)</i>		
<b>AFRICA</b>		
AFR/SD – IDSR	NCPDCID/DEISS	\$550,000
Madagascar	NCHHSTP/DSTD/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
<b>E&amp;E</b>		
Russia	NCHHSTP/DTBE	\$700,000
<b>ANE</b>		
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
	<b>Field Support Total:</b>	<b>\$7,755,000</b>
III. <i>Mission Funds (MAARDS)</i>		
Indonesia	NCZVED/DPD/MB	\$50,000
Mexico	NCHHSTP/DTBE	\$454,731
	<b>MAARD Total:</b>	<b>\$504,731</b>
	<b>TOTAL:</b>	<b>\$11,139,731</b>

## **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























