
Siobah Walsh
104 East 40th Street
Suite 903
New York, NY 10016

Subject: Cooperative Agreement No. GHS-A-00-06-00018-00

Dear Mr. Walsh:

Pursuant to the authority contained in the Foreign Assistance Act of 1961, as amended, the U.S. Agency for International Development (USAID) hereby awards to Concern Worldwide USA, Inc., hereinafter referred to as the "Recipient", the sum of $4,000,000.00 to provide support for a program in Rwanda as described in the Schedule of this award and in Attachment B, entitled "Program Description."

This Cooperative Agreement is effective and obligation is made as of the date of this letter and shall apply to expenditures made by the Recipient in furtherance of program objectives during the period beginning with the effective date September 30, 2006 and ending September 29, 2011. USAID will not be liable for reimbursing the Recipient for any costs in excess of the obligated amount.

This Cooperative Agreement is made to the Recipient on condition that the funds will be administered in accordance with the terms and conditions as set forth in Attachment A (the Schedule), Attachment B (the Program Description), and Attachment C (the Standard Provisions), all of which have been agreed to by your organization.

Please sign the original and all enclosed copies of this letter to acknowledge your receipt of the Cooperative Agreement, and return the original and all but one copy to the Agreement Officer.

Sincerely yours,

Bruce Baltas
Agreement Officer

Attachments:
- A. Schedule
- B. Program Description
- C. Standard Provisions

ACKNOWLEDGED:

BY: _____
TITLE: _____
DATE: _____

**A. GENERAL**

| | | |
|---|---|---|
| 1. Total Estimated USAID Amount | : | $4,000,000.00 |
| 2. Total Obligated USAID Amount | : | $ 950,000.00 |
| 3. Cost-Sharing Amount (Non-Federal) | : | $2,043,341.00 |
| 4. Total Program Cost | : | $6,043,341.00 |
| 5. Activity Title | : | "UMUSANZA For The Children" |
| 6. USAID Technical Office | : | GH/HIDN |
| 7. Tax I.D. Number | : | 13-371-2030 |
| 8. DUNS No. | : | 878388424 |
| 9. LOC Number | : | HHS-A1331P1 |

**B. SPECIFIC**

| | | |
|---|---|---|
| Commitment Document Type | : | PR |
| Commitment Number | : | GH/HIDN/10682 |
| BBFY | : | 2006 |
| EBFY | : | 2007 |
| Fund | : | CD |
| OP Unit | : | GH/HIDN |
| Strategic Objective | : | 936-003 |
| Distribution | : | 936-3114 |
| BGA | : | 696 |
| SOC | : | 410000 |
| Amount | : | $950,000.00 |

**C. PAYMENT OFFICE**

USAID
Office of the Chief Financial Officer
M/CFO/CMP, RRB 7th floor
1300 Pennsylvania Ave, NW
Washington, DC 20523

**TABLE OF CONTENTS**

## Attachment A

## SCHEDULE

### A.1 PURPOSE OF COOPERATIVE AGREEMENT

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

### A.2 PERIOD OF COOPERATIVE AGREEMENT

The effective date of this Cooperative Agreement is September 30, 2006. The estimated completion date of this Cooperative Agreement is September 29, 2011.

### A.3 AMOUNT OF COOPERATIVE AGREEMENT AND PAYMENT

1. The total estimated amount of this Cooperative Agreement for the period shown in A.2 above is $4,000,000.00.

2. USAID hereby obligates the amount of $950,000.00 for program expenditures during the period set forth in A.2 above and as shown in the Budget below. The Recipient will be given written notice by the Agreement Officer if additional funds will be added. USAID is not obligated to reimburse the Recipient for the expenditure of amounts in excess of the total obligated amount.

3. Payment will be made to the Recipient by Letter of Credit in accordance with procedures set forth in 22 CFR 226.

4. Incremental funds up to the total amount of the Agreement shown in A.3.1 above may be obligated by USAID subject to the availability of funds, satisfactory progress of the program, and continued relevance to USAID program objectives.

### A.4 COOPERATIVE AGREEMENT BUDGET

The following is the Agreement Budget. Revisions to this budget shall be made in accordance with 22 CFR 226.

Budget
September 30, 2006- September 29, 2011

| Cost Line Item | Amount |
|---|---|
| Child Survival Program in Rwanda | $4,000,000.00 |
| Recipient Cost Share | $2,043,341.00 |
| TOTAL ESTIMATED PROGRAM AMOUNT: | $6,043,341.00 |

## A.5 REPORTING AND EVALUATION

1. **Financial Reporting**

In accordance with 22 CFR 226.52, the SF 269 and SF 272 will be required on a quarterly basis. The recipient shall submit these forms in the following manner:

(1) The SF 272 and 272a (if necessary) must be submitted via electronic format to the U.S. Department of Health and Human Services (http://www.dpm.psc.gov). A copy of this form shall also be submitted at the same time to the Cognizant Technical Officer (CTO).

(2) The SF 269 or 269a (as appropriate) shall be submitted to the CTO.

(3) In accordance with 22 CFR 226.70-72, the original and two copies of all final financial reports shall be submitted to M/CFO and the CTO. The electronic version of the final SF 272 or 272a shall be submitted to HHS in accordance with paragraph (1) above.

2. **Program Reporting**

a) The recipient shall submit an original and one copy of a performance report to the CTO and the USAID Mission CSHGP contact. The performance reports are required to be submitted annually to the CTO and the USAID Mission CSHGP contact, within 30 days after the end of each project year (by October 31). Annual Reports are not required for those years when a mid-term evaluation or final report/evaluation are submitted. The Annual Report shall contain the information as set forth in 22 CFR 226.51(d) and in accordance with the CSHGP Annual Report Guidelines. These guidelines can be accessed at: http://www.usaid.gov/our_work/global_health/home/Funding/cs_grants/guidelines.html

b) In addition, one copy should be submitted to:

USAID/PPC/DEI/DIS
Attn: Sharon Sadler
Rm. 6.07-086, RRB
1300 Pennsylvania Avenue, NW
Washington, DC 20523

c) Mid-term evaluations: The recipient shall follow the Evaluation Plan content and the schedule presented in the approved Detailed Implementation Plan (DIP). The Mid-term Evaluation Report shall contain information according to the CSHGP Mid-term Evaluation Guidelines available at http://www.usaid.gov/our_work/global_health/home/Funding/cs_grants/gui

delines.html. The Recipient shall submit within 30 days after the project year (by October 31) the original report and one copy to the USAID CTO, one copy to USAID Mission CSHGP contact, and one copy to the USAID Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910, USA (or email: docsubmit@dec.cdie.org).

3. **Final Report**

a) The Recipient shall submit within 90 days after the expiration or termination of the award, the original and one copy of the final report, including the final evaluation, to the USAID CTO, the USAID Mission CSHGP contact, the Agreement Officer, and one copy to the USAID Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910, USA (or email: docsubmit@dec.cdie.org).

b) The final performance report shall briefly contain information set forth in 22 CFR 226.51(d) as well as in the CSHGP Final Evaluation Guidelines available at: http://www.usaid.gov/our_work/global_health/home/Funding/cs_grants/guidelines.html

## A.6 INDIRECT COST RATE

Pending establishment of revised provisional or final indirect cost rates, allowable indirect costs shall be reimbursed on the basis of the following negotiated provisional or predetermined rates and the appropriate bases:

| Description | Rate | Base | Type | Period |
|---|---|---|---|---|
| Overhead | 9.49% | 1 | Provisional | 01-01-05 |

1 Base of Application: Total direct program costs (including fundraising costs), excluding subcontracted services from Concern Worldwide, USA in excess of $100,000 per award per year and subrecipient awards of Concern Worldwide, USA in excess of $25,000 per award per year.

## A.7 TITLE TO PROPERTY

Property Title will be vested with the Cooperative Country.

## A.8 AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services under this award is 000.

## A.9 COST SHARING

The Recipient agrees to expend an amount not less than 34% or up to $2,043,341.00 of the total activity costs.

## A.10 SUBSTANTIAL INVOLVEMENT

Substantial involvement during the implementation of this Agreement shall be limited to approval of the elements listed below:

a) Approval of the Detailed Implementation Plan (DIP), submitted to USAID/GH/HIDN by April 16, 2007 and any subsequent revisions. GH/HIDN staff and technical specialists will review the DIP and meet with the recipient to discuss strengths and weaknesses. The DIP will provide a plan for the program, including plans for baseline and final surveys and collection of required indicators. Substantial changes resulting in any revisions to specific activities, locations, beneficiary population, international training costs, international travel, indirect cost elements, or the procurement plan may require a formal modification to the Agreement by the Agreement Officer. The approved DIP will supplement the initial Program Description in the Agreement and form part of the official documentation.

b) Approval of key personnel to include the following positions:

Headquarters Backstop
Field Program Manager
Mid-term Team Leader
Final Evaluation Team Leader

c) USAID involvement in monitoring progress toward the achievement of program objectives during the performance of this Agreement, include written guidelines for the contents of annual reports, and mid-term and final evaluations in accordance with ADS 303.5.11a(3).

## A.11 PROGRAM INCOME

The Recipient shall account for Program Income in accordance with 22 CFR 226.24 (or the Standard Provision entitled Program Income for non-U.S. organizations). Program Income earned under this award shall be added to the project.

## A.12 USAID DISABILITY POLICY (DEC 2004)

(a) The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and

implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website: http://www.usaid.gov/about/disability/DISABPOL.FIN.html.

(b) USAID therefore requires that the recipient not discriminate against people with disabilities in the implementation of USAID funded programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing the program under this grant or cooperative agreement. To that end and to the extent it can accomplish this goal within the scope of the program objectives, the recipient should demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

## A.13 EXECUTIVE ORDER ON TERRORISM FINANCING (FEB 2002)

The Contractor/Recipient is reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the responsibility of the contractor/recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts/subawards issued under this contract/agreement.

## A.14 FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES (JAN 2002)

Funds in this [agreement, amendment] may not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a public international organization, except as provided in ADS Mandatory Reference "Guidance on Funding Foreign Government Delegations to International Conferences" or as approved by the AO.

## Attachment B

## PROGRAM DESCRIPTION, BRANDING STRATEGY, AND MARKING PLAN

The Recipient's Program Description entitled UMUSANZA For The Children submitted in response to RFA M/OAA/GH/HSR-06-001, the Branding Strategy, and Marking Plan are hereby incorporated as Attachments to this award.

## ATTACHMENT C

## MANDATORY STANDARD PROVISIONS FOR U.S., NONGOVERNMENTAL ORGANIZATIONS

### *1. APPLICABILITY OF 22 CFR PART 226 (May 2005)*

a. All provisions of 22 CFR Part 226 and all Standard Provisions attached to this agreement are applicable to the recipient and to subrecipients which meet the definition of "Recipient" in Part 226, unless a section specifically excludes a subrecipient from coverage. The recipient shall assure that subrecipients have copies of all the attached standard provisions.

b. For any subawards made with Non-US subrecipients the Recipient shall include the applicable "Standard Provisions for Non-US Nongovernmental Recipients." Recipients are required to ensure compliance with monitoring procedures in accordance with OMB Circular A-133.

[END OF PROVISION]

### *2. INELIGIBLE COUNTRIES (MAY 1986)*

Unless otherwise approved by the USAID Agreement Officer, funds will only be expended for assistance to countries eligible for assistance under the Foreign Assistance Act of 1961, as amended, or under acts appropriating funds for foreign assistance.

[END OF PROVISION]

### *3. NONDISCRIMINATION (MAY 1986)*

(This provision is applicable when work under the cooperative agreement is performed in the U.S. or when employees are recruited in the U.S.)

No U.S. citizen or legal resident shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity funded by this award on the basis of race, color, national origin, age, handicap, or sex.

[END OF PROVISION]

### *4. NONLIABILITY (NOVEMBER 1985)*

USAID does not assume liability for any third party claims for damages arising out of this award.

[END OF PROVISION]

### *5. AMENDMENT (NOVEMBER 1985)*

The award may be amended by formal modifications to the basic award document or by means of an exchange of letters between the Agreement Officer and an appropriate official of the recipient.

[END OF PROVISION]

### *6. NOTICES (NOVEMBER 1985)*

Any notice given by USAID or the recipient shall be sufficient only if in writing and delivered in person, mailed, or cabled as follows:

To the USAID Agreement Officer, at the address specified in the award.

To recipient, at recipient's address shown in the award or to such other address designated within the award

Notices shall be effective when delivered in accordance with this provision, or on the effective date of the notice, whichever is later.

[END OF PROVISION]

### *7. NEGOTIATED INDIRECT COST RATES - PROVISIONAL (Nonprofit) (April 1998)*

**NEGOTIATED INDIRECT COST RATES - PROVISIONAL (Nonprofit) (April 1998)**

a. Provisional indirect cost rates shall be established for each of the recipient's accounting periods during the term of this award. Pending establishment of revised provisional or final rates, allowable indirect costs shall be reimbursed at the rates, on the bases, and for the periods shown in the schedule of the award.

b. Within the earlier of 30 days after receipt of the A-133 audit report or nine months after the end of the audit period, the recipient shall submit to the cognizant agency for audit the required OMB Circular A-133 audit report, proposed final indirect cost rates, and supporting cost data. If USAID is the cognizant agency or no cognizant agency has been designated, the recipient shall submit four copies of the audit report, along with the proposed final indirect cost rates and supporting cost data, to the Overhead, Special Costs, and Closeout Branch, Office or Procurement, USAID, Washington, DC 20523-7802. The proposed rates shall be based on the recipient's actual cost experience during that fiscal year. Negotiations of final indirect cost rates shall begin soon after receipt of the recipient's proposal.

c. Allowability of costs and acceptability of cost allocation methods shall be determined in accordance with the applicable cost principles.

d. The results of each negotiation shall be set forth in a written indirect cost rate agreement signed by both parties. Such agreement is automatically incorporated into this award and shall specify (1) the agreed upon final rates, (2) the bases to which the rates apply, (3) the fiscal year for which the rates apply, and (4) the items treated as direct costs. The agreement shall not change any monetary ceiling, award obligation, or specific cost allowance or disallowance provided for in this award.

e. Pending establishment of final indirect cost rate(s) for any fiscal year, the recipient shall be reimbursed either at negotiated provisional rates or at billing rates acceptable to the Agreement Officer, subject to appropriate adjustment when the final rates for the fiscal year are established. To prevent substantial overpayment or underpayment, the provisional or billing rates may be prospectively or retroactively revised by mutual agreement.

f. Failure by the parties to agree on final rates is a 22 CFR 226.90 dispute.

[END OF PROVISION]

### *8. SUBAGREEMENTS (June 1999)*

Subrecipients, subawardees, and contractors have no relationship with USAID under the terms of this agreement. All required USAID approvals must be directed through the recipient to USAID.

[END OF PROVISION]

### *9. OMB APPROVAL UNDER THE PAPERWORK REDUCTION ACT (December 2003)*

*Information collection requirements imposed by this cooperative agreement are covered by OMB approval number 0412-0510; the current expiration date is 04/30/2005. The Standard Provisions containing the requirement and an estimate of the public reporting burden (including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information) are

| Standard Provision | Burden Estimate |
|---|---|
| Air Travel and Transportation | 1 (hour) |
| Ocean Shipment of Goods | .5 |
| Patent Rights | .5 |
| Publications | .5 |
| Negotiated Indirect Cost Rates - (Predetermined and Provisional) | 1 |

| | |
|---|---|
| Voluntary Population Planning | .5 |
| Protection of the Individual as a Research Subject | 1 |

| 22 CFR 226 | Burden Estimate |
|---|---|
| 22 CFR 226.40-.49 Procurement of Goods and Services | 1 |
| 22 CFR 226.30 - .36 Property Standards | 1.5 |

Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, may be sent to the Office of Procurement, Policy Division (M/OP/P) U.S. Agency for International Development, Washington, DC 20523-7801 and to the Office of Management and Budget, Paperwork Reduction Project (0412-0510), Washington, D.C 20503.

[END OF PROVISION]

***10. USAID ELIGIBILITY RULES FOR GOODS AND SERVICES (April 1998)***

(This provision is not applicable to goods or services which the recipient provides with private funds as part of a cost-sharing requirement, or with Program Income generated under the award.)

a. Ineligible and Restricted Goods and Services: USAID's policy on ineligible and restricted goods and services is contained in ADS Chapter 312.

(1) Ineligible Goods and Services. Under no circumstances shall the recipient procure any of the following under this award:

(i) Military equipment,
(ii) Surveillance equipment,
(iii) Commodities and services for support of police or other law enforcement activities,
(iv) Abortion equipment and services,
(v) Luxury goods and gambling equipment, or
(vi) Weather modification equipment.

(2) Ineligible Suppliers. Funds provided under this award shall not be used to procure any goods or services furnished by any firms or individuals whose name appears on the "Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs." USAID will provide the recipient with a copy of these lists upon request.

(3) Restricted Goods. The recipient shall not procure any of the following goods and services without the prior approval of the Agreement Officer:

(i) Agricultural commodities,
(ii) Motor vehicles,
(iii) Pharmaceuticals,
(iv) Pesticides,
(v) Used equipment,
(vi) U.S. Government-owned excess property, or
(vii) Fertilizer.

Prior approval will be deemed to have been met when:

(i) the item is of U.S. source/origin;

(ii) the item has been identified and incorporated in the program description or schedule of the award (initial or revisions), or amendments to the award; and

(iii) the costs related to the item are incorporated in the approved budget of the award.

Where the item has not been incorporated into the award as described above, a separate written authorization from the Agreement Officer must be provided before the item is procured.

b. Source and Nationality: The eligibility rules for goods and services based on source and nationality are divided into two categories. One applies when the total procurement element during the life of the award is over $250,000, and the other applies when the total procurement element during the life of the award is not over $250,000, or the award is funded under the Development Fund for Africa (DFA) regardless of the amount. The total procurement element includes procurement of all goods (e.g., equipment, materials, supplies) and services. Guidance on the eligibility of specific goods or services may be obtained from the Agreement Officer. USAID policies and definitions on source, origin and nationality are contained in 22 CFR Part 228, Rules on Source, Origin and Nationality for Commodities and Services Financed by the Agency for International Development, which is incorporated into this Award in its entirety.

(1) For DFA funded awards or when the total procurement element during the life of this award is valued at $250,000 or less, the following rules apply:

(i) The authorized source for procurement of all goods and services to be reimbursed under the award is USAID Geographic Code 935, "Special Free World," and such goods and services must meet the source, origin

and nationality requirements set forth in 22 CFR Part 228 in accordance with the following order of preference:

(A) The United States (USAID Geographic Code 000),
(B) The Cooperating Country,
(C) USAID Geographic Code 941, and
(D) USAID Geographic Code 935.

(ii) Application of order of preference: When the recipient procures goods and services from other than U.S. sources, under the order of preference in paragraph (b)(1)(i) above, the recipient shall document its files to justify each such instance. The documentation shall set forth the circumstances surrounding the procurement and shall be based on one or more of the following reasons, which will be set forth in the Recipient's documentation:

(A) The procurement was of an emergency nature, which would not allow for the delay attendant to soliciting U.S. sources,

(B) The price differential for procurement from U.S. sources exceeded by 50% or more the delivered price from the non-U.S. source,

(C) Compelling local political considerations precluded consideration of U.S. sources,

(D) The goods or services were not available from U.S. sources, or

(E) Procurement of locally available goods and services, as opposed to procurement of U.S. goods and services, would best promote the objectives of the Foreign Assistance program under the award.

(2) When the total procurement element exceeds $250,000 (unless funded by DFA), the following applies: Except as may be specifically approved or directed in advance by the Agreement Officer, all goods and services financed with U.S. dollars, which will be reimbursed under this award must meet the source, origin and nationality requirements set forth in 22 CFR Part 228 for the authorized geographic code specified in the schedule of this award. If none is specified, the authorized source is Code 000, the United States.

c. Printed or Audio-Visual Teaching Materials: If the effective use of printed or audio-visual teaching materials depends upon their being in the local language and if such materials are intended for technical assistance projects or activities

financed by USAID in whole or in part and if other funds including U.S.-owned or U.S.-controlled local currencies are not readily available to finance the procurement of such materials, local language versions may be procured from the following sources, in order of preference:

(1) The United States (USAID Geographic Code 000),
(2) The Cooperating Country,
(3) "Selected Free World" countries (USAID Geographic Code 941), and
(4) "Special Free World" countries (USAID Geographic Code 899).

d. If USAID determines that the recipient has procured any of these goods or services under this award contrary to the requirements of this provision, and has received payment for such purposes, the Agreement Officer may require the recipient to refund the entire amount of the purchase.

This provision must be included in all subagreements which include procurement of goods or services which total over $5,000.

[END OF PROVISION]

***11. DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS (January 2004)***

a. The recipient agrees to notify the Agreement Officer immediately upon learning that it or any of its principals:

(1) Are presently excluded or disqualified from covered transactions by any Federal department or agency;

(2) Have been convicted within the preceding three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, or obstruction of justice; commission of any other offense indicating a lack of business integrity or business honesty that seriously and directly affects your present responsibility;

(3) Are presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (1)(b); and

(4) Have had one or more public transactions (Federal, State, or local) terminated for cause or default within the preceding three years.

b. The recipient agrees that, unless authorized by the Agreement Officer, it will not knowingly enter into any subagreements or contracts under this cooperative agreement with a person or entity that is included on the Excluded Parties List System (http://epls.arnet.gov). The recipient further agrees to include the following provision in any subagreements or contracts entered into under this award:

DEBARMENT, SUSPENSION, INELIGIBILITY, AND VOLUNTARY EXCLUSION (DECEMBER 2003)

The recipient/contractor certifies that neither it nor its principals is presently excluded or disqualified from participation in this transaction by any Federal department or agency.

c. The policies and procedures applicable to debarment, suspension, and ineligibility under USAID-financed transactions are set forth in 22 CFR Part 208.

[END OF PROVISION]

***12. DRUG-FREE WORKPLACE (January 2004)***

a. The recipient agrees that it will publish a drug-free workplace statement and provide a copy to each employee who will be engaged in the performance of any Federal award. The statement must

(1) Tell the employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in its workplace;

(2) Specify the actions the recipient will take against employees for violating that prohibition; and

(3) Let each employee know that, as a condition of employment under any award, he or she

(i) Must abide by the terms of the statement, and
(ii) Must notify you in writing if he or she is convicted for a violation of a criminal drug statute occurring in the workplace, and must do so no more than five calendar days after the conviction.

b. The recipient agrees that it will establish an ongoing drug-free awareness program to inform employees about

(i) The dangers of drug abuse in the workplace;

(ii) Your policy of maintaining a drug-free workplace;

(iii) Any available drug counseling, rehabilitation and employee assistance programs; and

(iv) The penalties that you may impose upon them for drug abuse violations occurring in the workplace.

c. Without the Agreement Officer's expressed written approval, the policy statement and program must be in place as soon as possible, no later than the 30 days after the effective date of this award or the completion date of this award, whichever occurs first.

d. The recipient agrees to immediately notify the Agreement Officer if an employee is convicted of a drug violation in the workplace. The notification must be in writing, identify the employee's position title, the number of each award on which the employee worked. The notification must be sent to the Agreement Officer within ten calendar days after the recipient learns of the conviction.

e. Within 30 calendar days of learning about an employee's conviction, the recipient must either

(1) Take appropriate personnel action against the employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973 (29 USC 794), as amended, or

(2) Require the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for these purposes by a Federal, State or local health, law enforcement, or other appropriate agency.

f. The policies and procedures applicable to violations of these requirements are set forth in 22 CFR Part 210.

[END OF PROVISION]

## *13. EQUAL PROTECTION OF THE LAWS FOR FAITH-BASED AND COMMUNITY ORGANIZATIONS (February 2004)*

a. The recipient may not discriminate against any beneficiary or potential beneficiary under this award on the basis of religion or religious belief. Accordingly, in providing services supported in whole or in part by this agreement or in its outreach activities related to such services, the recipient may not discriminate against current or prospective program beneficiaries on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice;

b. The Federal Government must implement Federal programs in accordance with the Establishment Clause and the Free Exercise Clause of the First Amendment to the Constitution. Therefore, if the recipient engages in inherently religious activities, such as worship, religious instruction, and proselytization, it must offer those services at a different time or location from any programs or services directly funded by this award, and participation by beneficiaries in any such inherently religious activities must be voluntary.

c. If the recipient makes subawards under this agreement, faith-based organizations should be eligible to participate on the same basis as other organizations, and should not be discriminated against on the basis of their religious character or affiliation.

[END OF PROVISION]

### *14. IMPLEMENTATION OF E.O. 13224 -- EXECUTIVE ORDER ON TERRORIST FINANCING (March 2002)*

The Recipient is reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all contracts/subawards issued under this agreement.

[END OF PROVISION]

### *15. MARKING UNDER USAID-FUNDED ASSISTANCE INSTRUMENTS (December 2005)*

**(a) Definitions**

***Commodities*** mean any material, article, supply, goods or equipment, excluding recipient offices, vehicles, and non-deliverable items for recipient's internal use, in administration of the USAID funded grant, cooperative agreement, or other agreement or subagreement.

***Principal Officer*** means the most senior officer in a USAID Operating Unit in the field, e.g., USAID Mission Director or USAID Representative. For global programs managed from Washington but executed across many countries, such as disaster relief and assistance to internally displaced persons, humanitarian emergencies or immediate post conflict and political crisis response, the cognizant Principal Officer may be an Office Director, for example, the Directors of USAID/W/Office of Foreign Disaster Assistance and Office of Transition Initiatives. For non-presence countries, the cognizant Principal Officer is the Senior USAID officer in a regional USAID Operating Unit responsible for the non-presence country, or in the absence of such a responsible operating unit, the Principal U.S Diplomatic Officer in the non-presence country exercising delegated authority from USAID.

***Programs*** mean an organized set of activities and allocation of resources directed toward a common purpose, objective, or goal undertaken or proposed by an organization to carry out the responsibilities assigned to it.

***Projects*** include all the marginal costs of inputs (including the proposed investment) technically required to produce a discrete marketable output or a desired result (for example, services from a fully functional water/sewage treatment facility).

***Public communications*** are documents and messages intended for distribution to audiences external to the recipient's organization. They include, but are not limited to, correspondence, publications, studies, reports, audio visual productions, and other informational products; applications, forms, press and promotional materials used in connection with USAID funded programs, projects or activities, including signage and plaques; Web sites/Internet activities; and events such as training courses, conferences, seminars, press conferences and so forth.

***Subrecipient*** means any person or government (including cooperating country government) department, agency, establishment, or for profit or nonprofit organization that receives a USAID subaward, as defined in 22 C.F.R. 226.2.

***Technical Assistance*** means the provision of funds, goods, services, or other foreign assistance, such as loan guarantees or food for work, to developing countries and other USAID recipients, and through such recipients to subrecipients, in direct support of a development objective – as opposed to the internal management of the foreign assistance program.

***USAID Identity (Identity)*** means the official marking for the United States Agency for International Development (USAID), comprised of the USAID logo or seal and new brandmark, with the tagline that clearly communicates that our assistance is "from the American people." The USAID Identity is available on the USAID website at **www.usaid.gov/branding** and USAID provides it without royalty, license, or other fee to recipients of USAID-funded grants, or cooperative agreements, or other assistance awards

**(b) Marking of Program Deliverables**

(1) All recipients must mark appropriately all overseas programs, projects, activities, public communications, and commodities partially or fully funded by a USAID grant or cooperative agreement or other assistance award or subaward with the USAID Identity, of a size and prominence equivalent to or greater than the recipient's, other donor's, or any other third party's identity or logo.

(2) The Recipient will mark all program, project, or activity sites funded by USAID, including visible infrastructure projects (for example, roads, bridges, buildings) or other programs, projects, or activities that are physical in nature (for

example, agriculture, forestry, water management) with the USAID Identity. The Recipient should erect temporary signs or plaques early in the construction or implementation phase. When construction or implementation is complete, the Recipient must install a permanent, durable sign, plaque or other marking.

(3) The Recipient will mark technical assistance, studies, reports, papers, publications, audio-visual productions, public service announcements, Web sites/Internet activities and other promotional, informational, media, or communications products funded by USAID with the USAID Identity.

(4) The Recipient will appropriately mark events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences and other public activities, with the USAID Identity. Unless directly prohibited and as appropriate to the surroundings, recipients should display additional materials, such as signs and banners, with the USAID Identity. In circumstances in which the USAID Identity cannot be displayed visually, the recipient is encouraged otherwise to acknowledge USAID and the American people's support.

(5) The Recipient will mark all commodities financed by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs, and all other equipment, supplies, and other materials funded by USAID, and their export packaging with the USAID Identity.

(6) The Agreement Officer may require the USAID Identity to be larger and more prominent if it is the majority donor, or to require that a cooperating country government's identity be larger and more prominent if circumstances warrant, and as appropriate depending on the audience, program goals, and materials produced.

(7) The Agreement Officer may require marking with the USAID Identity in the event that the recipient does not choose to mark with its own identity or logo.

(8) The Agreement Officer may require a pre-production review of USAID-funded public communications and program materials for compliance with the approved Marking Plan.

(9) Subrecipients. To ensure that the marking requirements "flow down" to subrecipients of subawards, recipients of USAID funded grants and cooperative agreements or other assistance awards will include the USAID-approved marking provision in any USAID funded subaward, as follows:

*"As a condition of receipt of this subaward, marking with the USAID Identity of a size and prominence equivalent to or greater than the recipient's, subrecipient's, other donor's or third party's is required. In the event the recipient chooses not to*

*require marking with its own identity or logo by the subrecipient, USAID may, at its discretion, require marking by the subrecipient with the USAID Identity."*

(10) Any 'public communications', as defined in 22 C.F.R. 226.2, funded by USAID, in which the content has not been approved by USAID, must contain the following disclaimer:

*"This study/report/audio/visual/other information/media product (specify) is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of [insert recipient name] and do not necessarily reflect the views of USAID or the United States Government."*

(11) The recipient will provide the Cognizant Technical Officer (CTO) or other USAID personnel designated in the grant or cooperative agreement with two copies of all program and communications materials produced under the award. In addition, the recipient will submit one electronic or one hard copy of all final documents to USAID's Development Experience Clearinghouse.

**(c) Implementation of marking requirements.**

(1) When the grant or cooperative agreement contains an approved Marking Plan, the recipient will implement the requirements of this provision following the approved Marking Plan.

(2) When the grant or cooperative agreement does not contain an approved Marking Plan, the recipient will propose and submit a plan for implementing the requirements of this provision within [***Agreement Officer fill-in***] days after the effective date of this provision. The plan will include:

(i) A description of the program deliverables specified in paragraph (b) of this provision that the recipient will produce as a part of the grant or cooperative agreement and which will visibly bear the USAID Identity.

(ii) the type of marking and what materials the applicant uses to mark the program deliverables with the USAID Identity,

(iii) when in the performance period the applicant will mark the program deliverables, and where the applicant will place the marking,

(3) The recipient may request program deliverables not be marked with the USAID Identity by identifying the program deliverables and providing a rationale for not marking these program deliverables. Program deliverables may be exempted from USAID marking requirements when:

(i) USAID marking requirements would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials;

(ii) USAID marking requirements would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent;

(iii) USAID marking requirements would undercut host-country government “ownership” of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as “by” or “from” a cooperating country ministry or government official;

(iv) USAID marking requirements would impair the functionality of an item;

(v) USAID marking requirements would incur substantial costs or be impractical;

(vi) USAID marking requirements would offend local cultural or social norms, or be considered inappropriate;

(vii) USAID marking requirements would conflict with international law.

(4) The proposed plan for implementing the requirements of this provision, including any proposed exemptions, will be negotiated within the time specified by the Agreement Officer after receipt of the proposed plan. Failure to negotiate an approved plan with the time specified by the Agreement Officer may be considered as noncompliance with the requirements is provision.

**(d) Waivers.**

(1) The recipient may request a waiver of the Marking Plan or of the marking requirements of this provision, in whole or in part, for each program, project, activity, public communication or commodity, or, in exceptional circumstances, for a region or country, when USAID required marking would pose compelling political, safety, or security concerns, or when marking would have an adverse impact in the cooperating country. The recipient will submit the request through the Cognizant Technical Officer. The Principal Officer is responsible for approvals or disapprovals of waiver requests.

(2) The request will describe the compelling political, safety, security concerns, or adverse impact that require a waiver, detail the circumstances and rationale for the waiver, detail the specific requirements to be waived, the specific portion of the Marking Plan to be waived, or specific marking to be waived, and

include a description of how program materials will be marked (if at all) if the USAID Identity is removed. The request should also provide a rationale for any use of recipient's own identity/logo or that of a third party on materials that will be subject to the waiver.

(3) Approved waivers are not limited in duration but are subject to Principal Officer review at any time, due to changed circumstances.

(4) Approved waivers "flow down" to recipients of subawards unless specified otherwise. The waiver may also include the removal of USAID markings already affixed, if circumstances warrant.

(5) Determinations regarding waiver requests are subject to appeal to the Principal Officer's cognizant Assistant Administrator. The recipient may appeal by submitting a written request to reconsider the Principal Officer's waiver determination to the cognizant Assistant Administrator.

**(e) Non-retroactivity.** The requirements of this provision do not apply to any materials, events, or commodities produced prior to January 2, 2006. The requirements of this provision do not apply to program, project, or activity sites funded by USAID, including visible infrastructure projects (for example, roads, bridges, buildings) or other programs, projects, or activities that are physical in nature (for example, agriculture, forestry, water management) where the construction and implementation of these are complete prior to January 2, 2006 and the period of the cooperative agreement does not extend past January 2, 2006.

[END OF PROVISION]

### *16. REGULATIONS GOVERNING EMPLOYEES (AUGUST 1992)*

(The following applies to the recipient's employees working in the cooperating country under the agreement who are not citizens of the cooperating country.)

a. The recipient's employees shall maintain private status and may not rely on local U.S. Government offices or facilities for support while under this cooperative agreement.

b. The sale of personal property or automobiles by recipient employees and their dependents in the foreign country to which they are assigned shall be subject to the same limitations and prohibitions which apply to direct-hire USAID personnel employed by the Mission, including the rules contained in 22 CFR Part 136, except as this may conflict with host government regulations.

c. Other than work to be performed under this award for which an employee is assigned by the recipient, no employee of the recipient shall engage directly or indirectly, either in the individual's own name or in the name or through an

agency of another person, in any business, profession, or occupation in the foreign countries to which the individual is assigned, nor shall the individual make loans or investments to or in any business, profession or occupation in the foreign countries to which the individual is assigned.

d. The recipient's employees, while in a foreign country, are expected to show respect for its conventions, customs, and institutions, to abide by its applicable laws and regulations, and not to interfere in its internal political affairs.

e. In the event the conduct of any recipient employee is not in accordance with the preceding paragraphs, the recipient's chief of party shall consult with the USAID Mission Director and the employee involved and shall recommend to the recipient a course of action with regard to such employee.

f. The parties recognize the rights of the U.S. Ambassador to direct the removal from a country of any U.S. citizen or the discharge from this cooperative agreement award of any third country national when, in the discretion of the Ambassador, the interests of the United States so require.

g. If it is determined, either under (e) or (f) above, that the services of such employee should be terminated, the recipient shall use its best efforts to cause the return of such employee to the United States, or point of origin, as appropriate.

[END OF PROVISION]

### *17. CONVERSION OF UNITED STATES DOLLARS TO LOCAL CURRENCY (NOVEMBER 1985)*

(This provision applies when activities are undertaken outside the United States.)

Upon arrival in the Cooperating Country, and from time to time as appropriate, the recipient's chief of party shall consult with the Mission Director who shall provide, in writing, the procedure the recipient and its employees shall follow in the conversion of United States dollars to local currency. This may include, but is not limited to, the conversion of currency through the cognizant United States Disbursing Officer or Mission Controller, as appropriate.

[END OF PROVISION]

### *18. USE OF POUCH FACILITIES (AUGUST 1992)*

**(**This provision applies when activities are undertaken outside the United States.)

a. Use of diplomatic pouch is controlled by the Department of State. The Department of State has authorized the use of pouch facilities for USAID

recipients and their employees as a general policy, as detailed in items (1) through (6) below. However, the final decision regarding use of pouch facilities rest with the Embassy or USAID Mission. In consideration of the use of pouch facilities, the recipient and its employees agree to indemnify and hold harmless, the Department of State and USAID for loss or damage occurring in pouch transmission:

(1) Recipients and their employees are authorized use of the pouch for transmission and receipt of up to a maximum of .9 kgs per shipment of correspondence and documents needed in the administration of assistance programs.

(2) U.S. citizen employees are authorized use of the pouch for personal mail up to a maximum of .45 kgs per shipment (but see (a)(3) below).

(3) Merchandise, parcels, magazines, or newspapers are not considered to be personal mail for purposes of this standard provision and are not authorized to be sent or received by pouch.

(4) Official and personal mail pursuant to a.1. and 2. above sent by pouch should be addressed as follows:

Name of individual or organization (followed by
letter symbol "G")
City Name of post (USAID/_____)
Agency for International Development
Washington, D.C. 20523-0001

(5) Mail sent via the diplomatic pouch may not be in violation of U.S. Postal laws and may not contain material ineligible for pouch transmission.

(6) Recipient personnel are NOT authorized use of military postal facilities (APO/FPO). This is an Adjutant General's decision based on existing laws and regulations governing military postal facilities and is being enforced worldwide.

b. The recipient shall be responsible for advising its employees of this authorization, these guidelines, and limitations on use of pouch facilities.

c. Specific additional guidance on Recipient use of pouch facilities in accordance with this standard provision is available from the Post Communication Center at the Embassy or USAID Mission.

[END OF PROVISION]

## *19. INTERNATIONAL AIR TRAVEL AND TRANSPORTATION (JUNE 1999)*

(This provision is applicable when costs for international travel or transportation will be paid for with USAID funds. This provision is not applicable if the recipient is providing for travel with private funds as part of a cost-sharing requirement, or with Program Income generated under the award.)

a. PRIOR BUDGET APPROVAL

In accordance with OMB Cost Principles, direct charges for foreign travel costs are allowable only when each foreign trip has received prior budget approval. Such approval will be deemed to have been met when:

(1) the trip is identified. Identification is accomplished by providing the following information: the number of trips, the number of individuals per trip, and the destination country(s).

(2) the information noted at (a)(1) above is incorporated in: the proposal, the program description or schedule of the award, the implementation plan (initial or revisions), or amendments to the award; and

(3) the costs related to the travel are incorporated in the approved budget of the award.

The Agreement Officer may approve travel which has not been incorporated in writing as required by paragraph (a)(2). In such case, a copy of the Agreement Officer's approval must be included in the agreement file.

b. NOTIFICATION

(1) As long as prior budget approval has been met in accordance with paragraph (a) above, a separate Notification will not be necessary unless:

(i) the primary purpose of the trip is to work with USAID Mission personnel, or

(ii) the recipient expects significant administrative or substantive programmatic support from the Mission.

Neither the USAID Mission nor the Embassy will require Country Clearance of employees or contractors of USAID Recipients.

(2) Where notification is required in accordance with paragraph (1)(i) or (ii) above, the recipient will observe the following standards:

(i) Send a written notice to the cognizant USAID Technical Office in the Mission. If the recipient's primary point of contact is a Technical Officer in USAID/W, the recipient may send the notice to that person. It will be the responsibility of the USAID/W Technical Officer to forward the notice to the field.

(ii) The notice should be sent as far in advance as possible, but at least 14 calendar days in advance of the proposed travel. This notice may be sent by fax or e-mail. The recipient should retain proof that notification was made.

(iii) The notification shall contain the following information: the award number, the cognizant Technical Officer, the traveler's name (if known), date of arrival, and the purpose of the trip.

(iv) The USAID Mission will respond only if travel has been denied. It will be the responsibility of the Technical Officer in the Mission to contact the recipient within 5 working days of having received the notice if the travel is denied. If the recipient has not received a response within the time frame, the recipient will be considered to have met these standards for notification, and may travel.

(v) If a subrecipient is required to issue a Notification, as per this section, the subrecipient may contact the USAID Technical Officer directly, or the prime may contact USAID on the subrecipient's behalf.

c. SECURITY ISSUES

Recipients are encouraged to obtain the latest Department of State Travel Advisory Notices before travelling. These Notices are available to the general public and may be obtained directly from the State Department, or via Internet.

Where security is a concern in a specific region, recipients may choose to notify the US Embassy of their presence when they have entered the country. This may be especially important for long-term posting.

d. USE OF U.S.-OWNED LOCAL CURRENCY

Travel to certain countries shall, at USAID's option, be funded from U.S.-owned local currency. When USAID intends to exercise this option, USAID will either issue a U.S. Government S.F. 1169, Transportation Request (GTR) which the Recipient may exchange for tickets, or issue the tickets directly. Use of such U.S.-owned currencies will constitute a dollar charge to this cooperative agreement.

e. THE FLY AMERICA ACT

The Fly America Act (49 U.S.C. 40118) requires that all air travel and shipments under this award must be made on U.S. flag air carriers to the extent service by such carriers is available. The Administrator of General Services Administration (GSA) is authorized to issue regulations for purposes of implementation. Those regulations may be found at 41 CFR part 301, and are hereby incorporated by reference into this award.

f. COST PRINCIPLES

The recipient will be reimbursed for travel and the reasonable cost of subsistence, post differentials and other allowances paid to employees in international travel status in accordance with the recipient's applicable cost principles and established policies and practices which are uniformly applied to federally financed and other activities of the Recipient.

If the recipient does not have written established policies regarding travel costs, the standard for determining the reasonableness of reimbursement for overseas allowance will be the Standardized Regulations (Government Civilians, Foreign Areas), published by the U.S. Department of State, as from time to time amended. The most current subsistence, post differentials, and other allowances may be obtained from the Agreement Officer.

g. SUBAWARDS.
This provision will be included in all subawards and contracts which require international air travel and transportation under this award.

[END OF PROVISION]

***20. OCEAN SHIPMENT OF GOODS (JUNE 1999)***

**(**This provision is applicable for awards and subawards for $100,000 or more and when goods purchased with funds provided under this award are transported to cooperating countries on ocean vessels whether or not award funds are used for the transportation.)

a. At least 50% of the gross tonnage of all goods purchased under this agreement and transported to the cooperating countries shall be made on privately owned U.S. flag commercial ocean vessels, to the extent such vessels are available at fair and reasonable rates for such vessels.

b. At least 50% of the gross freight revenue generated by shipments of goods purchased under this agreement and transported to the cooperating countries on dry cargo liners shall be paid to or for the benefit of privately owned U.S. flag commercial ocean vessels to the extent such vessels are available at fair and reasonable rates for such vessels.

c. When U.S. flag vessels are not available, or their use would result in a significant delay, the Recipient may request a determination of non-availability from the

USAID Transportation Division, Office of Procurement, Washington, D.C. 20523, giving the basis for the request which will relieve the Recipient of the requirement to use U.S. flag vessels for the amount of tonnage included in the determination. Shipments made on non-free world ocean vessels are not reimbursable under this cooperative agreement.

d. The recipient shall send a copy of each ocean bill of lading, stating all of the carrier's charges including the basis for calculation such as weight or cubic measurement, covering a shipment under this agreement to:

U.S. Department of Transportation,
Maritime Administration, Division of National Cargo,
400 7th Street, S.W.,
Washington, DC 20590, and

U.S. Agency for International Development,
Office of Procurement, Transportation Division
1300 Pennsylvania Avenue, N.W.
Washington, DC 20523-7900

e. Shipments by voluntary nonprofit relief agencies (i.e., PVOs) shall be governed by this standard provision and by USAID Regulation 2, "Overseas Shipments of Supplies by Voluntary Nonprofit Relief Agencies" (22 CFR Part 202).

f. Shipments financed under this cooperative agreement must meet applicable eligibility requirements set out in 22 CFR 228.21.

[END OF PROVISION]

## *21. LOCAL PROCUREMENT (April 1998)*

(This provision applies when activities are undertaken outside the United States.)

a. Financing local procurement involves the use of appropriated funds to finance the procurement of goods and services supplied by local businesses, dealers or producers, with payment normally being in the currency of the cooperating country.

b. Locally financed procurements must be covered by source and nationality waivers as set forth in 22 CFR 228, Subpart F, except as provided for in mandatory standard provision, "USAID Eligibility Rules for Goods and Services," or when one of the following exceptions applies:

(1) Locally available commodities of U.S. origin, which are otherwise eligible for financing, if the value of the transaction is estimated not to exceed $100,000 exclusive of transportation costs.

(2) Commodities of geographic code 935 origin if the value of the transaction does not exceed the local currency equivalent of $5,000.

(3) Professional Services Contracts estimated not to exceed $250,000.

(4) Construction Services Contracts estimated not to exceed $5,000,000.

(5) Commodities and services available only in the local economy (no specific per transaction value applies to this category). This category includes the following items:

(i) Utilities including fuel for heating and cooking, waste disposal and trash collection;

(ii) Communications - telephone, telex, fax, postal and courier services;

(iii) Rental costs for housing and office space;

(iv) Petroleum, oils and lubricants for operating vehicles and equipment;

(v) Newspapers, periodicals and books published in the cooperating country;

(vi) Other commodities and services and related expenses that, by their nature or as a practical matter, can only be acquired, performed, or incurred in the cooperating country, e.g., vehicle maintenance, hotel accommodations, etc.

c. The coverage on ineligible and restricted goods and services in the mandatory standard provision entitled, "USAID Eligibility Rules for Goods and Services," also apply to local procurement.

d. This provision will be included in all subagreements where local procurement of goods or services is a supported element.

[END OF PROVISION]

***22. VOLUNTARY POPULATION PLANNING ACTIVITIES – MANDATORY REQUIREMENTS (MAY 2006)***

Requirements for Voluntary Sterilization Programs

(1) None of the funds made available under this award shall be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.

Prohibition on Abortion-Related Activities:

(1) No funds made available under this award will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to any person to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and (v) lobbying for or against abortion. The term "motivate", as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.

(2) No funds made available under this award will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.

## *23. PUBLICATIONS AND MEDIA RELEASES (MARCH 2006)*

a. The recipient shall provide the USAID Cognizant Technical Officer one copy of all published works developed under the award with lists of other written work produced under the award. In addition, the recipient shall submit final documents in electronic format unless no electronic version exists at the following address:

Online (preferred)
**http://www.dec.org/submit.cfm**

Mailing address:
Document Acquisitions
USAID Development Experience Clearinghouse (DEC)
8403 Colesville Road Suite 210
Silver Spring, MD 20910-6368
Contract Information
Telephone (301) 562-0641
Fax (301) 588-7787
E-mail: **docsubmit@dec.cdie.org**

Electronic documents must consist of only one electronic file that comprises the complete and final equivalent of a hard copy. They may be submitted online

(preferred); on 3.5” diskettes, a Zip disk, CD-R, or by e-mail. Electronic documents should be in PDF (Portable Document Format). Submission in other formats is acceptable but discouraged.

Each document submitted should contain essential bibliographic elements, such as 1) descriptive title; 2) author(s) name; 3) award number; 4) sponsoring USAID office; 5) strategic objective; and 6) date of publication;:

b. In the event award funds are used to underwrite the cost of publishing, in lieu of the publisher assuming this cost as is the normal practice, any profits or royalties up to the amount of such cost shall be credited to the award unless the schedule of the award has identified the profits or royalties as program income.

c. Except as otherwise provided in the terms and conditions of the award, the author or the recipient is free to copyright any books, publications, or other copyrightable materials developed in the course of or under this award, but USAID reserves a royalty-free nonexclusive and irrevocable right to reproduce, publish, or otherwise use, and to authorize others to use the work for Government purposes.

[END OF PROVISION]

***24. PARTICIPANT TRAINING (April 1998)***

a. Definition: A participant is any non-U.S. individual being trained under this award outside of that individual's home country.

b. Application of ADS Chapter 253: Participant training under this award shall comply with the policies established in ADS Chapter 253, Participant Training, except to the extent that specific exceptions to ADS 253 have been provided in this award with the concurrence of the Office of International Training.

c. Orientation: In addition to the mandatory requirements in ADS 253, recipients are strongly encouraged to provide, in collaboration with the Mission training officer, predeparture orientation and orientation in Washington at the Washington International Center. The latter orientation program also provides the opportunity to arrange for home hospitality in Washington and elsewhere in the United States through liaison with the National Council for International Visitors (NCIV). If the Washington orientation is determined not to be feasible, home hospitality can be arranged in most U.S. cities if a request for such is directed to the Agreement Officer, who will transmit the request to NCIV through EGAT/ED/PT.

[END OF PROVISION]

## *25. TITLE TO AND CARE OF PROPERTY (COOPERATING COUNTRY TITLE) (NOVEMBER 1985)*

a. Except as modified by the schedule of this cooperative agreement, title to all equipment, materials and supplies, the cost of which is reimbursable to the recipient by USAID or by the cooperating country, shall at all times be in the name of the cooperating country or such public or private agency as the cooperating country may designate, unless title to specified types or classes of equipment is reserved to USAID under provisions set forth in the schedule of this award. All such property shall be under the custody and control of recipient until the owner of title directs otherwise or completion of work under this award or its termination, at which time custody and control shall be turned over to the owner of title or disposed of in accordance with its instructions. All performance guarantees and warranties obtained from suppliers shall be taken in the name of the title owner.

b. The recipient shall maintain and administer in accordance with sound business practice a program for the maintenance, repair, protection, and preservation of Government property so as to assure its full availability and usefulness for the performance of this cooperative agreement. The recipient shall take all reasonable steps to comply with all appropriate directions or instructions which the Agreement Officer may prescribe as reasonably necessary for the protection of the Government property.

c. The recipient shall prepare and establish a program, to be approved by the appropriate USAID Mission, for the receipt, use, maintenance, protection, custody and care of equipment, materials and supplies for which it has custodial responsibility, including the establishment of reasonable controls to enforce such program. The recipient shall be guided by the following requirements:

(1) Property Control: The property control system shall include but not be limited to the following:

(i) Identification of each item of cooperating country property acquired or furnished under the award by a serially controlled identification number and by description of item. Each item must be clearly marked "Property of (insert name of cooperating country)."

(ii) The price of each item of property acquired or furnished under this award.

(iii) The location of each item of property acquired or furnished under this award.

(iv) A record of any usable components which are permanently removed from items of cooperating country property as a result of modification or otherwise.

(v) A record of disposition of each item acquired or furnished under the award.

(vi) Date of order and receipt of any item acquired or furnished under the award.

(vii) The official property control records shall be kept in such condition that at any stage of completion of the work under this award, the status of property acquired or furnished under this award may be readily ascertained. A report of current status of all items of property acquired or furnished under the award shall be submitted yearly concurrently with the annual report.

(2) Maintenance Program: The recipient's maintenance program shall be consistent with sound business practice, the terms of the award, and provide for:

(i) disclosure of need for and the performance of preventive maintenance,

(ii) disclosure and reporting of need for capital type rehabilitation, and

(iii) recording of work accomplished under the program:

(A) Preventive maintenance - Preventive maintenance is maintenance generally performed on a regularly scheduled basis to prevent the occurrence of defects and to detect and correct minor defects before they result in serious consequences.

(B) Records of maintenance - The recipient's maintenance program shall provide for records sufficient to disclose the maintenance actions performed and deficiencies discovered as a result of inspections.

(C) A report of status of maintenance of cooperating country property shall be submitted annually concurrently with the annual report.

d. Risk of Loss:

(1) The recipient shall not be liable for any loss of or damage to the cooperating country property, or for expenses incidental to such loss or

damage except that the recipient shall be responsible for any such loss or damage (including expenses incidental thereto):

(i) Which results from willful misconduct or lack of good faith on the part of any of the recipient's directors or officers, or on the part of any of its managers, superintendents, or other equivalent representatives, who have supervision or direction of all or substantially all of the recipient's business, or all or substantially all of the recipient's operation at any one plant, laboratory, or separate location in which this award is being performed;

(ii) Which results from a failure on the part of the recipient, due to the willful misconduct or lack of good faith on the part of any of its directors, officers, or other representatives mentioned in (i) above:

(A) to maintain and administer, in accordance with sound business practice, the program for maintenance, repair, protection, and preservation of cooperating country property as required by (i) above, or

(B) to take all reasonable steps to comply with any appropriate written directions of the Agreement Officer under (b) above;

(iii) For which the recipient is otherwise responsible under the express terms designated in the schedule of this award;

(vi) Which results from a risk expressly required to be insured under some other provision of this award, but only to the extent of the insurance so required to be procured and maintained, or to the extent of insurance actually procured and maintained, whichever is greater; or

(v) Which results from a risk which is in fact covered by insurance or for which the Recipient is otherwise reimbursed, but only to the extent of such insurance or reimbursement;

(vi) Provided, that, if more than one of the above exceptions shall be applicable in any case, the recipient's liability under any one exception shall not be limited by any other exception.

(2) The recipient shall not be reimbursed for, and shall not include as an item of overhead, the cost of insurance, or any provision for a reserve, covering the risk of loss of or damage to the cooperating country property, except to the extent that USAID may have required the recipient to carry such insurance under any other provision of this award.

(3) Upon the happening of loss or destruction of or damage to the cooperating country property, the recipient shall notify the Agreement Officer thereof, shall take all reasonable steps to protect the cooperating country property from further damage, separate the damaged and undamaged cooperating country property, put all the cooperating country property in the best possible order, and furnish to the Agreement Officer a statement of:

(i) The lost, destroyed, or damaged cooperating country property;

(ii) The time and origin of the loss, destruction, or damage;

(iii) All known interests in commingled property of which the cooperating country property is a part; and

(iv) The insurance, if any, covering any part of or interest in such commingled property.

(4) The recipient shall make repairs and renovations of the damaged cooperating country property or take such other action as the Agreement Officer directs.

(5) In the event the recipient is indemnified, reimbursed, or otherwise compensated for any loss or destruction of or damage to the cooperating country property, it shall use the proceeds to repair, renovate or replace the cooperating country property involved, or shall credit such proceeds against the cost of the work covered by the award, or shall otherwise reimburse USAID, as directed by the Agreement Officer. The recipient shall do nothing to prejudice USAID's right to recover against third parties for any such loss, destruction, or damage, and upon the request of the Agreement Officer, shall, at the Governments expense, furnish to USAID all reasonable assistance and cooperation (including assistance in the prosecution of suits and the execution of instruments or assignments in favor of the Government) in obtaining recovery.

e. Access: USAID, and any persons designated by it, shall at all reasonable times have access to the premises wherein any cooperating country property is located, for the purpose of inspecting the cooperating country property.

f. Final Accounting and Disposition of Cooperating Country Property: Within 90 days after completion of this award, or at such other date as may be fixed by the Agreement Officer, the recipient shall submit to the Agreement Officer an inventory schedule covering all items of equipment, materials and supplies under the recipient's custody, title to which is in the cooperating country or public or private agency designated by the cooperating country, which have not been consumed in the performance of this award. The recipient shall also indicate what disposition has been made of such property.

g. Communications: All communications issued pursuant to this provision shall be in writing.

[END OF PROVISION]

### *26. PUBLIC NOTICES (MARCH 2004)*

It is USAID's policy to inform the public as fully as possible of its programs and activities. The recipient is encouraged to give public notice of the receipt of this award and, from time to time, to announce progress and accomplishments. Press releases or other public notices should include a statement substantially as follows:

> "The U.S. Agency for International Development administers the U.S. foreign assistance program providing economic and humanitarian assistance in more than 120 countries worldwide."

The recipient may call on USAID's Bureau for Legislative and Public Affairs for advice regarding public notices. The recipient is requested to provide copies of notices or announcements to the cognizant technical officer and to USAID's Bureau for Legislative and Public Affairs as far in advance of release as possible.

[END OF PROVISION]

### *27. COST SHARING (MATCHING) (July 2002)*

a. If at the end of any funding period, the recipient has expended an amount of non-Federal funds less than the agreed upon amount or percentage of total expenditures, the Agreement Officer may apply the difference to reduce the amount of USAID incremental funding in the following funding period. If the award has expired or has been terminated, the Agreement Officer may require the recipient to refund the difference to USAID.

b. The source, origin and nationality requirements and the restricted goods provision established in the Standard Provision entitled "USAID Eligibility Rules for Goods and Services" do not apply to cost sharing (matching) expenditures.

[END OF PROVISION]

### *28. REPORTING OF FOREIGN TAXES (March 2006)*

a. The recipient must annually submit a report by April 16 of the next year.

b. Contents of Report. The report must contain:

(i) Contractor/recipient name.

(ii) Contact name with phone, fax and email.

(iii) Agreement number(s).

(iv) Amount of foreign taxes assessed by a foreign government [each foreign government must be listed separately] on commodity purchase transactions valued at $500 or more financed with U.S. foreign assistance funds under this agreement during the prior U.S. fiscal year.

(v) Only foreign taxes assessed by the foreign government in the country receiving U.S. assistance is to be reported. Foreign taxes by a third party foreign government are not to be reported. For example, if an assistance program for Lesotho involves the purchase of commodities in South Africa using foreign assistance funds, any taxes imposed by South Africa would not be reported in the report for Lesotho (or South Africa).

(vi) Any reimbursements received by the Recipient during the period in (iv) regardless of when the foreign tax was assessed and any reimbursements on the taxes reported in (iv) received through March 31.

(vii) Report is required even if the recipient did not pay any taxes during the report period.

(viii) Cumulative reports may be provided if the recipient is implementing more than one program in a foreign country.

c. Definitions. For purposes of this clause:

(i) “Agreement” includes USAID direct and country contracts, grants, cooperative agreements and interagency agreements.

(ii) “Commodity” means any material, article, supply, goods, or equipment.

(iii) “Foreign government” includes any foreign governmental entity.

(iv) “Foreign taxes” means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

d. Where. Submit the reports to: [insert address and point of contact at the Embassy, Mission or FM/CMP as appropriate. see b. below] [optional with a copy to ]

e. Subagreements. The recipient must include this reporting requirement in all applicable subcontracts, subgrants and other subagreements.

f. For further information see **http://www.state.gov/m/rm/c10443.htm**.

[END OF PROVISION]

### *29. FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES (January 2002)*

Funds in this agreement may not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government's delegation to an international conference sponsored by a public international organization, except as provided in ADS Mandatory Reference "Guidance on Funding Foreign Government Delegations to International Conferences or as approved by the Agreement Officer.

These provisions also must be included in the Standard Provisions of any new grant or cooperative agreement to a public international organization or a U.S. or non-U.S. non-governmental organization financed with FY04 HIV/AIDS funds or modification to an existing grant or cooperative agreement that adds FY04 HIV/AIDS.

[END OF PROVISION]

### *30. USAID DISABILITY POLICY - ASSISTANCE (DECEMBER 2004)*

a. The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website: **http://www.usaid.gov/about/disability/DISABPOL.FIN.html**

b. USAID therefore requires that the recipient not discriminate against people with disabilities in the implementation of USAID funded programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing the program under this grant or cooperative agreement. To that end and to the extent it can accomplish this goal within the scope of the program objectives, the recipient should demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

[END OF PROVISION]

### 31. PROHIBITION OF ASSISTANCE TO DRUG TRAFFICKERS (JUNE 1999)

a. USAID reserves the right to terminate assistance to, or take other appropriate measures with respect to, any participant approved by USAID who is found to

have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

b. (1) For any loan over $1000 made under this agreement, the recipient shall insert a clause in the loan agreement stating that the loan is subject to immediate cancellation, acceleration, recall or refund by the recipient if the borrower or a key individual of a borrower is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

(2) Upon notice by USAID of a determination under section (1) and at USAID's option, the recipient agrees to immediately cancel, accelerate or recall the loan, including refund in full of the outstanding balance. USAID reserves the right to have the loan refund returned to USAID.

c. (1) The recipient agrees not to disburse, or sign documents committing the recipient to disburse, funds to a subrecipient designated by USAID ("Designated Subrecipient") until advised by USAID that: (i) any United States Government review of the Designated Subrecipient and its key individuals has been completed; (ii) any related certifications have been obtained; and (iii) the assistance to the Designated Subrecipient has been approved. Designation means that the subrecipient has been unilaterally selected by USAID as the subrecipient. USAID approval of a subrecipient, selected by another party, or joint selection by USAID and another party is not designation.

(2) The recipient shall insert the following clause, or its substance, in its agreement with the Designated Subrecipient:

“The recipient reserves the right to terminate this [Agreement/Contract] or take other appropriate measures if the [Subrecipient] or a key individual of the [Subrecipient] is found to have been convicted of a narcotic offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.”

[END OF PROVISION]

**[END OF STANDARD PROVISIONS]**

## Executive Summary

Rwanda is a small, land-locked country with over 8 million people and a tragic history culminating in the 1994 genocide. Militias, military men, and ordinary citizens killed over 800,000 of their compatriots in three months, destroying the country's infrastructure in the course of their retreat. Rwanda ranked 18th from the bottom of the human development index this year.[1] with one-third of families living in extreme poverty with less than a dollar per day.[2] The child mortality rate, **152**, has declined from over 20% over the last five years,[3] but remains unacceptably high, with one in seven children dying before their fifth birthday, the vast majority of them from easily preventable conditions.

**Concern Worldwide (Concern)**, the **International Rescue Committee (IRC)** and **World Relief (WR)** have worked over the past five years to improve maternal and child health in Rwanda, with funding from the USAID Child Survival Health Grants Program (CSHGP) and from the USAID Mission in Rwanda. These three Private Voluntary Organizations (PVOs), working at community and facility level, have demonstrated that significant progress can be made. The work of the three PVOs has resulted in substantial gains in coverage of key child survival interventions, as documented in mid-term and final evaluations. The three PVOs have collaborated closely in their work through cross-visits, shared indicators, and joint trainings. This partnership has already had a substantial impact on national policy, as the three PVOs worked with the National Malaria Control Program and with CORE to design and implement Rwanda's first community case management program.

The lead agency, Concern, with its partners, the IRC, and WR, now propose to build on their past accomplishments and mature partnership to implement an **expanded impact child survival program**, called **"UMUSANZA" FOR THE CHILDREN**, meaning "contributing towards a common goal of child survival." Specifically, the program's goal is to **reduce child mortality in six underserved districts reaching** an estimated population of **279,000 children under five years of age**. Interventions will address the three leading direct causes of child mortality - malaria, diarrhea, and pneumonia - through a community integrated management of childhood illness (C-IMCI) strategy. This strategy will prioritize local mobilization and community case management. Key approaches are built around enhancing family health practices at the household level and increasing quality of child health care services at the community level. Mechanisms to ensure that newborns also receive appropriate care are included to reach this special need population. Program objectives include:

***Prevention and Treatment of Malaria with a 35% level of effort:***

**1.** Increase proportion of children under-five with fever who receive appropriate antimalarial treatment within 24 hours of onset of fever from 13%[4] to 60%.

**2.** Increase proportion of children under five sleeping under a treated mosquito net the previous night from 13%[5] to 35%

***Control of Diarrheal Disease with a 35% level of effort:***

**1.** Increase use of oral rehydration therapy and zinc among children with diarrhea with from 12% to 50%

**2.** Increase hand-washing with soap at critical times (after defecation, after handling children's feces, before preparing food, and before feeding children/eating) from 35%6 to 50%

***Pneumonia Case Management with a 30% level of effort:***

**1.** Increase the proportion of children with pneumonia (as determined by C-IMCI criteria) who receive appropriate treatment from an estimated 15%[7] to 60%

**2.** Maintain the proportion of children 6-59 months and mothers of newborn children who receive vitamin A above 90%, even in the absence of periodic campaigns

The working area was jointly selected with the **Ministry of Health (MoH)**, the local USAID mission, and IntraHealth's Twubakane Project. District selection was based on need, potential for synergy and mainstreaming of multiple interventions, and building on previous work of the PVOs under the CSHGP. Program area includes Gikongoro, Gisagara, Kibungo, Kirehe, Nyamasheke, and Nyaruguru Districts – a total population of 1,734,925[8] *(including 67,004 children age 0-11 months; 52,894 age 12-23 months; and 159,383 age 24-59 months)*. These districts increase by 75% the total population covered by the original CSHGPs in Rwanda.

The purpose of this program is to mobilize communities as part of local health systems in order to protect and treat children so as to avoid unnecessary deaths and reduce costs of illness and treatment. The program will harness a network of over 11,000 community health workers (CHWs) building on best practices for the care group methodology. It is the intention of the three PVOs for this program to become a leader for national replication and scale-up of C-IMCI throughout Rwanda. Key institutional partners will actively contribute to the program through the Program Advisory Committee: MOH, USAID, UNICEF, IntraHealth's Twubakane Project and Capacity Programs, and BASICS III.

This application is the product of the Child Survival Program (CSP) staff under the lead of Concern and its sub-grantees IRC and WR; our District Health Team counterparts; Cathy Mugeni, Interim Director of the MCH Unit, Marc Ndayambaje, IMCI Desk Officer, and Claude Sekabaraga, Director of Unit of Quality of MoH; the USAID Mission's Health, Population & Nutrition Team: John Dunlap, Christian Jung, and particularly Matt Chico; Laura Hoemeke, Twubakane Director; Jane Briggs of MSH/RPM+; and Diana Silimperi of BASICS III. Principle authors are Michelle Kouletio (Concern), Emmanuel d'Harcourt (IRC), and Melanie Morrow and Bukola Ojuola (WR). Inquiries regarding this expanded impact application should be directed to Siobhan Walsh, Executive Director, Concern Worldwide US, whose contact information is on the cover.

This five-year proposal, from October 2006 through September 2011, has a total budget of $7.4 million, including $4 million from USAID/Washington and the local mission, and $3,410,814 matching funds from the three PVOs, including significant seed funding for anti-malarial drugs for home based treatment.

# 1 Description of PVO Applicants

The lead agency, **Concern Worldwide US, Inc. (Concern)** is a US-based NGO and an affiliate of Concern Worldwide in Ireland, an international relief and development agency founded in 1968. With programs in 30 of the poorest countries in the world, Concern's work spans Africa, Asia and the Caribbean, and targets countries in the bottom-tier of the UNDP Human Development Index. Concern US' 2004 revenue of $9.2m contributes to about one-tenth of the agency's global annual revenue ($106m). Its funding sources include multilateral and bilateral government assistance, and substantial support from corporations and private foundations and individuals.

Concern's mission is to help people living in extreme poverty achieve major and lasting improvements in their lives. Through this work, Concern aims to significantly contribute to the Millennium Development Goals (MDGs), and tracks impact annually across five development priorities: Health, HIV/AIDS Prevention, Education, Livelihood Security, and Emergency Relief/Mitigation. Concern strives to implement programs with and through partners, and only undertakes direct implementation during emergencies or in communities where desperately needed services do not exist. With a strong ethos for partnership and two-way capacity building and learning, Concern's slogan **"we are in this together"** is taken seriously, as no single agency can have impact required to make lasting changes to the world's poverty.

Concern's approach builds up government engagement with civil society to strengthen effective health systems, and it has realized such achievement through its renowned health and nutrition programs currently spanning 22 countries. In 2004, Concern's global health programs realized training for 4,600 health workers and benefited the lives of 3.5m people. Concern currently implements three child survival grants in Bangladesh, Haiti and Rwanda. In Bangladesh, the urban child survival program pilot that began in 1998 has grown from serving 160,000 people to one million, and is proving to be a model for urban health care recognized for its impact in behavior change and in building capacity with political leaders and community groups. Concern's Haiti program builds on this approach by supporting the government to develop an effective and sustainable urban health strategy based on its work with FOCAS and GRET in five slum areas of Port au Prince.

Concern has also proven its ability to effectively monitor and evaluate large-scale programs through its work with Community Therapeutic Care (CTC) in countries such as Ethiopia, Sudan, and Niger. This research initiative, undertaken by Concern and Valid International, and published by Humanitarian Practice Network and The Lancet, has produced ground-breaking evidence showing that an outpatient model for managing uncomplicated acute malnutrition among children is more effective than traditional therapeutic care approaches, as CTC achieves significantly higher coverage levels - nearly 70%. In November 2005, this research was presented at the World Health Organization (WHO) for incorporation in developing community protocols for community management of acute malnutrition. Concern now leads a practitioner's network for emergency nutrition to advance the practice of CTC.

Concern has been operational in Rwanda since 1994, working in Child Survival, Basic Education and Community Development. And it actively forges alliances with NGOs; Concern's Rwanda Country Director, Eddie Rogers, has served as Chair of the NGO Network since 2003. As such, Concern has well-established working agreements with local MOH representatives and NGOs in the former Provinces of Butare, Gitarama, and Ruhengheri. Concern has been assisting the Kibilizi Health District with material and technical assistance since 1998, a program which was awarded a five-year CSHGP grant in 2001. Achievements include integrating antenatal care with complementary services of prevention of mother-to-child transmission (PMTCT); subsidized insecticide treated bed nets (ITNs); reactivating the district CHW program with 172 volunteers; implementing PD/Hearth to combat child malnutrition in five highly-affected communities; and establishing a district-wide maternal and newborn care strategy at international standards, a model for the country, underway with Columbia University's Averting Maternal Death and Disability (AMDD) program and UNCIEF. Highlights of health improvements include increasing the number of children sleeping under ITNs from 1% to 45%;

immediate breastfeeding practice from 38% to 56%; children with fever treated within 24 hours from 14% to 93%; and skilled attendants at delivery from 8% to 28%.

The **International Rescue Committee (IRC)** bases its mission to provide relief, protection and resettlement services to refugees, internally displaced persons, and victims of oppression and conflict, on a commitment to freedom, human dignity and self-reliance. An annual budget of $180m supports offices in 30 countries throughout Africa, Asia, the Middle East and Europe. Primary funding sources include governments and institutional organizations (i.e., Bureau for Population, Refugees, and Migration of the U.S. State Department, USAID, and European governments). Other funding sources include local USAID missions, United Nations institutions, and numerous foundations, corporations, and individuals. The IRC's health programs, which account for 40% of the agency's budget, are currently being implemented in 21 countries and are impacting the lives of about 6.1m people. Many of the IRC's health programs focus on community health and primary care, especially in countries affected by conflict. The IRC works with communities and other local partners to develop sustainable and scaleable models in settings where this is often thought difficult or improbable, and where child mortality is extremely high. Because 80% of the world's refugees are women and children, the IRC specializes in successfully implementing maternal and child health services. The IRC has had particular success, documented in external evaluations, in implementing sustainable community health networks, and in developing community-level information systems.

The IRC has been active in Rwanda since the immediate aftermath of the 1994 genocide. The IRC in Rwanda focuses on child survival, and on governance and civil society programming, for which it currently has two major USAID grants. The IRC's Rwanda CSP, 1999 – 2005, serves four health districts covering the entire Kibungo Province. The program reaches a total population of over 700,000, including over 110,000 children under five and 175,000 women of reproductive age (WRA) with interventions in nutrition, malaria control, and maternal and newborn health. The final evaluator concluded that the Kibungo program was "a well-designed, well-managed project which achieved most of its objectives on a large scale." The evaluator found that "the model used by this project leaves excellent hope for sustainability and is also a realistic model for replication of community level activities elsewhere," and recommended that "IRC continue with the same approach for the new C-IMCI project." The report highlighted, in addition to the program's large scale and effective sustainability and partnership strategies, the creation of a community health information system that was widely used and integrated into the district health system, and serves as a national model. The IRC brings to this partnership a strong record of achievement in monitoring and evaluation for child survival through its programs. The IRC has received CSHGP grants in Rwanda, DR Congo, and Sierra Leone.

**World Relief (WR)** works in more than 20 countries to alleviate poverty and human suffering through community based programs in maternal and child health, HIV/AIDS prevention and care, child development, microfinance, disaster response, refugee resettlement, and agriculture and food security. Founded in 1944, WR is the relief and development arm of the National Association of Evangelicals, representing a constituency of over 30m Americans from 45,000 churches and over 50 denominations. WR programs serve everyone in need, regardless of religious affiliation.

WR specializes in developing sustainable health and development programs in countries emerging from complex humanitarian disasters - a pattern of organizational competence easily discernable in Rwanda. Programs are implemented primarily at the community

level, and are designed to build the capacity of local partners and empower community groups and institutions to sustain gains achieved through project interventions.

The FY06 budget for WR is $54m; funding sources include US government grants, international associations, private foundations, private donor contributions and local grants within countries of operation. WR has been awarded a total of 16 USAID CSHGP grants in Africa, Asia, Latin America, and the Caribbean, with current CSP grants in Cambodia, Malawi, Rwanda, and an expanded impact award in Mozambique. WR is recognized as a leader in community mobilization and behavior change because of its successful Care Group methodology, first pioneered in Mozambique in 1995. The model, as it has been used so far, is unique in achieving universal coverage of beneficiary households and overcomes the usual difficulties associated with training, supervising, and sustaining large numbers of community volunteers. Care Group has already been scaled up by WR in all subsequent CSPs, including the present project in Rwanda. To accelerate diffusion and replication of the methodology, the CORE Group awarded WR a Diffusion of Innovations grant in 2004 for production of a manual on Care Groups. Future Generations sought out WR as a formal mentor for its first CSHGP grant (2005-2009), a relationship that further validates WR's reputation for building the capacity of others to implement high quality community health programs.

WR's operation in Rwanda started in a relief capacity during the 1994 genocide before transitioning to long-term development. WR began health work in Rwanda in 1998 with its HIV/AIDS program *Mobilizing for Life*. With $12m in support from PEPFAR, that program expanded to reach all former provinces of Rwanda plus 11 other countries. *Umucyo,* WR's CSP in Kibogora Health district, began in 2000 and uses the Care Group model to reach a population of 174,000 people with C-IMCI and HIV/AIDS interventions. Early successes in behavior change could already be measured at midterm (e.g. ITN use increased from 3% to 66%; complete immunization coverage from 47% to 87%; hand washing from 34% to 84%; and breastfeeding within the first hour of birth from 37% to 71%). WR participates in the district and national dialogue on C-IMCI and malaria control.

**Since 2001, Concern has worked specifically with the IRC and WR to improve maternal and child health at the household, community, and health-facility levels.** A notable accomplishment of the tri-agency partnership was the 2005 implementation of a health advocacy and education campaign, which increased from 13% to greater than 60% the number of children under one with fever treated within 24 hours, exceeding the Abuja target and saving lives. **Umusanza For the Children** is about bringing together the skills, field experience, working tools, and methodologies of these three PVOs to bring C-IMCI to scale, including integrated community case management. Each of the PVOs is registered with the Ministries of The Interior, Foreign Affairs, and Planning, and External Cooperation and have agreed to this application as outlined in the pre-teaming agreement in Annex B.

# 2 Situation Analysis

## *2.1 The Program Area*

The program will cover six of the 30 Districts. Operation areas were selected based on key factors of health need, economic profiles, consistency with USAID strategic districts for the Twubakane Project, proximity to original program areas of the PVO CSHGPs, and relative lack of other support from child health.

**Table 1: Intervention Districts and Beneficiaries**

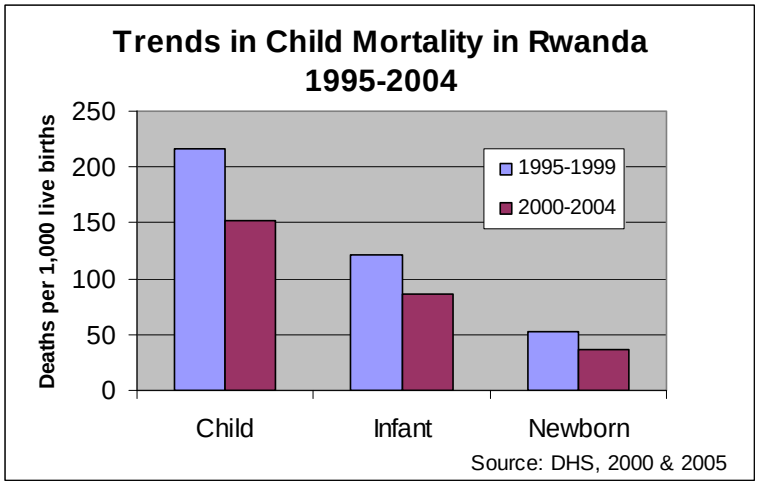
| District | Population 2006 | *0-11 months* | *12-59 months* | TOTAL Children Under-5 | Women Aged 15-49 Years |
|---|---|---|---|---|---|
| **Kibungo** | 256,267 | *10,001* | *31,252* | 41,253 | 59,966 |
| **Kirehe** | 253,290 | *9,884* | *30,889* | 40,773 | 59,270 |
| **Gikongoro** | 314,423 | *12,270* | *38,344* | 50,614 | 73,575 |
| **Gisagara** | 294,082 | *11,476* | *35,864* | 47,340 | 68,815 |
| **Nyaruguru** | 258,088 | *10,072* | *31,474* | 41,546 | 60,393 |
| **Nyamasheke** | 358,775 | *14,001* | *43,753* | 57,754 | 83,953 |
| **TOTAL** | **1,734,925** | ***67,704*** | ***211,576*** | **279,280** | **405,972** |

*Table based on 2002 Rwanda bureau of statistics census data with 2.5% annual growth. Demarcations based on Census Bureau and publications in national newspapers. Proportion of infants is 4.0% of the population and children 12-25 at 12.5% of population. WRA 23.4%.*

Selected areas are those among the worst off in terms of health and poverty. Most Rwandans living below the poverty line reside in the south and southwest areas of the country[9]. The vast majority of families are self-reliant farmers and day laborers. Land, a scarce and precious resource in Rwanda, is least available in the south. While nationally about 29% of households own less than 0.2 ha of land, the situation is much worse in Butare where with 62% own less than 0.2 ha, and in Gikongoro, where 59% of families have extremely limited landholdings or are landlessness. Religions and ethnicities in these districts resemble the national situation.

### *2.2 Maternal and Child Health*

Rwanda, with its population of 8,427,000, has made remarkable progress in many areas following the 1994 genocide. One crucial sector, however, remains underdeveloped: the health status of women and children. The DHS 2005 preliminary report indicates child mortality rate in Rwanda of 152. Newborn, infant and under-five mortality rates all proportionately declined by approximately 20% over the last five years,[10] in part due to the contribution of the CSHGP. However, the rate remains unacceptably high, with one in seven children dying before their fifth birthday, the vast majority of them from easily preventable conditions.




**Leading causes of death** include malaria, anemia, pneumonia and diarrhea; malnutrition is a contributing factor in over half of all child deaths. Household surveys reveal that of

children under five, 26% had fever, 17% had acute respiratory infection symptoms, 27% had diarrhea, and 23% had weight/age malnutrition within the two-weeks of the survey.[11] Also, co-infection of illness is common and many mothers consider mild symptoms as normal, taking no special course of action.[12]

**Vaccination levels** are fairly good, with a national full coverage of 75%; proposed expanded impact region levels range from 67% in the east to 84% in the south zones.[13] Improvements have been measured over the past five years in all districts supported under the CSPs, whether or not there was a specific intervention. For example, in Kibogora, full vaccination coverage increased from 47% to 85%[14]. The program will work with district health authorities and MOH to continue to ensure prompt identification, confirmation, and an effective response to epidemics as appropriate.

The country is in a general **HIV/AIDS** pandemic crisis. Preliminary DHS 2005 data indicates that adult prevalence is 3.6% among women and 2.3% men. Prevention of Mother-to-Child Transmission (PMTCT) services are available for pregnant women in every district, and the government is working towards establishing this service at all health centers. For example, Nyaruguru and Gikongoro Districts collectively have four PMTCT sites and plan to expand to 17 by 2007. Participation in PMTCT has been high with over 90% volunteering to be tested and sero-prevalence levels ranging from 5 - 8% over the past three years in CSP-supported districts.

Significant resources are available and effectively coordinated through PEPFAR, World Bank's MAPS II, and the Global Fund for the prevention, care, support, and impact mitigation of HIV/AIDS, including the national roll-out of antiretroviral treatments. As such, no direct intervention is planned under this program. However, mainstreaming is part of **Concern's global HIV/AIDS policy**. Therefore, a response to HIV will include connecting program components, such as health and nutrition education, through CHWs, community health planning, as well as workplace education for CSP staff.

**Maternal health** is intertwined with child survival; it affects the survival of the newborn, and the child who loses his/her mother in childbirth has greatly diminished odds for survival. The national maternal mortality ratio is a staggering 1071[15], and UNICEF estimates that it has increased to 1300. Women have a lifetime risk of 6:100 of dying due to childbirth-related complications. Major direct causes are post-partum hemorrhage, obstructed labor, infections, and eclampsia.[16] At least 96% of pregnant women attend antenatal services, which include screening, presumptive treatment for malaria (IPT), iron folate supplementation, and tetanus toxoid vaccinations. Improvements have been seen in first trimester attendance with the introduction of IPT and subsidized ITNs, and 17% of pregnant women are now sleeping under ITNs.[17] Reproductive pressures are high with a total fertility rate of 6.1 per woman.[18] While there has been recent improvement in uptake of modern contraception, from 4% to 10%, over the past five years[19], almost half of Rwanda's health services are provided by church-based providers who do not offer family planning services.

Two-thirds (67%) of **girls have attained primary school level education**.[20] Nationally, 34% of all households are female headed. Concern's 2002 gender and health study in Kibilizi concluded that women are responsible for health promotion in the home but that the husband has authoritative voice when it comes to seeking care outside the home. The program will leverage support from Twubakane, GTZ, and ARBEF, which are already working in reproductive and maternal health in the program area.

With **75,000 children dying of preventable and low cost, and treatable diseases**, the expanded impact program is focused on working with MoH and UNICEF to scale-up C-IMCI and forge leadership for community case management. In Rwanda, as in most countries with high mortality levels, over 70% of child deaths occur at home. The WHO/BASICS/UNICEF rapid child health assessment in 2005 concluded that home herbal remedies, purchasing drugs from pharmacies and the informal sector, and prayer were the most common frontline treatments for sick children. When care is sought a large number go to the public hospitals (36%), pharmacies (29%), health centers (12%), and traditional healers (11%).[21] A bounty of household data regarding perceptions, beliefs and practices exists from CSPs and has been studied and incorporated in behavior change interventions.

**Clients pay for health services in Rwanda**, which represents a huge barrier for the 36% of families living in extreme poverty of less than $1/day. National health accounts indicate that people paid for over 50% of health expenditure in 2003. And, average cost of health care per consultation has risen to $1.15 (710 Rfw). National expansion of "mutuelles," a community-based social insurance health program, is increasingly significant in reducing financial barriers to health care for a good portion of the population and includes exemptions for about 10% of the population. However, the system is still nascent with formal guidelines and the 2004-initiated training program is still underway. Household mutuelle coverage now stands at 35% nationally. Family membership costs about $6 annually and covers consultation, drugs, and some include emergency ambulance transport. A few districts are considering extending benefits for hospital and community services.

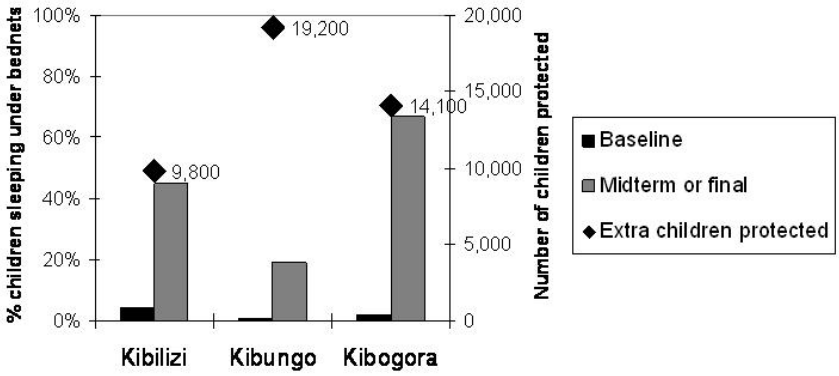
**Malaria is a major burden** to the country, and is the principal cause of morbidity and mortality, causing 40% of health facility visits and 43% of all deaths. Children are at particularly high risk. In Rwinkwavu Health District in Kibungo, in 2002, community health workers reported 588 deaths of children under five in the community, almost three quarters of which were attributed to febrile illness. Only 42, or 7%, of these deaths occurred at health facilities. Studies in the CSP areas regarding **caregiver knowledge** indicate a universal understanding that mosquitoes bring malaria at night and that bed nets can protect people, and beliefs linger regarding transmission to humans from bad water.

**Access to treatment and care-seeking for malaria** is poor. A special community malaria study in the initial three CSP health districts of the PVOs showed that only 57% of mothers with children under five knew two or more danger signs of febrile children requiring urgent attention. In a survey conducted in Kibungo and Ruhengeri health Districts by the National Malaria Integrated Control Program with the Quality Assurance Project, children less than five years of age were found to get appropriate treatment an average of three days after the onset of fever, whereas WHO recommends treatment within 24 hours. Reasons for this delay include distance from the health center and the cost of treatment. Many children do not get appropriate care at all. The 2005 DHS indicated that 26% of children had fever in past two weeks but only half were seen by a trained provider for care. Other surveys have found that as little as 9% of febrile children receive appropriate treatment.

Social marketing of **bed nets** yielded almost no progress in coverage. Yet, coverage increased dramatically with highly subsidized provision through antenatal clinics. Nationwide, only 13% of children sleep under a treated net, according to preliminary

analysis of the 2005 DHS. As shown by the following graph, this figure is much higher in Butare, Cyangugu, and Kibungo provinces where CSPs are active.

***Impact of Bed Net Promotion in Districts Supported by CSHGP Programs***




Early on, CSPs directly subsidized nets to pregnant women, but national supply has greatly improved because of support from the Global Fund and other donors: there are over 525,000 long lasting nets planned for distribution between 2004 and 2006. Nets are subsidized at 200 Rfw (US$0.35) for pregnant women and children-under five and at 400 Rfw (US$0.70) for members of the *mutuelles*.

**Diarrhea is a leading public health risk to families**. Recent surveys have found 27% of children under five[22] suffer from diarrhea during two-week recall surveys. Children aged 6 – 23 months (29%), and children under five residing in the new Gikongoro and Nyaruguru Districts (24.5%), are the most severely affected.[23] Weaning practices and poor hygiene are primary direct causes to diarrhea and largely attributable to reliance on open water sources that are distant from homes reducing the quantity of water available in households, and consumption of untreated water, particularly in areas with high point prevalence. Handwashing with soap practice is also low.

Most diarrhea cases receive no treatment outside of the home, as reflected in very low cases presented at hospitals and health centers.[24] Infants are much less likely to be seen at a health facility than older children. Much improvement in home treatment practices is possible. In 2005, 43% of cases received some form of oral rehydration therapy and only 12% received oral rehydration solutions (ORS). There has been almost no change since the DHS 2000. While nationally 86% of mothers self reported that they were familiar with ORS, baseline studies in Kibilizi found that only 45% of them were able to accurately described how to prepare ORS, and only 11% used ORS when a child was sick with diarrhea.[25] Zinc therapy is under consideration by the MoH.

**Home treatment** for diarrhea first involves traditional medicines and prayers, and providing off-the-shelf syrups and antibiotics as a second course of action. In Kibilizi 30% of cases were seen at the health center, 12% by traditional healers, and the rest were managed at home.[26] Furthermore, many mothers believe they should provide fewer fluids than usual to dry up the diarrhea, and in practice, at the baseline, 40% gave fewer liquids, 22% provided no liquids, and 48% provided less breastmilk than usual.[27] These findings contrasted to national DHS findings that only 19% of children with diarrhea received less fluids than normal.

**Zinc therapy** is not yet available, but national discussions are underway and MoH is likely to adopt it in the coming months. IRC was one of the first PVOs to field-test the operationalization of therapeutic zinc in Africa in its DRC CSP.

**Pneumonia** is a leading cause of under-five mortality and morbidity in Rwanda, as in many other sub-Saharan Africa countries. The relatively high immunization coverage in Rwanda effectively prevents some pneumonia cases, but poor nutritional status leaves many children exposed. Acute respiratory infections accounted for 27% of outpatient consultations for young children in 2004 –second only to malaria– and 10% of deaths, according to national health information statistics. Access to care is limited by the same factors that impede care for malaria and diarrhea. These obstacles include distance, with many household being over an hour's walk from a facility; cost, since many families cannot afford the cost of the consultation itself; and lost work. In addition, culture is also an obstacle, with families increasingly turning to "scratching" of the throat by traditional healers, a highly unsafe practice usually reserved for "gapfura," a disease described as being similar to tonsillitis or upper respiratory infection, but that may be invoked when lower respiratory symptoms are present.

### *2.3 Decentralization*

The Government of Rwanda passed an initial decentralization policy in 2001, and in early July 2005 launched an administrative reform and redistricting process that is preceding quickly for implementation before the March 2006 local government elections. The new territorial and administrative reform process will be phased in from October 2005 – March 2006. These changes will affect all donors and programs, and so high-level consultations and negotiations are planned in last phase of the reforms to improve coordination of resources.

An essential element of this new redistricting is that the former health districts, which have operated fairly autonomously at the local level, and have reported directly to MoH, will now become health departments within the administrative districts. This will mean that the district health officers, in addition to reporting technically to MoH, will report administratively to district officers and locally-elected mayors. This should ensure greater community participation and involvement in health, as locally-elected mayors will be evaluated and elected according to their support for a variety of social services, including health. While the basic village unit of "cell" remains unchanged, the remaining structure does change:

**Table 2: Snapshot of Decentralization Structure Changes**

| LEVEL | Before | After |
|---|---|---|
| Regional Level | 12 Provinces + Kigali Ville | 5 Zones |
| District Level | 40 Health Districts<br>106 Administrative Districts | 30 Districts |
| Sub-District Level | 1545 Sectors | 418 Sectors |
| Sub-Village Level | Nyumbakumi of about 10 households | Umudugudugudu of 25-40 households |

The decentralization of the health system will lend itself to the further development of primary health care, including minimum and complementary service packages at local health centers and district-level hospitals. The plan is to establish one hospital per district and one health center per sector, as most health centers currently cover two sectors,

serving about 15-25,000 people. While nearly 40% of all facilities are privately run by missionary services, relationships between private and government sectors are improving with the implementation of formal reporting lines that have been established with the district health management team.

### *2.4 Collaboration with National Child Health Initiatives*

This program is about reducing newborn and child mortality in a significant way over the next five years by focusing on the leading killers of malaria, diarrhea, and pneumonia at the household level. By working with and through government and social structures, the PVOs will be able to implement this work at scale building on strong support from MoH, and by building on the collective CSP experiences of Concern, IRC, and WR. Consultative meetings held in May in Kigali were followed by a four-day design workshop in September 2005. These meetings greatly informed the basic scope of the program design with MoH, IntraHealth, MSH/RPM+, UNICEF and USAID. District health officers were also consulted individually about child health priorities, mapping of health and HIV/AIDS programs and partners, capacity of health services, and anticipated effects of decentralization. Furthermore, phone meetings and document exchanges followed the rapid child health assessment with BASICS. (Please refer to letters of support in Annex C.)

Collaboration with national programs includes the MoH's Maternal and Child Health Unit in community mobilization, reproductive health and C-IMCI; the National Malaria Control Programme (PNLP), which provides long-lasting mosquito nets and home based treatment; BASICS III, which implements recommendations of the 2005 rapid child health assessment; Population Service International (PSI), which promotes social marketing of Sur Eau point of use water treatment, condoms, deeply subsidized mosquito nets through ANC and EPI services; UNICEF's C-IMCI in four separate districts, which provides Vitamin A, iron, and potentially zinc; UNFPA, which focuses on reproductive health capacity building and contraceptive logistics; Management for Sciences and Health's RPM Plus, which focuses on community drug management and supply logistics; Family Health International's IMPACT program in HIV/AIDS prevention, care and support; Association Rwandais de la Bien-Etre Familalle (ARBEF), which provides long and short-term contraceptive services and community based distribution; and the National AIDS Commission, which is active in national and zonal HIV/AIDS services and coordination.

Every district offers a different set of partners: IntraHealth's Twubakane Project works on reproductive and child health in Gikongoro, Nyaraguru, Kibungo and Kirehe Districts; Food for the Hungry works in nutrition in Kibungo Distict; GTZ works in health system strengthening in Nyaraguru and Gisagara Districts; Health Unlimited has radio health communications in Nyaraguru and Gisagara Districts; and PEPFAR and MAPS partner in VCT, PMTCT and care and support interventions throughout the country. Umusanza for the Children will be responsive and flexible to leveraging resources and approaches among all partners.

# 3 Program Strategy and Interventions

### *3.1 Goal and Objectives*

**The goal of Umusanza for the Children is to <u>reduce child mortality in six underserved districts</u>, with an estimated population of 279,000 children under five, <u>by the year 2011</u>.**

Objectives include:

- **Increasing access to prompt first-line treatment** for young children with malaria, diarrhea, and pneumonia
- **Increasing coverage of key preventive interventions** including bed nets and Vitamin A supplementation
- **Increasing adoption of key family practices** including hand-washing with soap, prompt care seeking, and better feeding of the sick child

Specific objectives and targets are detailed in the description of each intervention.

### *3.2 Major Strategies*

The three program interventions, delivered through a C-IMCI strategy to support national scale-up, will address the major direct causes of child mortality in Rwanda: **malaria control, pneumonia case management, and diarrhea control**. Specific strategies will include:

**Increasing Access to Quality Treatment:** The program will work on the major components of access and quality. The services will be made accessible geographically by using local CHWs, and financially through subsidies for drugs, particularly anti-malarial. All three PVOs in this proposal are experienced with this methodology, having worked together to pilot the community malaria treatment program currently being extended nationwide. Staff and partners will increase demand for treatment, particularly for malaria and diarrhea, by improving recognition of danger signs and care-seeking behavior through behavior change campaigns carried out by district, health center, and community agents. The PVOs will improve and maintain quality through quality assurance methodologies, which are well implanted in Rwanda because of the work of the USAID-supported Quality Assurance Project. The staff from all three organizations has experience with quality assurance methodologies.

**Increasing Coverage of Key Preventive Interventions:** The program will use two major strategies to extend the reach of preventive interventions. Some services, such as vitamin A supplementation, will be provided through outreach clinics. Currently, outreach clinics are used mostly for immunization, but the IRC and Concern's experience in Rwanda demonstrates that these outreach sessions can serve to provide many services. Other services will be provided by community providers. For example, bed nets will be distributed at the community level.

The experience of the IRC and others indicate that two other strategies need to be in place for coverage of preventive services to stay high. First, the program's quality assurance personnel will work with partners to insure that systems are in place in each district and each health center to procure key inputs, such as vitamin A and iron, and prevent stock-outs. Secondly, the program's monitoring and evaluation manager, and the monitoring and evaluation officers in each district, will train and supervise health center staff to insure that coverage is monitored in each health center. This will allow district health staff to identify low-coverage areas and remedy problems proactively; it will also motivate health center staff to perform better, by giving recognition for good performance, and by allowing them to identify problems earlier.

**Increasing Adoption of Key Family Practices:** The project will increase adoption of key family practices through behavior change communication at the household level and to enhance equity. It will include appropriate formative research to identify key obstacles and opportunities, testing of key messages, and the development of related written and

illustrated materials. Strategies will be developed using the BEHAVE Framework, and by building on proven approaches from Concern, IRC, and WR CSP programs in Rwanda. The program will focus on passing key messages through formal and informal mechanisms, and through a variety of channels and people, including district, health center, and community agents.

### *3.3 National Health Policy*

One key objectives of the **2002-2007 PRSP** is establishing more effective human resource practices, in terms of better health care to reverse the decline in health indicators and confront major killers such as HIV/AIDS and malaria, as well as reducing inequality as a foundation of life. Poor health is viewed as both a cause and consequence of poverty. The National Poverty Assessment clearly found that difficulty accessing health care - given low household incomes, inadequate facilities, high drug prices, and malnutrition - places an unjust burden on families. Through this program, both close ratios of equipped CHWs for health education, as well as the implementation of primary curative care practices, will be instrumental in making an impact on mortality levels in the six disadvantaged districts.

The goal of **Rwanda's National Health Policy (2004-2009)** is to contribute to the well-being of the population by providing quality health services that are accessible to the majority of the people, and that are provided with their participation. The program will support both of these key policy priorities by first **increasing access to quality child health** services by organizing the provision of child health services at the community level, and by developing supervision and motivation systems to ensure that these services are of high quality. The program will also **promote participation** by involving community members in the organization and delivery of community health services, and by working with associations, local leaders, and community providers to increase community organization for health promotion. All of these actions, combined with promotion of key family practices, will **increase the well-being** of women and children.

### *3.4 Program Scale*

The proposed program already represents considerable scale by proposing to provide curative and preventive health services for 25% of the children in Rwanda at the household level; that is over 279,000 children under-five. This represents scale in terms of equity, geographic, and impact. The program's Team Leader and senior staff will work with senior MoH staff to scale up effective community interventions further, through several mechanisms. First, regular meetings will be held between senior staff from the program and the MoH. Also, on-site visits of staff from other districts to program areas will be used for cross learning. And, key program tools will be developed and shared (e.g. registers, databases, and educational material) in collaboration with other partners such as the Twubakane Project, UNICEF, the Belgian Technical Cooperation, GTZ, and Health Unlimited, all of which have significant presences across the country.

### *3.5 PREVENTION AND TREATMENT OF MALARIA*

35% level of effort. Objectives are to:

- Increase the proportion of children under five sleeping under a treated mosquito net the previous night from 13% to 35%
- Increase the proportion of children under five with fever in the past two weeks who received anti-malarial treatment according to NMCP policy within 24 hours of onset of fever from 13% to 60%

- Increase proportion of mothers with infants 0-11 months who received two observed IPTs during last pregnancy to 90%

MoH policy recommends three major strategies to lessen the burden of malaria: the use of ITNs for prevention, particularly among vulnerable groups including pregnant women and children under five; early diagnosis and treatment with combination therapy, currently amodiaquine and sulfadoxine/pyrimethamine (SP/AQ); and, more recently, intermittent preventive treatment (IPT) during pregnancy with SP, which was incorporated into Ministry policy in February 2005.

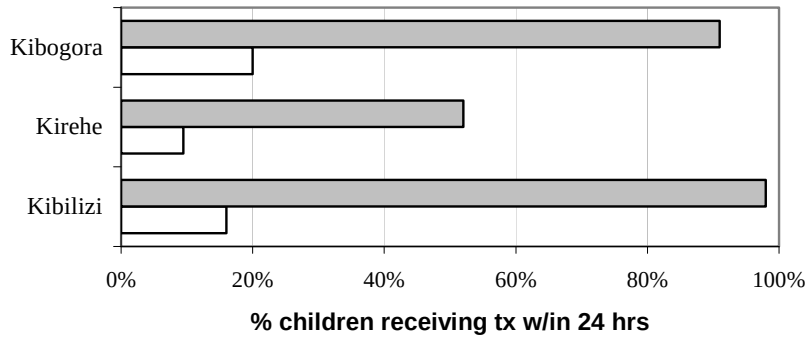
3.5.1 **Promotion of protective practices: bed net use, prompt care-seeking, and compliance with IPT:** Awareness of the connection between mosquitoes and malaria, as well as ITN use for protection from malaria, is nearly universal among adults in Rwanda. As previously mentioned, heavily subsidized long-lasting nets (L)ITNs are available through the health system and uptake is very high. This program will build on this high level of awareness and improved accessibility of nets to promote (L)ITN utilization by pregnant women and children under five though the mobilization efforts by local leaders, CHWs and other community resource persons (refer to community mobilization section below). In regions including Nyamasheke and Gisagara Districts, coverage of standard bednets is 20%.[28] To ease the transition from ITNs to (L)ITNs, CHWs will organize re-treatment campaigns for bed nets using KAO Tab 1-2-3, insecticide provided free of charge by the National Malaria Control Program.

Malaria is endemic n Rwanda, and pregnant women are at high risk of asymptomatic infections, which can have serious effects on newborns. The national policy is to provide two IPTs at the health center, during first antenatal visit, and the second observed dose one month later to reduce the burden of parasite infection of the placenta and adverse fetal outcomes. CHWs will counsel all pregnant women to attend antenatal care frequently and to start early. Mothers will learn that by receiving IPT early in pregnancy they can reduce the risk of perinatal death and low birth weight babies.

There is a need to improve the timeliness of seeking care outside the home for children with fever, including newborns. Group talks and individual interactions between CHWs and the families they serve is an effective means of raising awareness about the importance of immediate medical consultation. Experience from the home-based malaria treatment pilot demonstrated that a key factor in families seeking care from a trained provider in less than 24 hours of the onset of fever is the availability of trained and equipped CHWs who are able to manage simple, uncomplicated malaria near the home.

3.5.2 **Community case management of uncomplicated fever:** Community case management of malaria is a national health priority, and has been incorporated into the C-IMCI protocols following pilots in six districts. This effort was supported by CSPs with NMCP leadership, and financed by USAID, Belgian Technical Cooperation, and CORE Inc. The effort resulted in significant increases in prompt management of fever, as shown in the graph below.

*Impact of community treatment for fever*




This community based approach to case management for uncomplicated fevers in children will be scaled up and implemented through CHWs who will each serve a unit of 30 households grouped in an *umudugudugudugu* (see page 11). A three-day malaria training curriculum has been developed under the previous program and will be reviewed for use with national stakeholders at the start of this program. The curriculum includes basic facts about malaria transmission and prevention, the screening and treatment algorithm, counseling skills for CHWs, record-keeping and reporting and stock management.

Using quality assurance principles, the program will build the skills of district trainers to train, coach, and monitor CHWs in their working areas. The district trainer team includes the district-based supervisor, two nurses from each health center, and the sector-level CHW peer leaders. Optimal feeding practices for sick children will also be emphasized by CHWs. As such, CHWs will promote beneficial feeding behaviors including continued feeding, increasing fluids during illness, and increased recuperating feeding for at least two weeks following an acute illness.

The case management algorithm is for children aged 6 to 59 months; infants under six months with fever are referred to the health center for appropriate care. CHWs will screen sick children for danger signs of severe illness that require treatment at the health center: convulsions, loss of consciousness, vomiting more than three times or vomiting everything, inability to drink, breastfeed, or eat, tiredness, inability to stand, cough with fast, rapid breathing, and/or severe anemia or pallor.

There is a significant overlap between the clinical presentation of malaria and that of pneumonia. A recommendation of the rapid child health assessment was to include community treatment for pneumonia in CSP programming, building on the fact that diarrhea and malaria treatment standards are already in place. This is under serious consideration as discussed in section 3.2 below. However, CHWs will not be expected to distinguish between the two, but rather to treat both conditions if children present with symptoms that meet treatment criteria for both. A team from Boston University will be working with the IRC in 2006 to examine the effect of this clinical overlap on community treatment, and to make recommendations for the treatment algorithm.

To improve the quality of prescribing practices of anti-malarials for children and caretaker compliance, NMCP developed red blister packets for children aged 6 to 36 months and yellow packets for 36 to 59 months. The first treatment is directly observed by the CHW. Drugs will be procured by CHWs from the health center pharmacy according to their registers of cases treated. Cost of treatment at the community level was set by the National Home Based Malaria Technical Committee, which was determined to keep the price low and affordable so as to avoid barriers to drug access. To date, MoH has

succeeded in finding donors to cover the pilot stage of this initiative. CHWs charge a fee of 50 Rfw (US$0.08, modest even by the standards of rural Rwandese communities) per treatment, and the revenue is returned directly to the CHW association as a performance incentive.

An issue for scaling up and sustaining home based treatment for malaria nationally is the absence of a drug supply strategy. While working with NMCP and MSH's RPM+ to identify longer term funding mechanisms, including long-term donors notably the Global Fund, the program will advocate for the inclusion of community services under social health insurance and exemption programs (e.g. *mutuelles*), or direct cost recovery for longer term supply. Recognizing that this will take time, the PVOs have committed a seed stock under matching funds of over $1m to purchase anti-malarials. If after this time period a regular supply cannot be found, families will still benefit. They will be better equipped to recognize malaria early and more familiar with anti-malarial treatments, improving overall practice of seeking care at the health center within 24 hours as the direct result of this intervention.

To track the impact of this component, CHWs will meet monthly with the health center manager and health district representative to provide a report on the number of cases seen, and the numbers treated, referred, and of deaths in the past month. Each CHW will be supervised in his or her area by health center staff at least twice per year. These visits will include observation of case management, follow-up home visits, and review of drug availability and condition. Health centers will visit more often if anomalies in reporting indicate a possible problem.

Another challenge is that S/P resistance is increasing, particularly in the eastern part of the country leading to the government's planned adoption of Coartem (Artesunate Combined Therapy) as front-line treatment at the health facilities. However, as resistance levels are still low, the policy position at this time is that CHWs will continue to provide SP/AQ at the community level and monitor for resistance levels and potential policy change through the monthly meetings mentioned. The three PVOs will continue to serve an advocacy role to ensure that the treatment provided by CHWs is effective.

3.5.3 **Referral level care for fever:** Referral level care for fever is available at local health centers for complicated malaria and other causes of fever. Specific facility assessments will be conducted with the DHMT at baseline to further determine the quality of care provided and identify areas that need strengthening. Note that, while this program's primary focus is at the household and community level, it will coordinate with other partners such as the NMCP, the Twubakane Project, and GTZ to ensure that a standard of care is maintained. Both Gisagara and Nyamasheke Districts are not supported by Twubakane Project funding for health facility C-IMCI, but the program will advocate with the MoH, UNICEF and WHO to ensure that basic training and supportive supervision is provided in these areas to adequately supervise CHWs and to effectively manage cases

### *3.6 CONTROL OF DIARRHEAL DISEASE*

35% level of effort. Objectives are to:

- Increase hand washing with soap at critical times (after defecation, after handling children's feces, before preparing food, and before feeding children/eating) from 35% to 50%
- Increase ORS use among children with diarrhea from 12% to 50%. and increase 14-day zinc therapy among children with diarrhea to 50%

- Increase the proportion of children offered more food and fluids during diarrhea from 17% to 40%

**3.6.1 Strategies of care:** Control of diarrhea disease will be addressed through culturally appropriate health education, including key home practices for prevention (e.g. hand washing, proper disposal of feces, latrine use, safe water use) and home case management (immediate use of ORS/home available fluids, zinc supplementation, continued feeding with increased frequency of small portions). Social marketing of Sur'eau, ORS packets and zinc will also be employed. CHWs will be equipped and skilled to promote hygiene and sanitation through community based education/home visits, to improve access to and use of ORS and home available fluids, and to encourage rational drug use. Specific *preventive messages* will include:

- Improved hygiene practices such as washing hands with soap before food preparation, before feeding children and after defecation; point of use water treatment with Sur'eau (a point-of-use water purifier)
- Exclusive breastfeeding for the first six months of life and appropriate complementary feeding
- Improved sanitation practices (safe disposal of feces, use of latrines, use of Sur'eau to purify water).

Specific messages for diarrhea *case management* will include:

- Recognition of danger signs (blood in stool, signs of severe malnutrition, acute watery diarrhea with dehydration, and persistent diarrhea lasting 14 days or more) for seeking treatment immediately from appropriate health care provider
- Treatment with ORS/home available fluids
- Zinc supplementation for 10-14 days during and after diarrheal episode
- Increased fluid and food intake (frequent, small feedings) and increased fluids and food for two weeks following diarrheal episode
- More frequent breastfeeding
- Discouragement of anti-diarrheals and antibiotics (unless prescribed by trained provider)

Building on WR's success in Kibogora Health District, where hand washing practices increased from 34% to 84% from 2001 to 2003, CHWs will also mobilize families to establish 'hand washing stations' in their homes. These stations are a specific place in the household with clean water and soap in a receptacle, such as a bottle or bucket with soap/ash, that allows washing to be done frequently without separate trips to a distant water source.

CHWs will be taught, according to the C-IMCI protocols to look for signs of dehydration by checking eyes, lips, thirst, and respiration rates; check for fever to exclude possible co-infection; and to identify cases for referral by asking about blood in stool, signs of severe malnutrition, acute watery diarrhea with dehydration, and persistent diarrhea lasting 14 days or more. The use of anti-diarrheals and antibiotics for managing acute watery diarrhea will be discouraged, since they are ineffective, and potentially dangerous. CHWs will conduct follow-up visits to monitor the condition of children recovering from diarrhea.

**3.6.2 Access and quality assurance:** Quality assurance of CHW case management will include an initial training of 16 hours, review of cases during regular CHW meetings with health center nurses and the Sector CHW Leader, direct supervision of CHWs during spot checks twice per year by the health center staff, including a review of registers, and role play during refresher trainings.

Supply of drugs and supplies, including ORS, Zinc and vitamin A will be provided by UNICEF, with reinforcement from this program and monitoring by the Community Heath Committee (COSA) and CHW Associations. Drug stocks will be available for CHWs from health centers located within a 2-3 hours walk from most intervention areas within each district. Given the global evidence that fees for service serve as a barrier to health service utilization, this program takes a strong stance in favor of free or deeply subsidized community care. To ensure sustainability of supplies beyond the program, advocacy will be undertaken for the inclusion of community care services through the country's health insurance "mutuelle de sante."

The MoH is reviewing policy to recommend systematic treatment with ORS and zinc through trained and supervised CHWs. Supply by the CHW will be based on two-day treatment as follows: children under two years – 500 ml/day; children two to five years 1000 ml/day.[29] CHWs will be trained to demonstrate accurate measurement and preparation of ORS to mothers/caregivers. Children under four months will be referred to the health center, and mothers will be encouraged to increase breast feeding of all children with diarrhea who have not yet been weaned.

As mentioned earlier, two districts are not supported by other programs for facility C-IMCI, but this program will advocate with the MoH, UNICEF and WHO to ensure that basic training and supportive supervision is provided in these areas to adequately supervise CHWs and to effectively manage cases referred from the community.

### *3.7 PNEUMONIA CASE MANAGEMENT*

30% level of effort. Objectives are to:

- Increase the proportion of children with pneumonia (as determined by IMCI criteria) who receive appropriate treatment from an estimated 15%[30] to 60%
- Double the number of infants under two months with pneumonia referred to health centers
- Maintain the proportion of children 6-59 months and mothers of newborn children who receive vitamin A above 90% even in the absence of periodic campaigns

The program contributes to pneumonia prevention by making **zinc treatment available** for children with diarrhea, and also reduces risk of future cases of pneumonia by insuring that children and new mothers are **supplemented with vitamin A**. This helps reduce mortality from pneumonia and other infectious diseases. Zinc treatment is described in more detail in the Diarrhea section.

The proposed intervention includes four major components: **prevention of pneumonia** through zinc treatment and through distribution of vitamin A; **promotion of prompt care-seeking** for respiratory symptoms; **community case management**, including treatment and referral; and **improvement of quality** at facility level.

3.7.1 **Pneumonia prevention:** Program staff and partners will prevent pneumonia by making zinc treatment for diarrhea available, which also prevents future cases of

pneumonia, and by insuring that children and new mothers are supplemented with vitamin A, which reduces mortality from pneumonia and other infectious diseases. (Zinc treatment is described in the diarrhea control section.)

Children 6 to 59 months will continue to receive vitamin A during campaigns as is currently the case. Campaigns are being progressively phased out, however, as the immunization drives that have been used to fund them are coming to an end. As this occurs, district and health center staff will train CHWs to identify all children 6 to 59 months in their work area, and to provide these children with vitamin A capsules every six months. To avoid double-dosing, all children within one district will be treated at the same time. District health staff will set a calendar and prepare adequate stocks and distribute vitamin A through health centers to make sure this is the case. Health center staff will pass on the vitamin A, prepare distributors, and monitor coverage in their area. CHWs will give the vitamin A and provide reports to health center staff.

Women should also receive vitamin A within six weeks of giving birth, and are poorly served by periodic campaigns since births occur continuously, and not in semi-annual campaigns. Therefore, CHWs will be given a small stock of vitamin A dosed for post-partum women, and will give vitamin A to all mothers of newborns. They will report the number of doses given to post-partum women, which will be compared monthly to the number of births reported and annually to the number of expected births.

Vitamin A coverage for both children and post-partum women will be included in the community health information system, and tracked at both the district and national level.

3.7.2 **Promotion of prompt care-seeking:** District and health center staff will engage community leaders to increase proper care seeking for respiratory symptoms. These leaders may include elected officials, CHWs, school teachers, and leaders of community associations. Program staff in each district will conduct a qualitative assessment, using the BEHAVE framework, to gain a better understanding of obstacles to care. The Mobilization Manager will gather representatives from each of the districts and use the information to design written and illustrated materials, which will be distributed in all six districts. The materials will serve to support a coordinated campaign to educate community members about the benefits of quality treatment.

District and national staff will use the semi-annual performance assessments to evaluate the progress of the campaigns, and to make changes if necessary. Messages will focus on detection of respiratory distress in infants less than two months, who should not be treated at community level and who, according to the 2005 DHS, are less likely to get treatment than infants six months and older. The success of this component will be measured by tracking the number of children who get treatment for respiratory symptoms in health centers and communities, and by the number of infants less than two months old who receive treatment at health centers.

**3.7.3 Community case management of Pneumonia:** CHWs will provide first-line treatment and referral at the community level through mechanisms similar to those described for the malaria and diarrhea interventions.

District staff will **train CHWs**, using an algorithm already developed by the national C-IMCI working group. The working group has chosen Amoxicillin for first-line treatment because of the widespread use of co-trimoxazole for prevention of opportunistic infections in PLWA. CHWs will use a maternal report of cough or respiratory difficulty, along with an observed elevated respiratory rate, as criteria for treatment. The program will procure and provide respiratory timers manufactured for this purpose by UNICEF. Drugs will be

directly procured for the first two years of the program while the program supports the MoH to secure support of a long-term donor.

CHWs will **procure** amoxicillin directly from the health centers, who will procure it through the normal distribution channels from the national and district pharmacies.

**Quality assurance** mechanisms, described in more detail in the QA section of this proposal, will be supervised by district and health center staff. This will involve a review of cases during the monthly meeting; on-site supervision to verify registers; and random visits to the families of children who have been treated. District staff will aim to visit each distributor at least twice a year, and will use routine community health data to determine if some distributors need more support, as evidenced by either patterns of unusually high or low consultation, or from complaints from community members.

CHWs will be trained in **referral protocol**, e.g. referring children under two months of age, or those showing signs of severe pneumonia, such as the inability to eat or drink. District and health center staff will track the number of infants less than two months that are seen at the health center, and target low-referral areas for particularly intensive education of caregivers and training of CHWs.

It is important to note that **MoH policy** is currently considering allowing treatment of pneumonia by CHWs, as described in this proposal, and is expected to allow this on a pilot basis, but has not yet done so. Concern and its partners, with support from BASICS and USAID, have, and will continue to, advocate for community case management of pneumonia. However, community treatment activities will not begin without MoH consent and full participation.

**Community treatment activities** will be tracked monthly through quality assurance indicators, such as the proportion of children consulted for whom a respiratory rate is recorded, and through the number of children seen, treated, and referred.

3.7.4 **Improved quality of facility case management:** The program's case management component will increase access to appropriate treatment by improving quality at the health center level; by making quality treatment available at the community level; and by increasing demand for appropriate treatment.

**Quality assurance will focus on care of young infants and children with signs of severe pneumonia,** the two groups who at particular risk of death, and who should not be treated at the community level.

**District and health staff will work together to improve quality at the health facilities**, using quality assurance techniques already piloted by all three PVOs. These will include the formation of small teams, with representatives from all levels (from district to community) that will assess quality at each health center, identify common problems, and design and implement appropriate solutions. Quality at the health center will be tracked through quality assurance indicators, such as indicators for correct assessment and treatment

### *3.8 Community Health Mobilization Approach*

Good health begins in the home, where caregivers of children make up the largest non-formal workforce in the health system. To influence what happens at home requires a comprehensive approach to behavior change communication, one that engages multiple

levels of community organization and decision making for a common goal: healthy children and families.

Relationships at the community level are developed through informal meetings and by demonstrating respect in frequent visits, transparency, and involving community members to identify and address community problems. Program officers and promoters will lead the community mobilization effort, engaging all stakeholders at project start up. In addition, they will, through the CHWs, relate to community leaders. The project will recruit mobilization officers who have experience working with communities, and who possess excellent communication and facilitation skills. The district level project staff will all be nationals fluent in Kinyarwanda and with a solid understanding of the socio-cultural and political milieu in which they work. Relationships will be developed and nurtured through open and transparent communication with all stakeholders and partners, and concerted effort will be given to building a strong sense of community among the CHWs and program staff.

Through CHWs, promoters, nurses, and project officers, the village leaders will be educated about the purpose of the new program, and the advantages it will bring to the community. Village leaders will be involved in such activities as CHW selection, planning meetings, regular monitoring and evaluation activities, and program implementation. Village leaders will be consulted concerning program direction, and will receive verbal and follow-up written reports of the community health information data, highlighting the program's progress and results, and overall impact on maternal and child health.

Central to the mobilization strategy for promotion of C-IMCI and key family practices is a vast network of volunteer CHWs, one per *umudugudugudugu*, the smallest grouping of households in Rwanda's new system of civil organization. Each CHW is trained in all project interventions to promote key family practices for C-IMCI in addition to assisting with case management and treatment at community level per MoH guidelines.

CHWs are trained and supervised in groups that meet monthly in their sector with either health center nurses or project promoters. At each meeting they review health education lessons, using culturally appropriate adult education techniques including dialogue, pictures, stories, songs and dramas, that are then replicated during home visits. CHWs learn not just to repeat messages, but to respond to the individual situation of each family in their *umudugudugu*, be it managing a present illness, following up on a sick child or helping families to address the problem of barriers to optimal practices.

While caregivers of children are most likely to be mothers, the toll of HIV/AIDS increases the likelihood that grandmothers and older siblings will also have significant childcare responsibilities. When a CHW visits the home, at least once each month (more often in homes with newborns and infants), she targets the primary caregiver but also welcomes others present in the household. This helps earn buy-in from grandmothers who may otherwise oppose new practices and from fathers who are gatekeepers to seeking care outside the home. Male support is also important so that husbands will value and encourage their wives to serve as CHWs. Additional strategies for reaching a cross section of the population are described below.

In addition to implementing project specific interventions, CHWs will also support mainstreamed interventions by using their influence in the home to promote participation in EPI outreach and other activities central to MoH priorities for maternal and child health. As interventions are phased in, and as CHW expertise grows, they become equipped to respond to comprehensive child health needs either directly or via referral as appropriate. Throughout, CHWs have the regular support of their peers in addition to regular contact with their supervisors. Also, CHWs can be paired for home visits so that weaker ones learn from their more naturally inclined counterparts in an unstated mentoring relationship. The relationships that develop between CHWs collectively, and with the

households they visit, serve to strengthen the social fabric of the community, not an insignificant point given Rwanda's recent history.

In addition to the peer and social support that comes from being part of a group, the CHWs have many sources of motivation to remain in their role. Benefits include social standing, public recognition from community leaders, regular training opportunities, small incentives that help to identify them as CHWs, copies of picture cards to be used in health education during home visits, and membership in CHW associations. CHW associations are very popular in Rwanda. Members share profits from community treatment activities, ITN sales and the like to fund member-determined income-generation activities. The regular review of community health information data also serves as a motivating factor, because it helps CHWs to see the impact of their efforts. WR has extensive experience with successful retention of large numbers of volunteer CHWs in Rwanda of 95%. MSH/RPM+ also has excellent tools that will be used to assess CHW motivation factors.

CHWs do not act alone in the community. Their messages are reinforced and validated by opinion leaders such as teachers, religious and other community leaders who are trained by project promoters to spread consistent messages to a cross section of the community. Given that convulsions associated with malaria may be misperceived as a spiritual rather than medical condition and that many people in Rwanda call on their religious leaders to pray for the sick, equipping spiritual leaders to refer sick children for treatment is critical to community mobilization.

For this program to meet its objectives, and to assure that the interdependent elements essential to maternal and child health are sustained, it will build the capacity of its staff and its partners, in technical and leadership areas. The three PVOs, MoH, CHWs, and the communities, must all work together to build institutional, community and individual capacity in order to effectively design, implement, monitor and evaluate its health-related interventions. Specific objectives for capacity building will include:

- To strengthen involvement of 5000 community development committees (CDCs) in health activities and CHW support
- To ensure staff supervision occurs at all levels at least twice a year.
- To build capacity of 440 CHW associations to play a leadership role in community health

Activities will include developing supervision guidelines for program staff and relevant health center staff, assessing existing quality of care for selected health services, identifying means of increasing coverage and utilization of services, strengthening the link between the community and health services, and promoting the efficient use of data collected for appropriate decision making.

### *3.9 Fit of Approach with USAID Objectives*

Program objectives are aligned to fulfilling the USAID/Rwanda mission's strategic objective of **Increased Use of Community Health Services** and its four intermediate results as follows:

- Reinforced capacity for implementation of the decentralization policy in USAID mission focal districts of Gikongoro, Kirehe, Kibungo, and Nyaruguru
- Increased access to selected essential health commodities and community health services for malaria, diarrhea, malnutrition, and acute respiratory infections coordinated through networks of CHWs serving 30 households each – close proximity to the household
- Improved quality of community health[1] services

- Improved community level responses to health issues through participatory local situation assessments, C-IMCI orientation and local strategic plans, health planning with CDCs and leveraging resources from reproductive and child health programs such as Twubakane and HIV/AIDS programmers

Further, this program embraces the objectives of USAID's CSHGP. As described in sections I-III, the program works in disadvantaged districts helping USAID to meet Program Result 1 of Improved Health Status of Vulnerable Target Populations. That is why the program operates in an area reaching 25% of the country and is designed for scale and replication through MOH, UNICEF, USAID. In this way, the program and its partners also contribute to Program Result 2 of Increased Scale of Health Interventions. Finally, this program is designed to effectively disseminate and adopt international best practices and innovations to national strategies for C-IMCI, as demonstrated by the early introduction of zinc and community management of pneumonia. Services such as these will help achieve USAID's Program Result 3 to Increase contribution of CSHGP to the global capacity and leadership for child survival and health.

Reviewers should refer to Annex D for the program matrix and USAID mission's strategic framework for health.

# 4 Performance Monitoring and Evaluation

All three PVO partners involved have had significant success, documented in external evaluations, in using information systems to inform management decisions and increase health worker motivation. The proposed program's monitoring and evaluation plan will build on that experience, but also take advantage of new opportunities.

The performance monitoring plan will have several major components. The central component will be a **Community Health Information System (HIS),** which will collect data at the community level and use that data to inform management and public health decisions at community, health center, district, and national level. The program will focus on integrating the community data gathering and analysis process within MOH's system. Secondly, program managers will use performance indicators, developed as part of a **Management Monitoring System (MMS)** that was designed to improve human resource management, alongside data from the HIS, from supervision, and from quality assurance investigations, to monitor performance of CHWs and clinic workers. Thirdly, staff and partners will work together to conduct **program performance assessments** twice a year. These assessments will gather qualitative and quantitative information from household visits to detect problems, as well as strategies that are functioning well, and to perform a quality assurance check on the HIS data. Finally, participants at all levels of the system will participate in **comprehensive, periodic collaborative evaluations** including **coverage surveys** and qualitative reviews facilitated by an external evaluator. In addition, program managers and partners will define and follow indicators to measure sustainability; this process is described in the sustainability section of the proposal.

**Chart 1: Major Monitoring and Evaluation Systems**

| *System* | *Main Objective of System* | *Reporting Frequency* |
|---|---|---|
| HIS | To collect ongoing information about community health for short-term and long-term decision making | Monthly |
| MMS | To evaluate and improve staff performance | Twice a year |
| Program Performance | Quality assurance of HIS data, and to monitor and improve | Twice a year |

| | | |
|---|---|---|
| Assessments | program effectiveness between surveys | |
| Coverage Surveys | To get scientifically valid quantitative data | Baseline, Mid-term, Final |
| External Evaluations | To conduct formal, official, participatory evaluations of the program | Mid-term, Final |

### *4.1 Community Health Information System*

At the **community level**, CHWs will gather data and pass this data on, in a half-page form to the nearest health center. The basic unit of data gathering will be the *cell*, an administrative area covering about 1,000 households. All births and deaths will be recorded in one *cell* register, whereas information from community service providers will come from registers held by those individual community providers. For the six health centers in which a more intensive care group approach will be used, care group volunteers will also be involved in gathering data.

A list of the information to be collected through HIS is included in the table shown. The list has been simplified based on the experience of the existing programs.

**Data Collected at Community Level**

1. Births that month
2. Deaths that month
    a. < 5
    b. 5 and over
    c. Maternal deaths
3. Children <5 treated for fever
4. Children <5 treated for difficult and rapid breathing
5. Children <5 treated for diarrhea
6. Drugs received, per drug
7. Drugs in stock, per drug
8. Children screened for malnutrition

The data will first be **analyzed at the community level**. The experience of all three PVOs has been that community-level data analysis is the key to making community health sustainable and scaleable. Consequently, we have designed this program so that community analysis is fostered and properly resourced. Community analysis of the information will occur at several points. For example, a community distributor may highlight an increased number of deaths in her area when she submits her report to the health worker coordinating activities for the *cell*; or, CHWs may discuss what the impact of bed net distribution has been on malaria incidence; or, *cell* health workers may, during the monthly community health meetings at the health center, discuss the measures necessary to contain a nascent epidemic of diarrhea evident from submitted reports. The program will also support district's efforts to organize semi-annual meetings with representatives from each of the *cells* and each of the health centers. During these meetings, district health staff will review data from a variety of sources, including the HIS, to assess the health situation of communities and make recommendations.

At the **health center and sector level**, workers will help to pass on the data to district managers and health center staff will also play an important role in data analysis. Health center workers will compile and comment on the reports given by *cell* health workers during the monthly community health meetings. National and district-level monitoring and evaluation staff from the program will offer formal and on-the-job training to enable the health center workers to lead community analysis more effectively. Health center workers will also discuss the data from the HIS during their monthly meeting at the district.

At the **district level**, the district health director and her or his three health staff members will be trained to handle and analyze the information. They will input this information into an Access Database and use Epi-Info and Excel to analyze the information with tables and graphs. In addition, the program's Monitoring and Evaluation Manager will work with national health information authorities and partners to enable district managers to map information from the HIS with the GIS infrastructure already in place at the national university, and several national institutions in Rwanda.

**District health staff will analyze** the information in at least five different ways. First of all, staff will look at the information and identify important trends when they input the information from paper reports into an electronic database. Secondly, district health staff will meet with each other to produce tables and graphs for dissemination at the community and health center level. Thirdly, district staff will help health center and sector leaders analyze the information during monthly district health meetings. Fourth, district health staff will also meet at least once a month with the district director to discuss key trends and proposed actions. Finally, the district health director and her or his staff will get the chance to discuss the information during CSP coordination meetings, which will occur every two months. At these meetings, representatives from all six districts will report on data and activities, and take recommendations based on information from the HIS. Representatives from the Twubakane Project, from the USAID Mission, and from other USAID partner organizations, will also be invited to these meetings.

The new program will insure that information is also passed on and discussed at the **national level**, as recommended by the recent USAID-sponsored Rapid Child Health Assessment for Rwanda. This is a step that has been missing from the current district-level pilots. First, national program staff and MoH and Ministry of Local Government staff will attend the program coordination meetings mentioned in the previous paragraph, will give input into decisions and, when appropriate, will use the information to make appropriate policy and resource decisions. Secondly, the program's Monitoring and Evaluation Manager will work with the person in charge of MoH's health information systems to integrate the community health database into the national GESIS health information database. The Government of Rwanda anticipates that districts will gradually be equipped with internet access, and when this occurs, districts will be able to transfer community health information –and other information– electronically, as well as receive feedback and comparative data.

### *4.2 Program Performance Assessments*

Program staff and partners will conduct a qualitative and quantitative assessment of the program's performance every six months. This assessment will be an intermediate step between weekly and monthly monitoring of routine health data, and the bi-annual formalized surveys and evaluations. This assessment was conceived based on the experience of all three PVOs with participatory evaluations, their blend of qualitative and quantitative participatory data-gathering, and particularly, on the experience of WR with Local Rapid Assessments (LRAs) in Rwanda and elsewhere.

**The assessments will consist of three major steps.** First, district and health center staff, with support from a district-level program monitoring and evaluation officer, will select 19 households at random for the district, using lists of households available to the project (these lists already exist in the areas in which Concern, the IRC, and WR are currently working, and are relatively easy to gather in Rwanda). Secondly, small teams including health center, district, and program staff will interview these households over a two-week period, as they travel to the selected communities in the course of their regular work, to **collect qualitative and quantitative data.** They will begin with a short, targeted quantitative questionnaire developed using standard project indicators targeting specific interventions. The indicators will change as the program evolves: for example, the program may begin with questions related to malaria as this will be the main focus in the first year of the program, and then switch to questions about diarrhea and respiratory illnesses as the malaria interventions become well established. The goal will be to keep the form to a maximum of 15 questions.

Thirdly, teams will gather at district and national levels to review the data gathered and make recommendations. The data will be compiled first in each district. Participants will

tabulate the data manually, rather than with PDAs as during the formal surveys, because there is a smaller volume of data, and because manual tabulation will allow for more ownership of the data and a greater focus on the qualitative information. At the national level, team members will aggregate the 19 households from each district, making a total of 114 households, which will be used to get an estimate of coverage for the indicators targeted in the assessment. The qualitative data will also be treated with a thorough discussion. At the district level, district teams will meet with health center staff to discuss the district and national data. The teams will use the LQAS methodology –already well-implemented in Rwanda thanks to Concern, the IRC, and WR– to determine if the district's performance is significantly above or below the average, and/or meeting the desired objective.

### *4.3 Management Monitoring System*

The HIS will serve a major role to monitor health status, and program coverage.

**List 3: Performance indicators derived from the community health information system**

1. Proportion of *cells* within a given area that have a legible birth and death register
2. Proportion of *cells* within a given area that give reports each month
3. Proportion of health centers that have had a community meeting each month
4. Proportion of health centers that have received tables and graphs from their district supervisor
5. Proportion of districts that have at least two people who can enter data into an electronic database, and at least two people who can produce basic tables and graphs
6. Proportion of districts that have the capability to present health data in map form
7. Number of epidemics detected by the system
8. Proportion of districts for which the Maternal and Child Health Unit has data for the previous month

The HIS will not be the only source of information for management decisions. Senior program staff will work with national and district partners to draft job descriptions for key personnel. These job descriptions will include specific performance indicators –some of them drawn from the list above– which will be used to monitor and improve the performance of personnel, ranging from community workers and the health center staff member in charge of community health, to the district monitoring and evaluation staff.

### *4.4 Coverage Surveys*

Program staff will conduct coverage surveys at three points: a baseline survey within a few months of project start-up, in the dry season between December 2006 and February 2007; a midterm survey two years later; and a final survey four years later, in 2011. At each of these points a survey will be done in each of the six districts included in the program area, using LQAS methodology. All three PVOs will also involve their partners in the design, sampling, and data gathering for the survey, as this has proven to be an excellent partnership-building tool, as documented in IRC's 2000 CORE presentation.

The IRC will also work with its partners to introduce hand-held Personal Digital Assistants (PDAs) to conduct surveys. These devices, which IRC Rwanda staff first used in August 2005, allow for more flexibility for questionnaire design, save photocopying costs, and allow for more rapid analysis. The program's Monitoring and Evaluation Manager will work with each district to introduce the PDAs.

The Monitoring and Evaluation Manager will also work with staff in each district to insure that the surveys are conducted in a uniform way. There will be several steps taken to

insure this is the case. First, the six district-level monitoring and evaluation officers will participate in a survey in at least one other district to increase capacity and uniformity of surveying. Secondly, in each district, staff will use the same questionnaire, although, in each district, managers may choose to add a few questions related to the needs of that particular program.

### *4.5 Mid-term and Final Participatory External Evaluation*

The program will complement its regular monitoring and periodic meetings with two large-scale participatory external evaluations. All three PVOs have used a participatory methodology for their mid-term and final evaluations, and are comfortable with stakeholders participating in defining objectives, in data gathering, and in analysis. Equally, they are comfortable when an external evaluator serves as facilitator. The evaluations will be planned for a full three weeks, given the scale of the proposed program. The evaluations will include representatives from the MCH Unit, the USAID Mission, and the Twubakane Project, as well as all local partners. The IRC will work with its partners to recruit an external evaluator, which all three PVOs will have to approve.

### *4.6 Operational Research and New Technologies*

The program's Monitoring and Evaluation Manager, and district-level officers, will work with partners, including the MoH and the Twubakane Project, to evaluate new approaches that may significantly improve monitoring and evaluation in Rwanda. These approaches include:

- The use of PDAs for routine data entry, perhaps at the health center level.
- The difference in sensitivity of community mortality data collection between care group and non-care group areas.
- The use of cell phones for direct data entry from the community.

# 5 Management Plan

Programs operating at large scale require solid coordination, planning, and logistics for good performance. Based on full consultation with partners, this section includes information about program staffing structure, coordination with PVO Public Health professionals at HQ, working with MoH counterparts, planning and coordination meetings, and advisory committee for collaboration with external agencies. Further information and organization charts are presented in **Annex G** clearly showing relationships and management lines between the partners at field and HQ levels. Inventory of all human resources, internal and external to the PVOs, is also included.

**Concern's role** will be in the area of partnership, IMCI/QA and overall program management and coordination. The agency will take on overall responsibility for management of the grant and building up the team to bring out the best of all the partners. Concern will also work with other health programs in Rwanda to ensure mainstreaming of interventions and coordination of resources. The **IRC's** role will be in the area of monitoring and evaluation, health information systems strengthening, and advocating for community case management of pneumonia and inclusion of zinc in diarrhea protocols. This includes setting up information management systems and design and management of surveys. And **WR's** role will be in the area of community mobilization, social behavior change, and scaling up an adapted care group approach in all six districts. WR commits to providing technical support to the six districts and establishing a state-of-the-art training center in **Kibogora** for community mobilization through care groups.

### *5.1 Program Staffing*

The scale and numbers of partners requires strong and flexible management mechanisms to ensure program success. Staff teams are at the national level, district level, and at the HQ level. Upon notice of recommendation for funding by USAID, all positions will be posted for both internal and external candidates. Positions will be competitively filled through a tri-party panel of the three PVOs, with the hiring organization retaining final decision on its choice of staff. Selected individuals for the key positions of the Team Leader and Monitoring and Evaluation Manager will discussed with USAID for approval. (See Annex G-4 for key post job descriptions.)

**Kigali based Staff Team:** A **Team Leader (Concern)** will head the program staff. He/she will be holding at least 8-10 years of management experience with public health programming in Africa and significant experience in partnership development. The Team Leader will be supported by a skilled Kigali based team of managers listed here (with their organization affiliation in parentheses) :

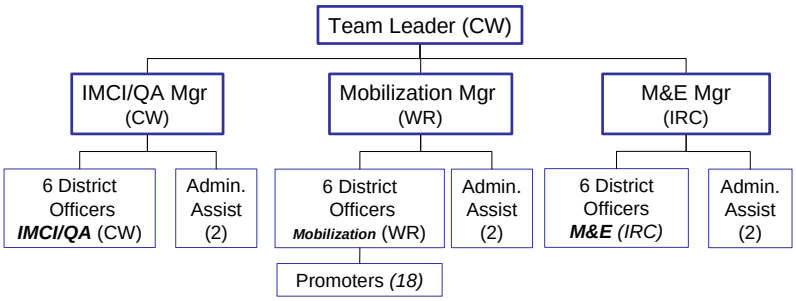
- **Mobilization Manager (WR):** Ensure technical standards of program for community mobilization; lead behavior change strategy and implementation; participate in national technical forums.
- **Monitoring and Evaluation Manager (IRC):** Refine monitoring and evaluation system; facilitate progress tracking and action; action and operations research; and population surveys.
- **IMCI/Quality Assurance Manager (Concern):** Ensure technical standards of program; C-IMCI case management strategy and implementation; community driven quality assurance of health facilities; participate in national technical forums.

**A lead agency will be assigned to two districts comprised as follows:** the IRC will manage Kibungo and Kirehe Districts; WR will manage Gikongoro and Nyamasheke Districts; and Concern will manage Gisagara and Nyaruguru Districts. Lead district functions are to ensure cross-functionality of managers, an appropriate level of technical and administrative oversight, and continuity of institutional presence in former child survival districts.

The Managers will be based in Kigali in a shared office space. A range of options are being considered including the MoH Maternal and Child Health Unit, possibly Twubakane Project, depending on availability. The team will work collaboratively on assessments, strategies, training and education curricula, and program monitoring.

**At the district level, the program will be staffed** by a small team based in each of the six districts comprised of three officers, an Administrative Assistant, and three promoters based at the District Hospital or Administrative block, depending on availability of space. Each of the organizations will have staffing affiliation in all six districts in accordance with their technical niche as shown in the figure below:

**Figure 5: Country Program Team Organization Chart**



The **Officers** will have shared roles for project implementation in a sub-area of three to four health centers each, as well as a technical liaison role with one of each of the three Kigali-based managers. Their responsibilities include training, support and supervising district trainers of CHWs team, overseeing M&E system, coordinating with DHMT, and facilitating CDC health leadership and health center outreach. Their role is to mentor and support the community child health program but not to "implement it."

One officer in each of the districts will also carry a special role in team coordination and supervision of the Administrative Assistant; this role will be given to the Officer of the PVO who has management oversight of the district. Other special roles carried by the officers are split as follows: the **Mobilization Officer** plans with DHMT for BCC/Mobilization, leads TOT in intervention topics; **IMCI/QA** officer plans for and leads TOT topics related to QA/IMCI; **M&E Officer** plans for and leads TOT activities related to M&E, integration of data into District system, and monthly CIMCI District reporting. Each Officer will work with a DHMT counterpart for skill transfer and supervision and integration of activities.

The Officer will manage three **Promoters** that will implement an extended community mobilization in two health center zones per district to develop care groups of 10-15 CHWs. Through demonstration and exchange of approaches, the program will meld the best of the less intensive with the best of high quality interpersonal interactions and organization development, allowing the program to fine-tune an optimal balance between approaches that will have obvious benefits for informing national replication.

**Staff Team Coordination:** Supervision and team management will be carefully coordinated through monthly visits of managers to all districts, as well as regular meetings and planning systems as follows:

- **A weekly coordination meeting for Kigali Managers** chaired by Team leader at their shared office space. Review plans and priorities for the week, observations from the field, and vehicle schedule.
- **A weekly coordination meeting for district officers with District Health Management Team** at District Office. Review plans and priorities for the week, observations from the field, and vehicle schedule.
- **A monthly District Staff Meeting** led by the Manager, with lead responsibilities for given district meetings with Officers, Admin, Promoters and District Health Director to review progress, achievements, constraints, priorities for the month, as well as program updates and issues.
- **Quarterly staff meetings** with rotating location across the six districts and Kigali. These s 2-3 day meeting will include a review of progress, joint field site visits, skill building sessions and allow time for sector specific team work (e.g. mobilization team, M&E team, etc). The team will review performance against annual plan and prepare detailed quarterly plans.
- **A quarterly finance meeting** with Team Leader, Managers, and Financial Accountants from each of the three PVOs to review financial status, raise issues about financial reports and requests for reimbursements, review policies and other administrative issues.
- **An annual internal review** scheduled by the Team Leader with the M&E Manager for the project staff with support of the Program Advisory Committee to analysis performance towards objectives, document achievements, problem-solve around constraints and challenges; and develop next annual workplan.

**Coordination of Headquarters Technical Support:** Each of the PVOs has dedicated 20-50% time of their maternal and child health experts at their HQs based in New York and Baltimore. Each of these staff has significant experience with the USAID CSHGP and active in the CORE Inc. membership. These committed child survival advocates are

renowned for pushing standards, innovation and dissemination of field experience. Each will complete one field trip per year. They will coordinate through monthly phone meetings, contribute to each others field visit terms of reference and debrief each other on trip report feedback. The team will gather for an annual program review. Concern's Health Advisor, Michelle Kouletio, will serve lead the HQ technical support in terms of scheduling, agenda and action items. She will also serve as the liaison with the Overseas Director of Concern Worldwide in Rwanda and Ireland.

**Conflict Resolution:** In the event that organizational issues cannot be resolved between the Managers and Team Leader, a panel of the PVO's country directors will convene to review and analyze the situation and make recommendations. Decisions will be reached through consultation and majority vote if required. Agency HQs may be involved if there are issues that mandate broader organizational consultation. As Lead Agency, Concern will reserve the right to convene conflict resolution meetings.

### *5.2 Government Human Resources*

**National:** The MoH's **Maternal and Child Health Unit** is the technical counterpart for the program, and the essential engine for policy, guidelines, as well as national replication. The unit was newly formed in 2005 and is staffed by a Unit Director, Nutrition Officer, Community Health Officer, C-IMCI Officer, and Reproductive Health Officer. Program Managers will meet with the unit on a regular basis for coordination, information exchange and support. To the extent possible, joint field visits and assessments will be completed with MoH unit staff.

**District-level:** The program teams will work hand-in-hand with the District Health Director, District Health Supervisors, and District Health Administrator to implement the program. The Director will assign each of the Officers to a supervisor and a set of health centers for joint technical and facilitation capacity building. The supervisors conduct regular visits to health centers, and will manage logistics and the health information system. Their roles in this program include weekly joint planning and; monthly meetings of all health staff for districts which will include all partner agencies; training health center staff; training CHWs and Health Center staff; and data analysis and reporting including monthly CIMCI district report.

**Health Center Level:** Each center has a team of nurses, including one head nurse, and auxiliary staff. Their size and number vary by location, but experience in child survival areas indicates 2-6 per health center and growing. Many are already supported under performance incentives for vaccination coverage, assisted deliveries, etc. as part of a national effort to improve motivation of its workforce.

This program will require the equivalent of one full-time nurse (or delegation of duties among the nurses) to support and supervise community health promotion and services as follows. Once a month half-day meeting with groups of 35 CHWs at the sector level x 5 groups per health center zone; weekly cell-level supervision of CHWs to review performance and meet with mothers (total two six-hour visits per year per cell); 2 days/month for EPI/ANC/GMP outreach services; 2 days/month for logistics, supplies and planning; 2 days/month for district meetings and other duties; 1 day/month for data analysis and reporting; and 2 days/month for project training events. Under **performance contracting**[31] with the health center, the nurse will conduct supervision in the working area of each CHW twice a year. Periodic technical CHW trainings will take place at the health center to better familiarize them with the personnel and facility, while monthly meetings will be held at the sector level. The program will review best practice experience with the MoH to establish criteria and contracts with the nurses in year one. A

review of this approach will be completed in year three. MSH will support the team with tools in motivation assessments for the workers.

**Community Health Workers**: As described in section 3.8, CHWs play a crucial role in reaching the household with child health preventive and curative services. Experience in Rwanda has proven that small ratios to households is essential. The MoH is in the process of developing new guidelines for community based workers to harmonize roles and activities so that there is one-type of worker per Umudugudugudu serving 25-40 households. CHWs form associations of about 35 members each for monthly meetings with the health center nurse to exchange information, network, and build skills.

CHW roles in this program at the household level include promotion of key health family health practices; front-line treatment of sick child for diarrhea, pneumonia, and malaria; participation in regular meetings of health workers; and assisting health center staff in health reporting and monitoring. Motivation of volunteers is essential. One method is a modest form of financial motivation. In addition to small fees for home treatment of malaria, the program will provide small grants that can be used for identifying items like identifying clothing and caps. Grant size to CHW associations will be based on performance against agreed upon annual plans.

Each health center zone has about two administrative sectors each. CHWs are grouped by sector and select a sector-level CHW to provide leadership and peer support to associations. The sector-level CHW will manage monthly meetings with the health center nurse and organize CHW reports. Under this program they will also serve as trainers and visit each of the CHWs in their working areas twice a year. This cadre also participates in the Community Health Center Management Committee and its monthly meetings. Sector CHWs will be provided quarterly leadership trainings and increased mentoring support by officers, promoters and health center personnel, as well as a modest transport stipend for transportation between cells and health centers.

An **extended community mobilization effort** takes this approach one step further to develop care groups, smaller community based organizations of 10-15 CHWs. A full-time staff of promoters will cover an area of 1-2 sectors each to facilitate the formation of care groups in tandem with the nurse and sector leaders. In order to replicate this approach, we recognize the need to find an equivalent existing resource person to the promoter, with a secondary education, strong interpersonal communications skill, health aptitude, basic analysis, reporting capacity, and negotiation skills. The program is advocating with the MoH to reconsider the selection criteria of the CHW sector leader to better suit this role. However, in the meantime, promoters are required to fill the gap in human resources to establish care groups.

### *5.3 Financial Management*

As lead agency, Concern Worldwide US has overall responsibility for financial transactions and reporting of the program to USAID. The IRC and WR will be sub-recipients of funds which are reimbursed on a quarterly basis according to agreed work and budget. Quarterly finance meetings will bring together Concern's Finance and Assistant Country Director of Systems, the Team Leader, the staff managers and the accountants of WR and IRC in Kigali to review financial reports, status, and address any questions or concerns. Respective agency Managers submit reports to the Team Leader which will in turn be processed through the finance department of Concern in Kigali. Administrative oversight and support is provided by Concern Worldwide US' Financial Director who will make one visit per year to Rwanda for monitoring and capacity building purposes.

Each agency will serve the role of "lead" in two districts as already shown on the organization chart. While all staff salaries are budgeted and paid directly through their

respective organizations, implementation costs are budgeted for and paid through the agency with lead role responsibility. An Administrative Assistant is dedicated to each district to provide logistics, cash management as well as basic accounting support. He/she will be directly supervised by the Manager based in Kigali who visits the district at least twice per month including holding a day long district team meeting.

### *5.4 Coordination with Other Health Initiatives*

Coordination with national programs and agencies is charged to the Team Leader and respective managers. Following lessons from Concern's scale-up program in Bangladesh, a national **Program Advisory Committee (PAC)** will serve as a guiding body to review performance against plans, technical guidance, coordination with other major health initiatives, and advocacy for replication of C-IMCI across the country. The committee will be formed and convene on a semi-annual basis. PAC members are chosen based on professional stature and institutional affiliations. Members will include the Maternal and Child Health Unit Director, Community Health Services and C-IMCI Desk Officers; UNICEF's Health Director; the MCH Officer of USAID mission; the Twubakane Project Director; and representatives from WHO, PSI, BASICS III, MSH/RPM+.

As every district has a different set of partners and initiatives, local level coordination is essential. The program will work with Twubakane's Coordinators and the District Health Directors to bring together agency plans with the district's own priorities, as well as resources and needs with other health and HIV/AIDS programs working in the territory. This will be done through annual district planning with all health actors and monthly district health team meetings with all partners; an excellent model for this has already been established by Concern, GTZ and CARE in Kibilizi Health District.

The Team Leader will fully participate in the quarterly USAID Cooperative Agency meeting to coordinate with other mission initiatives and leverage resources efficiently.

### *5.5 Five Year Work Plan*

A summary program work plan is included in **Annex E.** It highlights steps required for partnership and team development including administrative start-up, baseline assessments; monitoring and evaluation; and a phased roll out of implementation at the district level. The phase-in strategy consists of a year-one, phase I period for extending coverage in the four current child survival health districts to incorporate the new health center areas and make necessary adjustments in the CHW configurations. This phase would be followed by phase II in year two to incorporate the program in the new Districts of Gikongoro and Nyaruguru.

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[1] UNDP Human Development Report, 2005
[2] UNICEF, State of the World's Children 2005
[3] Demographic Health Survey, Rwanda 2000 and Preliminary Report November, 2005
[4] PVO Collaborative Research: Baseline Survey of the Rwanda Community Distribution of Anti-Malarials Pilot Program, CORE, August 2004
[5] DHS Preliminary Report, 2005
[6] DHS, 2005
[7] Rapid Child Health Assessment for Rwanda, 2005
[8] Gisagara District includes former Kibilizi Health District, implementation area of CONCERN CSHGP 2001-2006; Kibungo and Kirehe Districts fully include population served by IRC CSHGP 1999-2005; and Nyamasheke District includes Kibogora Health District served by WR CSHGP from 2001-2006.
[9] PRSP 2002
[10] Demographic Health Survey, Rwanda 2000 and 2005
[11] DHS 2005
[12] CONCERN 2001; WR 2001; IRC 2003
[13] DHS 2005

[14] World Relief, KPC
[15] DHS 2000
[16] MoH Rwanda and UNFPA 1998
[17] DHS, 2005
[18] DHS 2005
[19] DHS 2000, 2005
[20] DHS 2005
[21] Rapid Child Health Assessment, 2005
[22] DHS 2005
[23] DHS 2000
[24] DHS 2000
[25] CONCERN, 2001
[26] Participatory Assessment 2001, Concern Worldwide
[27] Concern, 2001
[28] UNDP Human Development Report, 2005
[29] MoH protocols from IMCI module consultation, September 2005
[30] Rapid Child Health Assessment for Rwanda, 2005
[31] *The government places priority on development of contractual approach to implement policy and increase individual accountability. In 2001 a voluntary agreement between independent partners committed to fulfilling reciprocal duties and obligations of benefit to both partners (p. 19 national health policy)*

# COST APPLICATION

**RFA M/OAA/GH/HSR-06-001**
**FY 2006 USAID**
**Child Survival & Health Grants Program**

# UMUSANZA FOR THE CHILDREN

**In six underserved rural districts of Rwanda**

***SUBMITTED ON NOVEMBER 21, 2005 TO USAID/GH/HIDN/CSHGP***

A bundled application lead by **Concern Worldwide**
in partnership with
the **International Rescue Committee**
and **World Relief**


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**COST PROPOSAL**: **EXPANDED IMPACT APPLICATION FOR COMMUNITY INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS IN SIX RURAL DISTRICTS OF RWANDA PROGRAM**

## I. SF-424

The Form SF 424 and 424A are included as Appendix 1

## II. Itemized Detailed Budget

A detailed itemized budget is included as Appendix 2

## III. Budget Narrative

### Introduction

Inflation has been included in the budget at a rate of 7% per annum.

This budget was originally prepared in the local currency (Rwandan Francs) and translated into US Dollars using exchange rate **1 US$ = 553 RwF**. (Source of rate is National Bank of Rwanda as at 17 November 2005).

A full breakdown of costs associated with the Lead Agency and each of the sub-grants is provided in the narrative. Each sub-grant is included as a separate line under the 'Other Cost' category.

**Budget Summary**

The following is a summary of the 5 year budget with percentage federal and non federal contributions.

| **5 Year Budget Summary** | **$ federal** | **$ PVO match** | **$ Total** |
|---|---|---|---|
| | | | |
| **Concern Worldwide** | 1,389,680 | 2,465,364 | 3,855,044 |
| | | | |
| **Subgrant to International Rescue Committee** | 1,304,154 | 437,487 | 1,741,641 |
| | | | |
| **Subgrant to World Relief** | 1,306,166 | 507,963 | 1,814,129 |
| | | | |
| **Totals** | **4,000,000** | **3,410,814** | **7,410,814** |
| | **54%** | **46%** | |

## IIa. Lead Agency Narrative: Concern Worldwide

## Personnel

International staff

International staff costs are in accordance with the Concern Worldwide Personnel salary structure. The time allocations to this objective are based on current Concern Worldwide allocation methodologies.

*Country Director* (*CD)* - responsible for the overall operation of all programs in Rwanda. This project will require the CD to dedicate 10% of their time to it.

*Assistant Country Director Programs (ACDP)* – responsible for providing technical support to programs in country. The ACDP will also spend 10% of their time on the project.

*Assistant Country Director Systems (ACDS)* - will be responsible for overseeing the consolidation of reports from the sub-grantees. This is expected to be a more time consuming requiring 15% of this position's time.

*Expanded Impact Team Leader* - has overall day-to-day management responsibility for the project. The three managers from the three organizations report to this person. This is a full-time position on this program.

Project staff

*IMCI/QA Manager* - responsible for leading implementation of the IMCI strategy across all six of the districts. This is a key role in ensuring the coherence and effectiveness of the rollout of the strategy across the entire program area.

*IMCI/QA Officers* - reporting to the Manager are six full time IMCI/QA officers – one for each district. Due to the phased rollout of the program, four will be required in the first year with an additional two being budgeted for in the second year as the project scales up.

*Administrative Assistant* - budgeted for in each of the districts in which Concern will be the Lead Agency – responsible for administrative duties in the district. As noted above, the phased rollout of the program means that only one Administrative Assistant will be required in the first year, with a second to be added in Year 2.

*Driver* - this project is expected to require the full-time use of one vehicle. One driver has been budgeted for full time to meet this demand.

*Accountant* - required ensuring that the finances of the project are maintained accurately and in accordance with USAID guidelines. This project is large and relatively complex due to the sub-grants and level of co-ordination required. 25% of the Accountant's time has been budgeted for this project.

*Guards* - Three guards have been budgeted for in this project to ensure the security of program assets.

Headquarters staff

*Health Advisor* - as Lead Agency on this project, Concern is responsible for the overall technical standards of the project. Consequently 50% of the Health Advisor's time has been included in the budget. This will be spent both during field visits to Rwanda and in a co-ordination function at head office level.

*Finance Director* - responsible for the overall financial management of the project. 10% of their time has been included to cover field monitoring visits, technical assistance from New York to Kigali and quarterly report writing, reviewing and lodging.

## Fringe Benefits

Fringe benefits – International

All fringe benefits are based on Concern Worldwide international personnel policies.

Fringe benefits include medical expenses, provision of housing and associated costs and a food allowance for each member of staff.

Fringe benefits – Local Staff

National staff benefits include mandatory employer contributions to Caisse Social du Rwanda (Rwanda's Social Security Fund), medical allowances, and funeral assistance. Budget to cover these costs were estimated at 20% of the gross salaries.

Fringe benefits – Headquarters

Fringe benefits for headquarters staff is for health insurance.

## Travel

International Travel

Prices for international flights are based on currently available market rates for an economy class ticket. All international flights are to be paid from the match component of the grant.

Two flights have been budgeted for staff from Rwanda to travel to the United States in order to present the Detailed Implementation Plan for the program during the first year.

Each of the partner agencies will then rotate a visit from a member of their staff to visit the United States on a learning trip. Concern has budgeted for a trip in Year 4 of the agreement.

Two trips per year are requested to travel from Rwanda to Nairobi to attend regional meetings, conferences and workshops.

Other travel

Per diems are based on Concern Rwanda's per diem policy. The number of per diems included in the budget is based on estimates of travel between Kigali and the program areas and also between program areas. Per diems are only paid when a night is spent away from the employees' home town.

Bus travel is budgeted for three trips per week for various employees to and from, and between, program areas. Prices are based on the current average rate for such trips.

Headquarters travel

Two flights are budgeted per annum for headquarters staff to visit the field. The trips will be taken by either the Finance Backstop or the Health Advisor, depending on the need at the time. Prices are based on currently available rates.

## Equipment

Two items of equipment are budgeted for over the life of the grant – a car to serve the six districts and a photocopier for the Kigali office. One car is required for the Mobilisation Manger that is based in Kigali but is required to travel frequently to all six districts. The photocopier is considered important given the high volume of documentation and reports expected to be generated by this project.

These two items are to be purchased from the match component of the grant.

## Supplies

Concern has strict purchasing and logistics guidelines that are required to be followed by all fields. Concern Rwanda has a well-established purchasing and logistics unit that ensures that all purchases made adhere to the procedures as set down in the manual.

All budget estimates are based on locally obtained quotes – all items will be purchased locally where possible – except where the item is not available or the cost of the item makes it prohibitive to do so.

*Motorbikes* – Twenty four motorbikes are required, that is four motorbikes for each district offices. It is anticipated that all twenty four motorbikes will be purchased in Year 1 in order to obtain the best price.

*Generators* - three small generators have been budgeted included in the budget. This represents one each for the District offices and one for the head office in Kigali.

*Computers* – sixteen new laptop computers have been included in the budget. These represent a laptop for each of the District Officers, the IMCI Manager and the Expanded Impact Team Manager. In addition one each for the Mobilisation manager, six Mobilisation officers and the HQ technical unit. It is considered necessary for each of these positions to have access to a computer at all times to ensure that all statistical information gathered can be analyzed in a timely fashion, and also to ensure that all reporting requirements are met.

*Printers* - three printers have been budgeted included, one for each location as noted earlier.

*Projector* - the program involves a significant level of training, both internally and externally. A projector is considered a key item in these sessions.

*Drugs* - anti-malarial drugs, amoxicillin, ORS and zinc have been included under the match component of the budget. The quantities are based on internationally accepted protocols. The drugs for five of the six districts are included under the match component of Concern's budget.

*Books and journals* - to be purchased to establish a basic resource centre for use in the program. A budget has been included to purchase twelve medical reference items per year.

*Office furniture* – to be purchased for each of the district offices and also for the head office. All furniture is budgeted to be purchased in Year 1 so that the second district office will be ready to commence operations in year 2.

*Office running supplies for the Kigali office* - based on current consumption for a project of this size. The office running costs in the district is based on the estimated costs for all stationery and other support materials required supporting program activities.

*Community Health Worker – Sector Leaders transport allowance* - commences in Year 2. The allowance will be paid to twenty three CHW – Sector Leaders per district at a rate of $5 per quarter. This rate has been agreed on by all partner agencies as the current market rate for such an allowance.

*Printing costs* - included in Years 1 and 3. This is to cover the cost of printing the forms and registers that will be required by all of the CHW's in their day-to-day work. The amount is based upon 11,566 CHW's in total, each requiring approximately $4 worth of forms and registers twice over the life of the project.

**Other:**

Performance Incentives

*Support for nurses under performance* – relates to Concern's contribution to performance incentives for nurses in the six districts.

*Support for CHW secteur associations* - The budget represents a contribution for performance recognition and support for secteur CHWs. The budget has been calculated @ (100) CHW secteur associations per district @ $50 per association.

*Motorcycle fuel and maintenance* – running costs for the six motorcycles being provided to the program by Concern. This amount is based on current field experience.

*Vehicle fuel and maintenance* – running costs for the one being provided to the program by Concern. This amount is based on current field experience.

*Generator fuel*– the cost associated with maintaining the three generators, one in each district and one in the Kigali office.

*Kigali office renting, maintenance and utilities* – cost associated with maintaining a head office in Kigali, which provides administrative support to the program. Amount is based on

Concern's current allocation policies based on level of support provided to individual programs.

*District office renting, maintenance and utilities* – cost associated with lead agency responsibilities for five districts.

*Kigali Administrative Support Unit* – a charge from Kigali to programs based on current allocation policies for administrative support such as purchasing, logistics and human resources.

### *Training*

The tables below present the cost details for all trainings and special events expected to take place during the life of the program. These are separated into three categories corresponding to trainings/events taking place at the national, district and health center/household level. For each training/event the costs are divided into two categories, food and lodging costs for participants listed under Participant Costs, and facilitator fees, materials and all other costs listed under Other Training Costs. The second table indicates the portion of the total costs for each training/event attributed to each partner agency (Concern Worldwide, IRC, and World Relief).

Reviewers should refer to Annex F in the technical proposal for the training plan detail.

| ***TABLE 1: TOTAL TRAINING*** <br> ***National level*** | *Participants* | *Days* | *Subtotal Particpant costs (Frw)* | *Facilitators* | *Days* | *Subtotal Trainer costs (Frw)* | *Other Costs* | *Total Cost by Activity (Frw)* | Total (US$) |
|---|---|---|---|---|---|---|---|---|---|
| Quarterly program staff meetings | 52 | 3 | 2,028,000 | 0 | | 45,000 | 45,000 | 2,073,000 | 3,749 |
| Training of immobilizers and promoters of Care Group – Group 1 | 16 | 5 | 1,040,000 | 2 | 5 | 75,000 | 175,000 | 1,215,000 | 2,197 |
| Training of mobilizers and promoters of Care Group - Group 2 | 8 | 5 | 520,000 | 1 | 5 | 75,000 | 75,005 | 595,005 | 1,076 |
| CIMCI CHW Protocol Review | 4 | 5 | 60,000 | 10 | 5 | 100,000 | 100,050 | 160,050 | 289 |
| ***District level*** | | | | | | | | | |
| KPC and LQAS methodology | 150 | 14 | 15,750,000 | 30 | 14 | 1,050,000 | 5,250,000 | 21,000,000 | 37,975 |
| Training of trainers for the district teams | 306 | 3 | 6,885,000 | 6 | 3 | 1,050,000 | 1,410,000 | 8,295,000 | 15,000 |
| Community IMCI strategy action development | 480 | 3 | 10,800,000 | 12 | 3 | 1,050,000 | 1,770,000 | 12,570,000 | 22,731 |
| Health centre level HMIS mentoring | 69 | 36 | 7,452,000 | 6 | 36 | 216 | 4,320,216 | 11,772,216 | 21,288 |
| ToT – Malaria | 306 | 3 | 6,885,000 | 6 | 3 | 1,050,000 | 1,410,000 | 8,295,000 | 15,000 |
| ToT – Diarrhea | 306 | 2 | 4,590,000 | 6 | 3 | 1,050,000 | 1,410,000 | 6,000,000 | 10,850 |
| ToT – Nutrition | 306 | 2 | 4,590,000 | 6 | 3 | 1,050,000 | 1,410,000 | 6,000,000 | 10,850 |
| ToT – ARI | 306 | 2 | 4,590,000 | 6 | 3 | 1,050,000 | 1,410,000 | 6,000,000 | 10,850 |
| Annual District Review | 480 | 5 | 7,200,000 | 6 | 1 | 1,200,000 | 1,320,000 | 8,520,000 | 15,407 |
| ***HC / household level*** | | | | | | | | | |
| Basic orientation of CHWs | 11,566 | 1 | - | 330 | 1 | 16,523,091 | 23,132,327 | 16,523,091 | 29,879 |
| CHW malaria training | 11,566 | 3 | 104,095,472 | 330 | 3 | 19,827,709 | 39,655,418 | 123,923,181 | 224,093 |
| ***National level*** | *Participants* | *Days* | *Participant* | *Facilitators* | *Days* | | *Other Costs* | *Subtotal* | Total (US$) |
| CHW diarrhoea | 11,566 | 2 | 69,396,981 | 330 | 2 | 6,609,236 | 6,609,236 | 76,006,218 | 137,443 |
| CHW nutrition | 11,566 | 2 | 69,396,981 | 330 | 2 | 6,609,236 | 6,609,236 | 76,006,218 | 137,443 |
| CHW ARI | 11,566 | 2 | 69,396,981 | 330 | 2 | 6,609,236 | 6,609,236 | 76,006,218 | 137,443 |
| CHW Secteur and Care Group Leaders | 330 | 48 | 47,586,501 | 6 | 48 | 720,000 | 3,600,000 | 48,306,501 | 87,354 |
| Staff development | 46 | 5 | 34,500 | | | | | 19,078,500 | 34,500 |
| | | | | | | | | **528,345,197** | **955,416** |

Table 2: Training Budget by Event by Organization Budget, in USD

| | Concern | IRC | WR | TOTAL |
|---|---|---|---|---|
| ***National level*** | | | | |
| Quarterly program staff meetings | 815 | 733 | 2,200 | 3,749 |
| Training of mobilizers and promoters of Care Group - Group 1 | | | 2,197 | 2,197 |
| Training of mobilizers and promoters of Care Group - Group 2 | | | 1,076 | 1,076 |
| CIMCI CHW Protocol Review | 289 | | | 289 |
| ***District level*** | | | | |
| KPC and LQAS methodology | | 37,975 | | 37,975 |
| Training of trainers for the district teams | 5,000 | 5,000 | 5,000 | 15,000 |
| Community IMCI strategy action development | 7,577 | 7,577 | 7,577 | 22,731 |
| Health centre level HMIS mentoring | 7,096 | 7,096 | 7,096 | 21,288 |
| ToT - Malaria | 5,000 | 5,000 | 5,000 | 15,000 |
| ToT - Diarrhea | 3,617 | 3,617 | 3,617 | 10,850 |
| ToT - Nutrition | 3,617 | 3,617 | 3,617 | 10,850 |
| ToT - ARI | 3,617 | 3,617 | 3,617 | 10,850 |
| Annual District Review | 5,136 | 5,136 | 5,136 | 15,407 |
| | | | | |
| ***HC / household level*** | | | | |
| Basic orientation of CHWs | 9,960 | 9,960 | 9,960 | 29,879 |
| CHW malaria training | 74,698 | 74,698 | 74,698 | 224,093 |
| CHW diarrhoea | 45,814 | 45,814 | 45,814 | 137,443 |
| CHW nutrition | 45,814 | 45,814 | 45,814 | 137,443 |
| CHW ARI | 45,814 | 45,814 | 45,814 | 137,443 |
| CHW Secteur and Care Group Leaders | 29,118 | 29,118 | 29,118 | 87,354 |
| Staff development | 11,500 | 11,500 | 11,500 | 34,500 |
| **TOTAL** | **304,481** | **342,085** | **308,850** | **955,416** |

**NICRA**

Concern Worldwide US' provisional negotiated indirect cost rate, as agreed on 6 October 2005 is 9.49%.

## Other direct costs

## *IIb. Sub grant to IRC*

The following is a detailed explanation of the amount to be sub granted to IRC.

**Personnel**

International Staff

*Country Director (CD)* – The CD will allocate 5% of their time in years 1 and 2, and 10% of their time in years 3 to 5. The position will provide management oversight of the program ensuring program quality, coordination, and grant compliance.

*Finance Controller (FC)* – The FC will allocate 10% of his time the program. The FC will be responsible for the fiscal management of the program assuring quality, impact and cost effectiveness. Responsibilities will include: financial management to ensure compliance with regulations and procedures; establishing finance and supporting function policies, systems and procedures, and directing or performing their development, documentation, and implementation.

Project Staff

These positions will be working on a full-time basis for the Program.

*Monitoring and Evaluation Manager* – M & E Manager will coordinate all IRC program activities, including planning, partner contact, training, surveying, implementation, monitoring, and reporting. Salaries and related costs will be covered in full during the program.

*Monitoring and Evaluation Officers* – M & E Officers will be hired to undertake monitoring and evaluation task across (6) Districts and will part of a district consortium team with Concern Worldwide and World Relief staff. There will (2) M & E Officers attached to each District.

*Administrative Assistants* - IRC will contribute (2) AOs staff to the Consortium for office management at (2) of the six District Offices. Duties will include cash management, payroll, HR and general administration at District office level for the consortium teams.

*Driver* – IRC will contribute (1) Driver to the consortium. The driver will ensure vehicle maintenance and provide transportation to implementation staff. The vehicle will be provided by IRC as in kind contribution.

*Guards* - IRC will contribute (2) Guards to the consortium. These guards will provide security at one of the District field offices.

*Management Support Staff* **–** these positions are based in Kigali main office and will provide central administrative, logistics, and finance support to the Program. (1) Senior Accountant (5%), 1 Payment Officer (5%), 1 Procurement Officer (5%), will provide support to the IRC program staff.

The allocation of staff costs that are not 100% allocable to the program will be based on monthly timesheets.

Headquarters Staff

*Health Advisor (HA)* – The Health Advisor will allocate 30% of his time to the Program from New York and he will also make in country visits to manage the quality of the IRC input from a Health outcome perspective.

**Fringe Benefits**

Fringe Benefits – International

Fringe benefits associated with international staff will primarily cover statutory benefits 35%, which includes Medical/Dental, FICA, Medicare, Pension, Workers Compensation, Life and AD&D Insurance and Other Insurance. Home leave, R&R leave, Housing, Excess baggage, Work permits and Visas etc have been calculated separately based on established IRC personnel policy.

Fringe Benefits – national (project) staff

National staff benefits include mandatory employer contributions to Caisse Social du Rwanda (Rwanda's Social Security Fund), medical allowances, and funeral assistance. Budget to cover these costs were estimated at 20% of the gross salaries.

Fringe benefits will be allocated in the same proportion to this program as personnel costs above.

Fringe Benefits – Headquarters

These are budgeted at 32% of base salary for the Health Advisor which includes Medical/Dental, FICA, Medicare, Pension, Workers Compensation, Life and AD&D Insurance and Other Insurance.

**Travel**

International Travel

Consultant will be hired to do the mid-term and final evaluation of the project. $5,000 is budgeted in years 3 and 5 that include airfare, *(New York-Rwanda)*, hotel and incidental costs to be incurred in relation to the trip.

Regional flights (Kigali – Nairobi)

Budgeted two (2) Regional flights per year for at an average cost of $500 per trip for the first year and applied the inflation rate in the succeeding years. The air ticket is estimated at $400 and incidental expenses (training fees, meals, transport and accommodation) shall are estimated at $100.

Local Travel

These budget lines will cover the cost of program staff visiting Kigali from the field**.** Local travel costs include 21 nights per Diem (7 pers. x 3 nights) @ $30 per night, plus 36 (6 x 6) bus trip costs per month @ $4.00 per return trip for M&E program staff attending meetings and training in Kigali and other field trips. The cost stated is for the first year and applied the inflation rate in the succeeding years.

Headquarters Travel

(New York-Rwanda)

The cost of travel is budgeted for economy class travel utilizing American carriers whenever possible, in accordance with USAID regulation and IRC policy. Funds are budgeted to cover cost of trip of Technical support staff from IRC headquarters in New York to provide monitoring, oversight and technical assistance to the project. The air ticket is estimated at $2,300 and incidental expenses (meals, transport, visa and accommodation) are estimated at $200 per person per trip for the first year and applied the inflation rate in the succeeding years.

## Equipment

All equipment and supplied will be purchased in line with IRC and USAID regulations covering procurement procedures and property title.

**Supplies**

*Motorbikes* - $18,000 for motorbikes for M&E officers in three district offices (in kind contribution).

*Motor vehicle* - $15,000 transport for M&E officer (in kind contribution).

*Generators* - two small generators have been included in the budget. This represents one for the District office and one in IRC match.

*Computers* – three desk top computers and peripherals have been included in the budget for each M&E officer in three districts. A lap top computer has been included for the M&E Manager.

*Palm Top Data Analyser:* These have been budgeted for use by M&E staff and temporary surveyors for investigations and down loadable into PCs.

*Data Projector:* Included in the budget for presentations and training tool for program.

*Printers* - a printer have been budgeted for use by M&E staff with desk top computers.

*Books and journals* - the books and journals will be used by direct program technical staff and by technical unit support staff for research and training resources, budgeted $250 in year 1.

*Office furniture* – Furniture will be purchased for a total of (8) field staff working in (2) District offices in year

*Office running supplies for the Kigali & District* - the budget allocation for office running supplies will cover IRC costs at (6) offices and also at Kigali main office for the program. It is estimated that it will cost an average of $60 per office per month in supplies and running

cost, mostly stationary and general office supplies in year 1 and adjusted by inflation rate in succeeding years.

**Evaluation**

IRC's specialized role is the area of monitoring and evaluation, health information systems strengthening, and community case management for the sick child. This includes setting up information management systems, design and management of surveys. IRC will also conduct training of its program staff in these areas (see details below).

A Baseline survey will be conducted in year (1) at District and National level. National and district meetings will occur each year over the course of the project. A mid term evaluation will be conducted in year 3. A Final evaluation will be conducted in year 5.

The total IRC budget projection for evaluation for the project is $154,989 over 5 years.

## Training

The total IRC budget projection for training for the project is $342,085 over 5 years, see tables 1 & 2 on pages 8-9 for details.

**Performance Incentives**

Support for Nurses under performance
The budget represents IRC contribution to incentive payments for Nurse training and development in (2) districts for 42 nurses per district or (14) health centres x (3) nurses @ $100 per year or $4,200 per district in year 1 and adjusted by inflation rate in succeeding years.

Support for Community Health Worker (CHW) secteur associations
The budget represents IRC contribution for performance recognition, motivation and support for secteur CHWs. The budget has been calculated @ (100) CHW secteur associations per district @ $50 per association, or $5,000 per district in year 1 and adjusted by inflation rate in succeeding years.

**Other Direct Costs**

Motor Cycle fuel and maintenance and insurance
IRC is contributing (6) motorcycles to the project for use by M&E officers as in kind contribution. The running costs represent relevant support costs to keep this equipment on the road.

Vehicle Fuel and maintenance and insurance
IRC is contributing (1) motor vehicle to the project for use by M&E officers as in kind contribution. The running costs represent relevant support costs to keep this equipment on the road.

Generator Fuel
These costs are IRC contribution to the running of district offices.

Kigali Office Rent and Maintenance Costs
These costs represent a small share of IRC main office costs in Kigali

District Office Rent, Rehabilitation and Maintenance costs
These costs represent IRC contribution to district office running costs and any initial rehabilitation costs that may be required.

Office Utilities
Utilities include electricity, water and gas charges at (2) District offices.

Bank Charges
The budget represents fee for the transfer of money from New York headquarters to Rwanda.

Communication Costs
These costs represent IRC share of internet, telephone and email costs of running (2) District offices and a share of Kigali office costs.

Kigali Logistical Support Costs
These costs represent logistics charges for freight and handling and other similar government charges associated with the project.

**NICRA**

Indirect cost recovery rate is at 10.45% of total direct costs. The NICRA is used to cover IRC Headquarters' costs directly related to supporting indirect or overhead costs incurred to support program activities. Indirect costs include overseas program support, human resources, finance, administration etc.

## *IIc, Sub grant to World Relief*

As per the project proposal, World Relief (WR) will be provided with a sub-grant to act as lead agency in 2 districts. The WR will also assume responsibility for the Community Mobilization component of the project across all 6 districts.

The following is a detailed explanation of the amount to be sub granted to WR.

**Personnel:**
To ensure proper compliance, all staff persons allocating less than 100% of their time to this project will track time spent on the project with WR's timesheet system.

Country-level staff

*Country Director*- This position is responsible for the overall management of WR programs in Rwanda. This project will require 10% of the Country Director's time for the life of the project.

*Finance Manager & Accountants*- These positions make up the WR Rwanda country finance team which will allocate 10% of its time to the program. This team is responsible for the fiscal management of the project, including proper financial recording and reporting in compliance with USAID guidelines. The Finance Manager will submit all required records and reports to the WR HQ finance department, which will in turn submit necessary documentation to the lead agency, Concern Worldwide.

*HR & Admin Manager, Administration Officer, Logistics, & HR Officer*- The project will require 10% of these positions, based in Kigali, which will support the general administration of the project.

*Director of Programs*- This position is responsible for the operation of all program activities in Rwanda and will assist the Mobilization Manager with the overall administration of the project. The Director of Programs will allocate 20% of his time to this project.

Project Staff
These positions will be working on a full-time basis for the Program

*Mobilization Manager*- This position will be responsible for coordinating the implementation of the community mobilization component of the project across all 6 of the districts. Key responsibilities include planning, training, monitoring, reporting and partner contact.

*Mobilization Officers*- These positions will report to the Mobilization Manager are 6 full time Mobilization officers – one for each district. Due to the phased rollout of the program, 4 will be required in the first year with an additional two being budgeted for in the remaining years as the project scales up.

*Promoters*- The key to the community mobilization component of the project, these positions will work directly at the grassroots level to mobilize communities and their CHWs in 2 health center catchment areas in each district. WR will pay the salaries of all Promoters in all 6 districts. In accordance with the phased rollout of the program, 12 promoters will start in year 1 of the project and 6 additional promoters will be added in year 2, when implementation begins in the remaining 2 districts.

*Administrative Assistants*- These positions will be responsible for administrative duties in the 2 districts in which WR is lead implementer. As noted above, the phased rollout of the program means that only one Administrative Assistant will be required in the first year, with a second to be added in Year 2.

*Guards* Three guards have been budgeted for this project to ensure the security of program assets in the 2 districts in which WR is lead implementer.

*Driver* This project is expected to require the full-time use of one vehicle. One driver has been budgeted for full time to meet this demand.

Headquarters Staff

*Health Advisor*- Salary and fringe benefits are based on a fraction of one FTE HQ backstop technical/support person per year.

**Fringe Benefits**

Country-level staff

All fringe benefits are based on World Relief's personnel policies. WR Rwanda fringe benefits are calculated at 20% of yearly salary.

Direct Program Staff

All CSP staff is paid according to WR Rwanda salary structures as harmonized with the Core Partners. WR Rwanda fringe benefits are calculated at 20% of yearly salary.

Fringe benefits – Headquarters

Fringe benefits for headquarters staff are calculated at 25% of yearly salary.

**Travel**

International Travel
Prices for international flights are based on currently available market rates for an economy class ticket. All international flights are to be paid from the match component of the grant.

Anticipated international travel expenses include a field staff visit to the US to attend/present at a US-based conference in year 3 of the project.

Other travel

For this program, WR will apply Concern Rwanda's per diem policies. The number of per diems included in the budget is based on estimates of travel between Kigali and the program areas and also between program areas. Per diems are only paid when a night is spent away from the employees' home town.

Bus travel is budgeted for 3 trips per week for various employees to and from, and between, program areas. Prices are based on the current average rate for such trips.

Headquarters travel

Budget includes field visits by HQ backstop in year 1 for the DIP, 1 visit in year two for monitoring and technical assistance, 1 visit in year 3 for the MTE, 1 visit in year 4 for monitoring and technical assistance, and 1 visit in year 5 for final evaluation. Prices are based on currently available rates (economy class tickets).

HQ domestic travel is for meetings in NY with the Concern and IRC staff, and for the Global Health Council, CORE meetings, and other Child Survival workshops. Modest prices are expected for transport, hotels and meals. All travel costs over $10 must be verified by a receipt.

**Equipment**

All equipment and supplied will be purchased in line with IRC and USAID regulations covering procurement procedures and property title.

**Supplies**

All budget estimates are based on locally obtained quotes – all items will be purchased locally where possible – except where the item is not available or the cost of the item makes it prohibitive to do so.

Prices of *motorcycles*, *generator*, *laptop and printers* are based on least costly but highest quality available in Rwanda (for prices and use, see table, below). Prices are based on past experience working in Rwanda/Central Africa.

*Motorcycle:* One motorcycle each s has been included for transport of 6 mobilization officers.

*Generator:* One generator has been included for use at one district office.

*Computers:* Seven lap top computers have been included for 1 Mobilization Manager, and 6 officers.

*Printer*s: two printers for 2 district offices.

*Drugs* – anti-malarial drugs, amoxicillin, ORS and zinc. No USAID money will be used for the purchase of drugs, which may be received as goods-in-kind. The drug quantities are based on internationally accepted protocols.

*Books and journals* - The books and journals will be used by direct program technical staff and by technical unit support staff for research and training resources, budgeted $125 in year 1.

*Office running supplies* - based on the estimated costs for all stationery and other support materials required supporting program activities.

*Community Health Worker – Sector Leaders transport allowance* - commences in Year 2. The allowance will be paid to 23 CHW – Sector Leaders per district at a rate of $5 per quarter. This rate has been agreed on by all partner agencies as the current market rate for such an allowance.

**Training**

Please refer to the Concern section of the budget narrative for a description of how the project-wide training expenses will be shared among the three partnering organizations. Four mobilization project officers and 12 Care Group promoters will receive community mobilization training in year 1, and refresher trainings in year two. The two additional Mobilization officers and 6 additional promoters will be trained in year 2, when the final 2 districts become operational. See tables 1 & 2 on pages 8-9 for further details.

**Other direct Costs**

*Support for Nurses under performance*: represents incentive payments for Nurse training and development in (2) districts in which WR is lead implementer for 42 nurses per district or (14) health centres x (3) nurses @ $100 per year or $4,200 per district in year 1 and adjusted by inflation rate in succeeding years, and phasing in the second district in year 2. This expense appears in the Concern section of the budget.*

*Support for Community Health Worker (CHW) secteur associations*: represents performance recognition, motivation and support for secteur CHWs. The budget is based on the estimated number of CHW associations in the 2 districts in which WR is lead implementer and has been calculated @ (100) CHW secteur associations per district @ $50 per association, or $5,000 per district in year 1 and adjusted by inflation rate in succeeding years. This expense appears in the Concern section of the budget.*

*Motor Cycle fuel and maintenance*: World Relief will cover the costs of motorcycle fuel and maintenance for the promoters in the 2 districts in which WR is lead implementer, as well as the motorcycles of the 6 mobilization officers. The running costs represent relevant support costs to keep this equipment on the road.

*Vehicle Fuel and maintenance*: These costs represent relevant support costs (fuel and maintenance) to keep 1 project motor vehicle on the road.

*Generator Fuel:* WR will cover this cost for the generator in a district office in which WR is lead implementer.

*District Office renting and maintenance costs:* represents district office rent, running costs and any initial rehabilitation costs that may be required in the 2 district offices in which WR is lead implementer. These expenses appear in the Concern section of the budget.*

*Communication costs*: include expenses associated with telephone, fax, and internet.

*Logistical support*: will facilitate the administration of the project (obtaining and distributing supplies, etc.) in Kigali as well as at the district level.

*As World Relief is providing a portion of the drug match, Concern Worldwide has agreed to assist with World Relief's cash expenses in an equivalent dollar amount.

**NICRA**
World Relief is currently renegotiating its Negotiated Indirect Cost Rate Agreement (NICRA). The projected rate is estimated at 17.2% and allows for direct expensing time allocated to the project by country-level staff. World Relief's official NICRA has been 21.60% since April of 2002.

**Child Survival and related health programs supported by Concern Worldwide Inc. U.S. in the past three years**

| Funded by | Contact person | Total budget and program area | Start/ end dates | Main Activities |
|---|---|---|---|---|
| USAID/GH/HIDN<br><br>(FAO-A-00-98-00077-00) | Susan Youll | $2,000,000<br><br>**Bangladesh** | 9/30/04 – 9/29/09 | Scaling up Municipal health system. IMCI and maternal and newborn care. |
| USAID/BHR/PVC<br><br>(FAO-A-00-98-00077-00) | Susan Youll | $1,853,893<br><br>**Bangladesh** | 9/30/00 – 9/29/04 | Capacity building of municpal health services. IMCI, Maternal & Newborn Care |
| USAID/BHR/PVC<br><br>(FAO-A-00-98-00077-00) | Susan Youll | $1,854,243<br><br>**Rwanda** | 9/29/01 – 9/29/06 | Capacity building of district health services. HIV/AIDS, malaria, nutrition, and maternal and newborn care |
| USAID/HIDN/NUT/CSHGP<br><br>(GHS-A-00-05-00018-00) | Susan Youll | $2,109,778<br><br>**Haiti** | 09/30/05 – 09/29/10 | Partnership building for diarrhea, maternal and newborn care, and pneumonia in urban slums of Port au Prince |

**U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT**

**REQUIRED FORMS, CERTIFICATIONS, ASSURANCES, AND OTHER STATEMENTS OF RECIPIENT**

**Required Forms for RFA's**

- Certifications:
  - Terrorist Financing
  - Assurance of Compliance with Laws and Regulations Governing Nondiscrimination in Federally Assisted Programs
  - Certification Regarding Lobbying
  - Prohibition on Assistance to Drug Traffickers for Covered Countries
  - AAPD 05-04 Certification for HIV/AIDS Program Funds (only for programs implementing HIV/AIDS interventions)

- Other Statements
  - Authorized Individuals
  - Taxpayer Identification Number
  - Contractor Identification Number – Data Universal Numbering System Number
  - Letter of Credit Number
  - Procurement Information
  - Past Performance Reference
  - Type of Organization
  - Estimated Cost of Communication Products

**I. Certification Regarding Terrorist Financing Implementing E.O. 13224**

By signing and submitting this application, the prospective recipient provides the certification set out below:

1. The Recipient, to the best of its current knowledge, did not provide, within the previous ten years, and will take all reasonable steps to ensure that it does not and will not knowingly provide, material support or resources to any individual or entity that commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated, or participated in terrorist acts, as that term is defined in paragraph 3.

2. The following steps may enable the Recipient to comply with its obligations under paragraph 1:

a. Before providing any material support or resources to an individual or entity, the Recipient will verify that the individual or entity does not (i) appear on the master list of Specially Designated Nationals and Blocked Persons, which list is maintained by the U.S. Treasury's Office of Foreign Assets Control (OFAC) and is available online at OFAC's website : http://www.treas.gov/offices/eotffc/ofac/sdn/t11sdn.pdf, or (ii) is not included in any supplementary information concerning prohibited individuals or entities that may be provided by USAID to the Recipient.

b. Before providing any material support or resources to an individual or entity, the Recipient also will verify that the individual or entity has not been designated by the United Nations Security (UNSC) sanctions committee established under UNSC Resolution 1267 (1999) (the "1267 Committee") [individuals and entities linked to the Taliban, Usama bin Laden, or the Al Qaida Organization]. To determine whether there has been a published designation of an individual or entity by the 1267 Committee, the Recipient should refer to the consolidated list available online at the Committee's website: http://www.un.org/Docs/sc/committees/1267/1267ListEng.htm.

c. Before providing any material support or resources to an individual or entity, the Recipient will consider all information about that individual or entity of which it is aware and all public information that is reasonably available to it or of which it should be aware.

d. The Recipient also will implement reasonable monitoring and oversight procedures to safeguard against assistance being diverted to support terrorist activity.

3. For purposes of this Certification-

a. "Material support and resources" means currency or monetary instruments or financial securities, financial services, lodging, training, expert advice or assistance, safehouses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials."

b. "Terrorist act" means-

(i) an act prohibited pursuant to one of the 12 United Nations Conventions and Protocols related to terrorism (see UN terrorism conventions Internet site: http://untreaty.un.org/English/Terrorism.asp); or

(ii) an act of premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents; or

(iii) any other act intended to cause death or serious bodily injury to a civilian, or to any other person not taking an active part in hostilities in a situation of armed conflict, when the purpose of such act, by its nature or context, is to intimidate a population, or to compel a government or an international organization to do or to abstain from doing any act.

c. "Entity" means a partnership, association, corporation, or other organization, group or subgroup.

d. References in this Certification to the provision of material support and resources shall not be deemed to include the furnishing of USAID funds or USAID-financed commodities to the ultimate beneficiaries of USAID assistance, such as recipients of food, medical care, micro-enterprise loans, shelter, etc., unless the Recipient has reason to believe that one or more of these beneficiaries commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated or participated in terrorist acts.

e. The Recipient's obligations under paragraph 1 are not applicable to the procurement of goods and/or services by the Recipient that are acquired in the ordinary course of business through contract or purchase, e.g., utilities, rents, office supplies, gasoline, etc., unless the Recipient has reason to believe that a vendor or supplier of such goods and services commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated or participated in terrorist acts.

This Certification is an express term and condition of any agreement issued as a result of this application, and any violation of it shall be grounds for unilateral termination of the agreement by USAID prior to the end of its term.

Signature _____Date___11/20/2005____
Name___Siobhan Walsh, Executive Director_____
Organization____Concern Worldwide US., Inc_____

**II. ASSURANCE OF COMPLIANCE WITH LAWS AND REGULATIONS GOVERNING NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS**

(a) The recipient hereby assures that no person in the United States shall, on the bases set forth below, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under, any program or activity receiving financial assistance from USAID, and that with respect to the grant for which application is being made, it will comply with the requirements of:

(1) Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352, 42 U.S.C. 2000-d), which prohibits discrimination on the basis of race, color or national origin, in programs and activities receiving Federal financial assistance;

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance;

(3) The Age Discrimination Act of 1975, as amended (Pub. L. 95-478), which prohibits discrimination based on age in the delivery of services and benefits supported with Federal funds;

(4) Title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), which prohibits discrimination on the basis of sex in education programs and activities receiving Federal financial assistance (whether or not the programs or activities are offered or sponsored by an educational institution); and

(5) USAID regulations implementing the above nondiscrimination laws, set forth in Chapter II of Title 22 of the Code of Federal Regulations.

(b) If the recipient is an institution of higher education, the Assurances given herein extend to admission practices and to all other practices relating to the treatment of students or clients of the institution, or relating to the opportunity to participate in the provision of services or other benefits to such individuals, and shall be applicable to the entire institution unless the recipient establishes to the satisfaction of the USAID Administrator that the institution's practices in designated parts or programs of the institution will in no way affect its practices in the program of the institution for which financial assistance is sought, or the beneficiaries of, or participants in, such programs.

(c) This assurance is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the recipient by the Agency, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

Signature _____Date___11/20/2005____
Name___Siobhan Walsh, Executive Director_____
Organization____Concern Worldwide US., Inc_____

**III. CERTIFICATION REGARDING LOBBYING**

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that: If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature _____Date___11/20/2005____
Name___Siobhan Walsh, Executive Director_____
Organization____Concern Worldwide US., Inc_____

**IV. PROHIBITION ON ASSISTANCE TO DRUG TRAFFICKERS FOR COVERED COUNTRIES AND INDIVIDUALS (ADS 206)**

USAID reserves the right to terminate this [Agreement/Contract], to demand a refund or take other appropriate measures if the [Grantee/ Contractor] is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140. The undersigned shall review USAID ADS 206 to determine if any certification are required for Key Individuals or Covered Participants.

If there are COVERED PARTICIPANTS: USAID reserves the right to terminate assistance to, or take or take other appropriate measures with respect to, any participant approved by USAID who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

Signature _____Date___11/20/2005____
Name___Siobhan Walsh, Executive Director_____
Organization_____Concern Worldwide US., Inc_____

KEY INDIVIDUAL CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

I hereby certify that within the last ten years:

1. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.

2. I am not and have not been an illicit trafficker in any such drug or controlled substance.

3. I am not and have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

Signature: _____

Date: 11/20/2005

Name: Siobhan Walsh_____

Title/Position: Executive Director____

Organization: Concern Worldwide US., Inc

Address: 104 East 40th Street, Room 903_

New York, NY 10016_____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140, Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain key individuals of organizations must sign this Certification.

2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

PARTICIPANT CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

1. I hereby certify that within the last ten years:

a. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.

b. I am not and have not been an illicit trafficker in any such drug or controlled substance.

c. I am not or have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

2. I understand that USAID may terminate my training if it is determined that I engaged in the above conduct during the last ten years or during my USAID training.

Signature: _____

Date: 11/20/2005

Name: Siobhan Walsh

Title/Position: Executive Director

Organization: Concern Worldwide US., Inc

Address: 104 East 40th Street, Room 903

New York, NY 10016

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140,Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain participants must sign this Certification.

2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

**V. AAPD 05-04 Certification for HIV/AIDS Program Funds**

ORGANIZATIONS ELIGIBLE FOR ASSISTANCE (ASSISTANCE) (JUNE 2005)
An organization that is otherwise eligible to receive funds under this agreement to prevent, treat, or monitor HIV/AIDS shall not be required to endorse or utilize a multisectoral approach to combatting HIV/AIDS, or to endorse, utilize, or participate in a prevention method or treatment program to which the organization has a religious or moral objection.

CONDOMS (ASSISTANCE) (JUNE 2005)
Information provided about the use of condoms as part of projects or activities that are funded under this agreement shall be medically accurate and shall include the public health benefits and failure rates of such use and shall be consistent with USAID's fact sheet entitled, "USAID: HIV/STI Prevention and Condoms. This fact sheet may be accessed at:
http://www.usaid.gov/our_work/global_health/aids/TechAreas/prevention/condomfactsheet.html"

PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING (ASSISTANCE) (JUNE 2005)
(a) The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. None of the funds made available under this agreement may be used to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.

(b) Except as noted in the second sentence of this paragraph, as a condition of entering into this agreement or any subagreement, a non-governmental organization or public international organization recipient/subrecipient must have a policy explicitly opposing prostitution and sex trafficking. The following organizations are exempt from this paragraph: the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Health Organization; the International AIDS Vaccine Initiative; and any United Nations agency.

(c) The following definition applies for purposes of this provision:

Sex trafficking means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. 22 U.S.C. 7102(9).

(d) The recipient shall insert this provision, which is a standard provision, in all subagreements.

(e) This provision includes express terms and conditions of the agreement and any violation of it shall be grounds for unilateral termination of the agreement by USAID prior to the end of its term.

(End of Provision)

_____Siobhan Walsh_____certifies compliance as applicable with the standard provision entitled “Condoms” and “Prohibition on the Promotion or Advocacy of the Legalization or Practice of Prostitution or Sex Trafficking.”

Name of Organization: __Concern Worldwide US, Inc_

Print Name: ____Siobhan Walsh_____

Title: _____Executive Director_____

Signature: _____

Date: ____11/20/2005_____

**VI. Other Statements**

1. AUTHORIZED INDIVIDUALS

The recipient represents that the following persons are authorized to negotiate on its behalf with the Government and to bind the recipient in connection with this application or grant:

| Name | Title | Telephone No. | Facsimile No. |
|---|---|---|---|
| Siobhan Walsh | Executive Director | 212-557-8000 | 212-557-8004 |
| Dominic MacSorley | Operations Director | 212-557-8000 | 212-557-8004 |
| Glenn Cummings | Finance Director | 212-557-8000 | 212-557-8004 |
| Michelle Kouletio | Health Advisor | 212-557-8000 | 212-557-8004 |

2. TAXPAYER IDENTIFICATION NUMBER (TIN)

If the recipient is a U.S. organization, or a foreign organization which has income effectively connected with the conduct of activities in the U.S. or has an office or a place of business or a fiscal paying agent in the U.S., please indicate the recipient's TIN:

TIN: __13-371-2030_____

3. CONTRACTOR IDENTIFICATION NUMBER - DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER

(a) In the space provided at the end of this provision, the recipient should supply the Data Universal Numbering System (DUNS) number applicable to that name and address. Recipients should take care to report the number that identifies the recipient's name and address exactly as stated in the proposal.

(b) The DUNS is a 9-digit number assigned by Dun and Bradstreet Information Services. If the recipient does not have a DUNS number, the recipient should call Dun and Bradstreet directly at 1-800-333-0505. A DUNS number will be provided immediately by telephone at no charge to the recipient. The recipient should be prepared to provide the following information:

(1) Recipient's name.
(2) Recipient's address.
(3) Recipient's telephone number.
(4) Line of business.
(5) Chief executive officer/key manager.
(6) Date the organization was started.
(7) Number of people employed by the recipient.
(8) Company affiliation.

(c) Recipients located outside the United States may obtain the location and phone number of the local Dun and Bradstreet Information Services office from the Internet Home Page at http://www.dbisna.com/dbis/customer/custlist.htm. If an offeror is unable to locate a local service center, it may send an e-mail to Dun and Bradstreet at globalinfo@dbisma.com.

The DUNS system is distinct from the Federal Taxpayer Identification Number (TIN) system.

DUNS: ____87-838-8424_____

4. LETTER OF CREDIT (LOC) NUMBER

If the recipient has an existing Letter of Credit (LOC) with USAID, please indicate the LOC number:

LOC: __HHS-A1331P1_____

5. PROCUREMENT INFORMATION

(a) Applicability. This applies to the procurement of goods and services planned by the recipient (i.e., contracts, purchase orders, etc.) from a supplier of goods or services for the direct use or benefit of the recipient in conducting the program supported by the grant, and not to assistance provided by the recipient (i.e., a subgrant or subagreement) to a subgrantee or subrecipient in support of the subgrantee's or subrecipient's program. Provision by the recipient of the requested information does not, in and of itself, constitute USAID approval.

(b) Amount of Procurement. Please indicate the total estimated dollar amount of goods and services which the recipient plans to purchase under the grant:

$ 2,044,743

(c) Nonexpendable Property. If the recipient plans to purchase nonexpendable equipment which would require the approval of the Agreement Officer, please indicate below (using a continuation page, as necessary) the types, quantities of each, and estimated unit costs. Nonexpendable equipment for which the Agreement Officer's approval to purchase is required is any article of nonexpendable tangible personal property charged directly to the grant, having a useful life of more than one year and an acquisition cost of $5,000 or more per unit.

| TYPE/DESCRIPTION (Generic) | QUANTITY | ESTIMATED UNIT COST |
|---|---|---|
| NONE | | |

(d) Source, Origin, and Componentry of Goods. If the recipient plans to purchase any goods/commodities which are not of U.S. source and/or U.S. origin, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, and probable source and/or origin. "Source" means the country from which a commodity is shipped to the cooperating country or the cooperating country itself if the commodity is located therein at the time of purchase. However, where a commodity is shipped from a free port or bonded warehouse in the form in which received therein, "source" means the country from which the commodity was shipped to the free port or bonded warehouse. Any commodity whose source is a non-Free World country is ineligible for USAID financing. The "origin" of a commodity is the country or area in which a commodity is mined, grown, or produced. A commodity is produced when, through manufacturing, processing, or substantial and major assembling of components, a commercially recognized new commodity results, which is substantially different in basic characteristics or in purpose or utility from its components. Merely packaging various items together for a particular procurement or relabeling items does not constitute production of a commodity. Any commodity whose origin is a non-Free World country is ineligible for USAID financing. "Components" are the goods which go directly into the production of a produced commodity. Any component from a non-Free World country makes the commodity ineligible for USAID financing.

| TYPE/ DESCRIPTION (Generic) | QUANTITY | EST. UNIT COST | GOODS COMPONENTS | PROBABLE SOURCE | GOODS COMPONENTS ORIGIN |
|---|---|---|---|---|---|
| NONE | | | | | |

(e) Restricted Goods. If the recipient plans to purchase any restricted goods, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, intended use, and probable source and/or origin. Restricted goods are Agricultural Commodities, Motor Vehicles, Pharmaceuticals, Pesticides, Rubber Compounding Chemicals and Plasticizers, Used Equipment, U.S. Government-Owned Excess Property, and Fertilizer.

| TYPE/ DESCRIPTION (Generic) | QUANTITY | ESTIMATED UNIT COST | PROBABLE SOURCE | PROBABLE ORIGIN | INTENDED USE |
|---|---|---|---|---|---|
| NONE | | | | | |

(f) Supplier Nationality. If the recipient plans to purchase any goods or services from suppliers of goods and services whose nationality is not in the U.S., please indicate below (using a continuation page, as necessary) the types and quantities of each good or service, estimated costs of each, probable nationality of each non-U.S. supplier of each good or service, and the rationale for purchasing from a non-U.S. supplier. Any supplier whose nationality is a non-Free World country is ineligible for USAID financing.

| TYPE/ DESCRIPTION (Generic) | QUANTITY | ESTIMATED UNIT COST | PROBABLE SUPPLIER (Non-US Only) | NATIONALITY for NON-US | RATIONALE |
|---|---|---|---|---|---|
| NONE | | | | | |

(g) Proposed Disposition. If the recipient plans to purchase any nonexpendable equipment with a unit acquisition cost of $5,000 or more, please indicate below (using a continuation page, as necessary) the proposed disposition of each such item. Generally, the recipient may either retain the property for other uses and make compensation to USAID (computed by applying the percentage of federal participation in the cost of the original program to the current fair market value of the property), or sell the property and reimburse USAID an amount computed by applying to the sales proceeds the percentage of federal participation in the cost of the original program (except that the recipient may deduct from the federal share $500 or 10% of the proceeds, whichever is greater, for selling and handling expenses), or donate the property to a host country institution, or otherwise dispose of the property as instructed by USAID.

| TYPE/DESCRIPTION (Generic) | QUANTITY | ESTIMATED UNIT COST | PROPOSED DISPOSITION |
|---|---|---|---|
| NONE | | | |

6. PAST PERFORMANCE REFERENCES

On a continuation page, please provide a list of all U.S. Government and/or privately-funded contracts, grants, cooperative agreements, etc., for similar programs for the last three years and the name, address, and telephone number of the Contract/Agreement Officer or other contact person.

7. TYPE OF ORGANIZATION

The recipient, by checking the applicable box, represents that -

(a) If the recipient is a U.S. entity, it operates as **[ x ] a corporation incorporated under the laws of the State of New York,** [ ] an individual, [ ] a partnership, [ ] a nongovernmental nonprofit organization, [ ] a state or loc al governmental organization, [ ] a private college or university, [ ] a public college or university, [ ] an international organization, or [ ] a joint venture; or

(b) If the recipient is a non-U.S. entity, it operates as [ ] a corporation organized under the laws of _____ (country), [ ] an individual, [ ] a partnership, [ ] a nongovernmental nonprofit organization, [ ] a nongovernmental educational institution, [ ] a governmental organization, [ ] an international organization, or [ ] a joint venture.

8. ESTIMATED COSTS OF COMMUNICATIONS PRODUCTS

The following are the estimate(s) of the cost of each separate communications product (i.e., any printed material [other than non- color photocopy material], photographic services, or video production services) which is anticipated under the grant. Each estimate must include all the costs associated with preparation and execution of the product. Use a continuation page as necessary.

NONE