RFTOP Number: 386-07-008
Issuance Date: 05/31/2007
Closing Date: 07/12/2007--1030 hours
(New Delhi time)

To: **TASC III IQC Holders**

SUBJECT: **REQUEST FOR COMPETITIVE TASK ORDER PROPOSAL NUMBER 386-07-008 FOR MCH SUSTAINABLE TECHNICAL ASSISTANCE AND RESEARCH (STAR)**

USAID/India intends to award a Task Order for Program in Maternal and Child health Sustainable Technical Assistance and Research (MCH STAR) under TASCS III IQC series as described in attached Statement of Work.

This request for Task Order Proposal (RFTOP) consists of the following sections:

A Proposal Preparation Instructions
B Evaluation Criteria
C Statement of Work
D Attachments
E Questions and USAID Responses (separate file document)

The government contemplates award of one Cost Plus Fixed Fee (CPFF) Task order with a total estimated cost between US$14 and US$15 million over 5 years period of performance, ending in September 2012. Issuance of Task Order is subject to availability of funds and successful negotiation of Task Order terms. Revealing the cost range for the task order does not mean that the offerors should necessarily strive to meet the maximum amount. The offeror must propose costs that it believes are realistic and reasonable for the work.

Please provide this office with your technical and cost proposals via email to the Regional Contracting Officer at IndiaRCO@usaid.gov for accomplishing the requirement contained in the attached Statement of Work (attached hereunder) no later than Thursday, July 12, 2007 by 1030 hrs New Delhi Time.

The Closing date for receipt of questions, if any, is Tuesday, June 12, 2007 (1600 hrs New Delhi time). Questions should be addressed to the Regional Contracting Officer, Mr. Marcus Johnson at IndiaRCO@usaid.gov.

Please note that this does not constitute any guarantee that Task Order will be awarded nor does it constitute any authorization by USAID to reimburse costs incurred in the preparation of a proposal.

Sincerely,
Marcus A. Johnson, Jr.
Regional Contracting Officer
USAID/India, Sri Lanka & Maldives

Section A - Proposal Preparation Instructions

Instructions to Offerors

The proposal should be submitted in two separate volumes: (a) technical, and (b) cost. Proposal should include following:

A. 1. Technical Proposal Instructions

Technical Proposals in response to this solicitation should clearly and concisely address how the Offeror intends to carry out the SOW contained in Attachment C. The technical proposal should state clearly its understanding of the requirements in the Statement of Work, its proposed approach to accomplish the contract objectives and achieve the expected results, as well as its personnel and organizational credentials to carry out the activity. Clarity, completeness, and directness are imperative. Elaborate formats are not desirable.

For the proposed key personnel, the Offeror shall clearly describe the professional qualifications of its proposed personnel, including the Chief of Party and the key personnel. The Offeror shall submit one resume or CV of not more than 3 pages each for all proposed technical personnel proposed both long-term and short-term. A letter of commitment from each proposed key person indicating his/her willingness and availability to work on this task order should it be awarded to your firm is required. The Offeror shall also include an overall staffing plan which shows the totality of individuals proposed. The Offeror shall indicate the percentage of time the key individuals will be available to perform work on the Task Order. The Offeror shall also demonstrate its ability to accomplish the requirements and expected results in the Statement of Work.

We expect the work to start work no later than October 1, 2007.

Technical proposal must be limited to 30 Pages. Pages submitted in excess of the page limit will NOT be evaluated. Cover pages, dividers, table of contents, and attachments [i.e. key personnel resumes (of no more than 3 pages)], table summarizing qualifications of proposed personnel, and past performance report forms/Contractors performance reports are not included in the 30 page limitation. An executive summary of a maximum of 2 pages over and above 30 page limit should be included in proposal.

Personnel

This evaluation category shall contain an introductory summary of the key personnel positions that the offerer proposes. The description shall include the responsibilities and authority of each position (including the relations among them in terms of responsibilities and authority), and the rationale for these positions in relation to achieving program results and objectives. USAID leaves the proposed personnel mix, expertise and skills needed to achieve the required work to be decided by the offerer. However, critical staff should have extensive experience in designing, implementing and evaluating the types of public health activities described in the statement of work. Exemplary qualifications for key personnel (COP) are provided below. It is strongly preferred that most or all key positions are staffed by persons with significant experience in India or other countries in the South Asia region.

Government Identified Minimum Key Personnel Positions

Chief of Party
At least 15 years experience in managing public health projects in developing countries is preferred. The person should have experience in directly working with government ministries and non-governmental institutions, multilateral and bilateral donor agencies, and relevant private sector bodies. The person must have formal education or training public health, holding at a minimum a Master's in Public Health or in a related field; doctoral level training is an advantage. In addition, the person should demonstrate past experience in executing technical assistance and capacity building programs to health sector institutions. He or she should demonstrated experience managing or an understanding of the requirements needed to manage research projects. Language requirement: English language fluency is required and at least conversational Hindi language is desired but not required.

Contract, Administrative or Financial Manager
At least 10 years experience in managing donor projects in developing countries is preferred. The person should have experience in directly working with government ministries and non-governmental institutions, multilateral and bilateral donor agencies, and relevant private sector bodies. The person must have formal management education, holding at least an undergraduate degree in business or public administration, management or in a closely related field; graduate level degree or professional certification in a relevant (to this task order) area of expertise is an advantage. In addition, persons with past experience in supporting technical assistance and capacity building programs to health sector institutions will be view as advantageous. Language requirement: English language fluency is required and at least conversational Hindi language is desired but not required.

Required Additional Documents:

1. Performance benchmarks and results to guide the implementation of the offerer's proposed technical approach and methodology.

2. A mobilization plan that illustrates how the offerer and its organization and partners will initiate the program of work outlined in their technical approach. The mobilization plan will provide details regarding the work to be carried out in the initial 90-day period of the contract. At a minimum it will discuss 1) the anticipated logistics of contract start-up and the process and timing to establish administrative and financial controls; 2) the timing and initial deployment of staff; 3) the plan for hiring additional qualified local staff beyond those named in the proposal.

3. A model for managing sub-contractors – including how to determine which partner will provide what aspect of the activity's technical approach (capacity building, non-SSI-provided technical assistance, research support, etc.), and how the prime and the partners will respond to requests for TA and other services.

4. Information regarding the qualifications and past performance of all proposed sub-contractors who will constitute 10% or more of the total yearly planned budget for any project year.

A. 2. Cost Proposal Instructions

The Cost Proposal shall be specific, complete in every detail and separate from the Technical Proposal. Certified cost or pricing data is required for this proposal. The cost proposal consists of your estimated price to perform the required effort as set forth in the Statement of Work and must be prepared in a manner that is current, accurate and complete. All cost/price information must be in the cost proposal. Do not include cost/price information in the technical proposal. The cost proposal must be mathematically correct. Row and column totals for all schedules must accurately tabulate.

Offers must include use the "A" cost proposal format for each year of performance and one overall, 5 years period budget for purposes of evaluation. The "B" cost proposal is to be used only for the 5 year period budget.

A. COST ELEMENT	AMOUNT
Total Direct Labor	
Salary and Wages	$_____
Fringe Benefits	$_____
Consultants	$_____
Travel, Transportation, and Per Diem	$_____
Equipment and Supplies	$_____
Allowances	$_____
Subgrants/contracts(SSIs)	$_____
Participant Training	$_____
Other Direct Cost	$_____
Overhead	$_____
G&A	$_____
Material & Handling Overhead	$_____
Total Estimated Cost	$_____
Fixed Fee	$_____
Total Estimated Cost Plus Fixed Fee	$_____

B. SUMMARY BUDGET

Budget CPFF completion Task Order:

For all Direct Cost _____

For All Indirect Cost _____

Maximum Fee _____

Ceiling Price **_____**

NOTE 1:All indirect rates offerors propose (in the above budget format) must match those ceiling rates authorized in the IQC or as authorized in the most recent NICRA .

NOTE 2: Some offerors may not have indirect cost pools, which allocate costs in the manner identified above. For those items which the offeror does not utilize to allocate indirect costs, please identify in the proposal that these categories are not applicable.

NOTE 3: For further clarification, the following budget line items include the costs as listed:
(a) Allowances – post differential, danger pay, housing for resident expatriates and TCN's, relocation expenses, education allowances, other related allowances.
(b) Participant Training – travel, per diem, and M&IE expense, tuition and fees for foreign nationals to receive training/education in a location which is outside of their country of residence.
(c) Other Direct Costs – bank fees, courier services, phone and fax, Internet services, books and periodicals, visa expenses, office rental, office utilities, office cleaning and maintenance.

A.3 MARKIGN REQUIREMENTS FOR ACQUISTION AWARDS

This branding web page provides guidance for all USAID funded acquisition awards. It contains an electronic version of the Graphic Standards Manual for the United States Agency for International Development (USAID). This manual is compulsory for all Agency employees and contractors producing communications and program materials funded by USAID. Print copies of the manual were distributed to Agency bureaus and Missions. Contractors should download copy from this site click link:

http://www.usaid.gov/branding/acquisition.html

Section – B Evaluation Criteria

A review panel established under the direction of the Regional Contracting Officer will evaluate the proposals. The review panel and the Regional Contracting Officer will use "Best value" criteria to determine the proposal most advantageous to the U.S. Government. All evaluation factors other than Cost/Price, when combined, are significantly more important than Cost/price factors.

Technical, Cost and other factors will be evaluated relative to each other, as described herein.

a) The technical; proposal will be evaluated by a technical evaluation committee using the criteria shown in this section
b) The cost proposal will be evaluated by the method described in this section
c) The criteria below are presented by major category in descending order of importance so that offerors will know which areas require emphasis in the preparation of proposals. The criteria below reflect the requirements of this particular solicitation,

Offerors should note that these below criteria (1) serve as the standard against which all proposals will be evaluated, and (2) serve to identify the significant matters which offerors should address in their proposals.

The award shall be made to the responsive and responsible offeror whose combined technical; and cost/price factor offer the best value to the U.S. Government.

B. 1. Technical Evaluation Factors

a. Technical Approach

1. Demonstrated understanding of the requirement in the Statement of Work, that is, the overall project context, the project concept, principles and approaches, and the target objectives and results of project;

2. Demonstrated reasonableness (realism) of the proposed strategy and approach for achieving the objectives and the timeframe for the start-up and establishment of systems to implement the activities described in the statement of work.

3. Demonstrated ability to identify constraints and risks associated with the proposed strategy and approaches to be employed to overcome them;

4. Demonstrated mobilization and management plan for subcontractors, collaborating partners and two to five SSIs (The work responsibility and selection of each sub-contractor must be described, including a description for how they are uniquely suited, what service they will provide and means the prime will use to ensure coordination between its partners).

b. Past Performance

1. Demonstrated level of the proposed team's past performance in providing high quality technical assistance that has met the needs of clients in the area of Maternal, Neonatal and Child Health and Nutrition in Asia;

2. Demonstrated past performance of the proposed team in meeting all requirements stated in the statement of work – including developing capacity building programs that use alliances, cross learning, mentoring and problem-based technical assistance; strengthening developing-country institutions' abilities to provide health sector TA; and increasing their capacity to conduct program and policy research and evaluations.

3. Demonstrated past performance of the proposed team in designing and managing sub-grant and sub-contract programs that provide the services requested in the statement of work either in India or other countries in Asia.

c. Management Structure and Staff Qualifications

1. Demonstrated professional qualifications, technical skill, and past experience of the Chief of Party (COP) and other key personnel and the extent to which their skill sets will directly contribute to and enhance the requirements stated in Section C;

2. Demonstrated past experience of the staff in integrating gender consideration into Maternal, Neonatal and Child Health and Nutrition activities;

B. 2. Cost/Price Evaluation Factor

While the overall Technical; Evaluation is the key factor in reviewing the offeror's proposal, the cost/price evaluation is nonetheless an essential factor in determining the final contract award and ability to get into and remain in the competitive range. It should be noted that estimate cost is and important factor and its importance as an evaluation factor will increase as the degree of equality of technical; competence between proposals increases. Additionally, the cost/price evaluation shall be carefully considered in determining the best value to the U.S. Government.

The Government shall evaluate the total cost proposal for the principal tasks identified in Statement of Work for realism, completeness and reasonableness. The contractor should have a structure that will allow it to provide the greatest value (higher results) at the lowest cost; minimizing or eliminating overall administrative cost, overhead, subcontract pass-through costs, profit, international staff benefits, home office communications and support. Each offeror's cost proposal shall be evaluated based on the following criteria in comparison with the cost proposal of other offerors.

1. Effectiveness of the proposed cost control structure
a) Budget transparency to effectively track expenditures; and
b) Subcontracting methods are clearly identified
A complete breakdown of subcontractor costs is required (i.e., labor, ODCs, indirects and fee).

2. Reasonableness of proposed Labor cost and structure
a) Expatriate salary structure and expense; and
b) Local salary structure and expense
c) STTA/Consultant salary structure and expense.

(Labor Cost for Proposed personnel, labor categories, proposed salaries and level of effort, identifying each with name and category. Biographical Data Sheets (Form AID 1420-17) is required to support salary information for the proposed personnel, containing salary history for the previous three years. (Bio-data forms must be properly certified and signed by both

employee and contractor in the appropriate spaces with all blocks completed, as appropriate.) Labor Cost for LES shall not exceed the thresholds in the local employee compensation plan.

Pursuant to AIDAR 722 the maximum rate under the US Mission Local Compensation Plan (LCP) in New Delhi, India is FSN Grade 12/Step 14 for a 40-hour workweek is INR 1,672,733 per annum, inclusive of allowances amounting to INR 713,511 per annum. This is current as of February 2007. Those allowances include Housing, Accommodation, Leave Travel, Conveyance and Loan allowances. The US Mission maximum LCP salary wage mentioned above does not include Bonus, Provident Fund, Superannuation Fund, Gratuity, and insurance benefits. One annual insurance premium payment is made by the U.S. Mission is to provide up to INR 400,000 medical/health coverage per employee and family.)

3. Cost efficiency of proposed Other Direct Costs (ODCs)
a) Offers market competitive pricing estimates of tangible items to be used for contract performance;
b) Competitiveness of pricing and soundness purchase methods of international and in-country air travel and surface transportation.

4. Cost-sharing, matching arrangements, and value of in-kind contributions, if any.

5. Profit or Fee: The Offerror shall indicate the Contractor's proposed fixed fee for the task order.

6. Reasonableness of overall proposed price

Price has not been assigned a numerical weight. Offerors are reminded that the U.S. Government is not obligated to award a negotiated contract on the basis of the lowest proposed cost (see FAR 15.101-1) or to the offeror with the highest technical evaluation score. **For this procurement technical proposal is of equal weight relative to cost or price when deciding who best might perform the work, price and other factors considered.** The significant technical factors are of equal weight. Therefore, after the final evaluation of the proposals, the Contracting Officer will make the award to the offeror whose proposal offers the best value to the Government, considering both technical and cost factors. It should be noted that estimate cost is an important factor and its importance as an evaluation factor will increase as the degree of equality of technical competence between proposals increases.

ACRONYMS

EAG States	:	Empowered Action Group States
FCRA	:	Foreign Contribution Regulatory Act
FY	:	Financial Year
GOI	:	Government of India
ICDS	:	Integrated Child Development Services Scheme
IMR	:	Infant Mortality Rate
IndiaCLEN	:	Indian Clinical Epidemiology Network
JRM	:	Joint Review Mission
MMR	:	Maternal Mortality Ratio
MWCD	:	Ministry of Women & Child Development
MNCHN	:	Maternal, Newborn, Child Health and Nutrition
MOHFW	:	Ministry of Health & Family Welfare
MCH-STAR	:	Maternal & Child Health-Sustainable, Technical Assistance & Research
NFHS	:	National Family Health Survey
NHSRC	:	National Health System Resource Center
NGO	:	Non governmental Organization
NRHM	:	National Rural Health Mission
PHFI	:	Public Health Foundation of India
PIP	:	Project Implementation Plan
RCH Program	:	Reproduction and Child Health Program
SSI	:	STAR Supported Institutions
SC/ST	:	Schedule Caste / Schedule Tribe
TA	:	Technical Assistance
TFR	:	Total Fertility Rate
UHRC	:	Urban Health Resource Center
U.P.	:	Uttar Pradesh
USAID	:	United States Agency for International Development

Section C - Statement of Work/Description/Specifications

Project Title: MCH Sustainable Technical Assistance and Research (MCH-STAR)

C. 1. Background

C.1.1 The Maternal, Newborn and Child Health and Nutrition Scenario in India

Improving the health of women and children in India is paramount for India at this stage in its development. The data shows the challenge:

- 20 percent of the world's births are in India;
- 20 percent of the world's maternal deaths are in India (the most of any country in the world);
- One woman dies every five minutes in India (more than 130,000 deaths a year) from causes related to pregnancy and childbirth;
- 25 percent of the world's child deaths are in India;
- Approximately half of all children under the age of three in India are malnourished; and
- Among children 12-23 months, only 43.5 percent are fully immunized.

Causes of Child and Maternal Death and Child Malnutrition in India are Preventable and Treatable.
The major causes of under-five and maternal deaths are preventable and treatable. In the case of children under five, one half of the deaths occur during the neonatal period (the first month of life), yet the major causes of morbidity and mortality are known and many feasible life-saving interventions exist. Some of the main causes of death of older children under the age of five include diarrhea, pneumonia, measles and other infections. For this age group, life-saving interventions also are known.

For women, the main causes of maternal death also reveal that saving these lives does not require extraordinary interventions or technology. The main causes of maternal death are hemorrhage, anemia, sepsis, complications from abortions, obstructed birth and toxemia. The low use of health services partly illustrates why these continue to cause so many deaths. Only 50 percent of mothers received three antenatal care visits for their last pregnancy and only 22 percent consume iron/folic acid tablets for 90 days or more. Strikingly, only 41 percent of deliveries take place in facilities and, at best, 48 percent of births are assisted by a trained health professional.

Malnutrition plays a major underlying role in both child and maternal health. Malnutrition is associated with more than 50 percent of childhood deaths and directly affects the severity of diseases such as measles and diarrhea. The impact of malnutrition is reflected in child health statistics including high levels of stunting, anemia, and maternal under-nutrition. The causes of under nutrition include delayed initiation of breast-feeding, early termination of exclusive breast-feeding, low vitamin A and iron/folic acid intake, inappropriate complementary feeding, and poor hygiene-related practices and related morbidities – diarrhea and intestinal helminthes.

During the past 25 years, mortality for children under five has declined in India, demonstrating that progress can be made in child survival at a national level. Yet, according to the Human Development Report 2005, the slower annual reduction in the Infant Mortality Rate[1] indicates that India has not been able to convert its substantial economic growth into human development gains. India's high maternal mortality ratio[2] (327 per 100,000 births) reinforces this claim.

The role gender plays in MNCHN deserves special attention. There has been a sharp decline of 35 points in the child sex ratio for girls between the 1981 census and the 2001 census. While neo-natal and infant mortality rates in boys and girls favor girls or are comparable, respectively, the child mortality rate is significantly higher for girls. This clearly establishes that environmental influences, including social values that lead to girls receiving low value and poor care, are a significant factor in girls' health. These inequities continue throughout the life of a woman. For a woman in India, the social distance is often a far greater gulf than the physical distance to a health facility. Also commonplace, an Indian woman does not have the autonomy to take decisions about the health and well-being of her family and herself. Gender interplays with caste, class, religion, age, geographical location economic and health status to further intensify a woman's vulnerability.

C.1.2 Status of Maternal, Newborn and Child Health in India's Northern States – The Empowered Action Group States (EAG)

Despite gains at the national level, clear differences in child mortality rates still exist between the states, by gender and between social and economic groups (SC/ST and groups with lower economic opportunity have the highest child mortality rates and the greatest needs). MNCHN problems are especially severe in India's Northern States. The states of Bihar, Jharkhand, Uttar Pradesh, Uttarakhand, Rajasthan, Orissa, Madhya Pradesh and Chhattisgarh

[1] Infant Mortality Rate (IMR): The infant mortality rate (IMR) is the ratio of the number of deaths among children less than one year old during a given year to the number of live births during the same year. It is expressed in per 1000 live births. Whereas India's rate is 57, China's is 26 and the U.S.' (the most populous developed nation) is 7.

[2] Maternal Mortality Ratio (MMR): The number of women who die while pregnant or within 42 days after pregnancy, form any cause related to or aggravated by pregnancy per 100,000 live births in a given year. Formula is MMR= # of maternal deaths in a year/100,000 live births in a year.

contribute significantly to the country's poor MNCHN status. These eight states, collectively referred to as the Empowered Action Group (EAG) states by the GOI, constitute 45 percent of the population and have similar, poor MNCHN indices. The National Rural Health Mission, RCH II and their assistance mechanisms like the National Health Systems Resource Center (NHSRC) are focused first and foremost on improving basic health indicators in the EAG states.

USAID's MNCHN approach has traditionally focused its efforts in select northern states (Jharkhand and Uttar Pradesh). The significance of focusing on states such as Uttar Pradesh (UP) is borne out by the state's MNCHN indices. Whereas the national average for infant mortality and under-five mortality rates[3] are 57 and 74, in UP (pop. 170 million – equivalent to the population of Brazil) the averages are 30 and 65 percent higher, respectively. UP accounts for one quarter of all child deaths in India and India accounts for 25 percent of the estimated 10.5 million children who die each year globally. In other words, more than 650,000 children die each year in the UP alone. Based on this, for any USAID effort to impact India's health statistics, it must target the most vulnerable in UP. USAID also focuses on Jharkhand, where health indices are among the poorest in India, but where its status as a new state presents special opportunities for rapid development. In both states, there is political and bureaucratic commitment to see rapid improvement. Focusing in these areas would positively affect not only the local population. It also would have impact at the national level and is critical to India's Millennium Development Goals, which call for reducing the IMR to 27, the U5MR to 42 and the MMR to 109 by 2015.

The very nature of MCH-STAR, which will look at operations and policy research, analysis, advocacy and technical support, means it will aim to have a national-level influence. MCH-STAR will attempt to influence national-level MNCHN policy based on evidence-based research and analyses. Nonetheless, MCH-STAR will still maintain a geographic focus in the EAG states and specifically in USAID's MNCHN focus states of UP and Jharkhand.

C.1.3 Government of India (GOI), MNCHN and the Need for MCH-STAR

In April 2005, the Government of India launched the National Rural Health Mission (NRHM) to highlight the importance of health in the process of economic and social development. This program follows the earlier Child Survival and Safe Motherhood, Reproductive & Child Health (RCH) I, and RCH II programs, and incorporates the RCH II program as its flagship activity. In February 2007, the GOI recommitted itself to addressing the country's health issues. The GOI's proposed budget for 2007 - 2008 calls for a 21.8 percent

[3] Under Five Mortality Rate (U5MR): The probability of dying between birth and exactly five years of age, expressed per 1,000 live births.

increase in health funding, including an increase in NRHM funding to approximately $2.2 billion annually.

The goal of the NRHM is to help improve availability and access to quality health care by people, particularly for those residing in the rural areas, the poor, women and children. NRHM:

- Outlines necessary corrections in the basic health care delivery system;
- Spells out inclusion of other determinants of good health (e.g. nutrition, sanitation, hygiene and safe drinking water);
- Corrects regional imbalances in health infrastructure in Northern and Eastern India;
- Proposes increased public expenditure on health;
- Pools public health resources;
- Integrates organizational structures;
- Optimizes health and human resources;
- Decentralizes management of health programs to the district level; and
- Promotes community participation and ownership.

The difficulty of implementing NRHM is generally acknowledged by the GOI and development partners. In January, 2007, the GOI concluded its 3rd Joint Review Mission (JRM) of its flagship NRHM program, RCH-II. The JRM – a GOI, donor and partner review of the progress against RCH outcomes – indicated that none of the states in India will achieve the RCH-II goals related to MMR by 2010 and only six to seven states will achieve the Infant IMR and Total Fertility Rate (TFR)[4] goals. The report states:

"Allocations for child health in state PIPs in 2005-06 and 2006-07 have been extremely low. Likewise, very little progress has been made on implementation, mirrored by the abysmal utilization of funds." (p 13) [5]

By the end of second quarter of the FY 06-07, the actual expenditure of the child health budgets was estimated to range between zero and 15 percent of planned expenditure at the state level and a meager two percent of planned expenditure at the national level – meaning much of the money allotted for children's health services is not being expended [6].

[4] Total Fertility Rate (TFR): The **total fertility rate** or **total period fertility rate** (TPFR) of a population is the average number of children that would be born to a woman over her lifetime if she were to experience the current age-specific fertility rates through her lifetime. It is obtained by summing the age-specific rates for a given time-point. The TFR (or TPFR) is a better index of fertility than the Crude birth rate (annual number of births per thousand women of childbearing age) because it is independent of the age structure of the population.

[5] Ref. Aide Memoir JRM-3: http://www.mohfw.nic.in/NRHM/Documents/Final_Aide_Memoire_JRM3.pdf

[6] Presentation made by Program Management Support Group for Donor Coordination Division, MOHFW, GOI on January 29, 2007 at Room # 249, A Wing, MOHFW, Nirman Bhawan, New Delhi during 3rd Joint Review Mission of RCH-2/NRHM

One important gap hampering NRHM's success is the lack of technical assistance to support effective implementation of evidence-based, sustainable MNCHN activities. NRHM's Framework for Implementation clearly recognizes this. It states the need for:

"Effective monitoring of performance, support for capacity development at all levels, and sharing the best national and international practices…"[7]

According to the NRHM Framework for Implementation, the Indian central government is to fill this role. To meet the need for technical assistance and the dissemination and implementation of best practices, GOI formed the National Health Systems Resource Center (NHSRC). The NHSRC is tasked with managing and facilitating access to:

- A pool of *institutions* and individuals that deliver high-quality technical assistance;
- Capacity development for achieving the health outcomes and objectives via government and non-government institutions and organizations at central, state, district and sub-district levels;
- Evidence-based insights on wider determinants of health outcomes for planning of the health sector at the national, state and district levels;
- Efficient implementation of the NRHM at central, state, district and sub-district levels;
- Monitoring and evaluation systems based on latest innovations and technology;
- Knowledge management, documentation and dissemination of knowledge and experiences, as well as good practices in health systems in India and across the world;
- Policy advice to the central and state governments, including on matters specifically pertaining to the health and family welfare sector; and
- Analytical work to continuously improve the planning, implementation, monitoring and review of the health sector reforms. [8]

The NHSRC will need access to a pool of health sector technical assistance institutions and individuals that can provide these services specifically to the MNCHN sector. These institutions currently do not exist. USAID's MCH-STAR activity will identify potential institutions and help strengthen their capacity to meet this need. This positioning of the NHSRC is clearly set forth in the National Rural Health Mission, Framework for Implementation which states:

"The National Health System Resource Centre (NHSRC), which is envisaged as an agency to pool the technical assistance from all the Development Partners.

[7] *National Rural Health Mission, Framework for Implementation (2005), page 22. See at http://www.mohfw.nic.in/NRHM%20state%20and%20district%20health%20mission-institutional%20setup.htm*

[7] Rules and Regulations of the National Health Systems Resource Center, Section 5.1.

. . (is) mandated as a single window for consultancy support (and) the NHSRC would quickly respond to the requests of the Centre/State/Districts for providing technical assistance . . . " (p 29)

The NHSRC has been under development for over two years. The first Governing Body meeting was held on 1 May 2007 and its first Executive Director was selected. State HSRC's in Jharkhand and UP are in the discussion and development phase.

Currently the NHSRC has a total of 35 positions. These positions are supported by USAID and UNFPA – 23 through USAID and 12 through UNFPA. About a third of these positions (13) are technical, while the remaining 22 positions are for the NHSRC Secretariat or provide support to various program divisions and the Finance Management Group at the MOHFW.

With respect to current technical positions at the NHSRC, USAID is providing support in six areas including health insurance, social marketing, monitoring and evaluation (including community needs assessment), family planning and human resources management. UNFPA support is focused in the areas of training, maternal health and adolescent reproductive health. Both USAID and UNFPA also support a few consultants for broader NRHM issues. USAID has also been requested to support two positions focused on urban health, but these are currently unfilled.

The GOI has strongly supported the creation of the Public Health Foundation of India (PHFI). PHFI was created to redress the limited institutional capacity in India for strengthening training and for research and policy development in all public health sectors. Its goal is to create public health training institutes throughout India – providing post-graduate courses and preparing India's next generation of public health professionals. In addition to designing and delivering post-graduate courses, PHFI will strive to impact government employees in the health sector. It will provide classroom teachings, teaching methodologies, demonstrations, field work, assignments, self learning, computer aids, case studies, critical thinking exercises, seminars and role play. Furthermore, PHFI Institutes also will conduct research relevant to individual states, regions and the country as a whole. Determination of research priorities shall be under the purview of the individual public health institutes with input from both the state government and other public health experts.

The creation of PHFI and NHSRC demonstrate that the GOI demands the type of service MCH-STAR will provide. These institutions also demonstrate the GOI wishes to have this service readily available from an indigenous source. MCH-STAR is designed to address this recognized gap and to accelerate progress where remedying activities have already begun.

C.1.4 USAID/India's Maternal, Neonatal, Child Health and Nutrition Strategic Approach

USAID's MNCHN goal is to improve maternal newborn and child health and nutrition at scale in India. USAID will achieve this goal by meeting two key objectives: 1) improved policies, program approaches and resource allocation to MNCHN programs, and; 2) effective implementation of the National Rural Health Mission (NRHM) and Integrated Child Development Services Scheme (ICDS) programs in key states.

Principles guiding the strategy include:

Who and Where:

- Focus on poor, vulnerable and marginalized populations and promote equity;
- Concentrate geographically
  - Build on USAID investments and successful platforms
  - Work where there is opportunity, and commitment to build effective partnerships
  - Co-invest with other PHN investments where RCH improvement is the common goal – focus efforts in UP and Jharkhand;
- Support appropriate approaches and sufficient focus for both urban and rural populations.

What:

- Support an evidence-based approach to programming;
- Focus on major causes of maternal, infant and child mortality and under-nutrition, and their proximate determinants;
- Address critical gaps and constraints to successful MNCHN program implementation;
- Work in areas of USAID's comparative advantage in MNCHN programs and stay focused on activities that will lead to measurable MNCHN improvements.

How:

- Focus from the very beginning on MNCHN results at scale;
- Leverage resources to influence larger programs and build on RCH II, NRHM, ICDS;
- Work with both public and private sectors;
- Build on Indian competencies and build capacity – providing for a legacy of Indian institutional capacity to sustain technical support in MNCHN and urban health;
- Link with other USAID/India health programs – geographically, programmatically, strategically;
- Consolidate and rationalize activities and minimize USAID management burden.

Geographic Focus:

MNCHN activities will be national in scope and will directly support the National Rural Health Mission (NRHM), Reproductive and Child Health II (RCH II)

and ICDS programs. As such, activities will directly support improved programs that can have impact in the areas of greatest need - specifically the 200 poorest performing districts in the EAG states. State specific activities will focus on USAID's RCH states of UP and Jharkhand, and close partnerships will be developed with these states on MNCHN matters. Urban health activities will concentrate in UP and Jharkhand to an extent, but will also include work in other EAG states, with city selection being based on demand from states and opportunities arising, and the assessment of the probability that a given city program will be influential to other city programs and nationally.

Strategic Choices

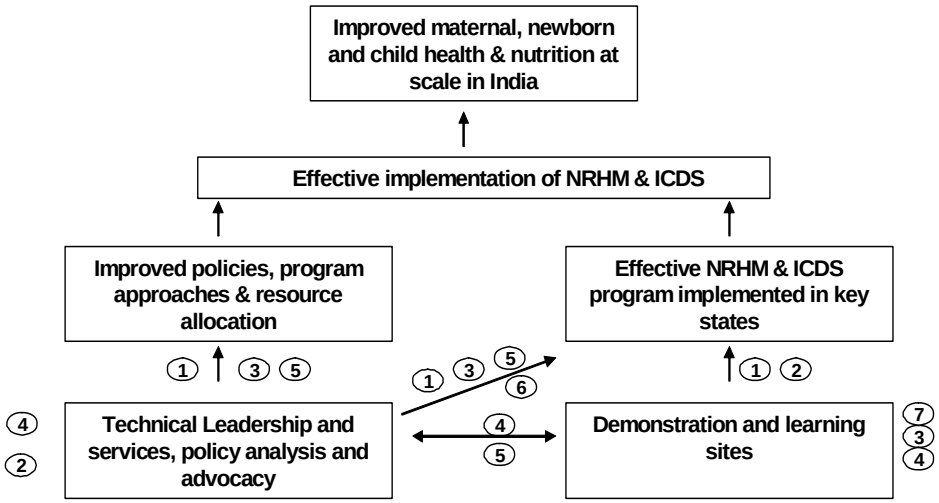
- Focus on community rather than institutional services (but intervene on services and links to services when essential to meet community needs);

- Program for demonstration, evidence, and leverage (rather than for direct service delivery with limited resources in an enormous country);

- Focus research investment on key program issues.

In addition to these strategic choices, USAID will leverage its resources for maximum impact. To do so, GOI programs will be a key focus of the USAID activities, with an aim to improve programs operating at scale. USAID supported institutions will be identified based on a set of criteria that indicate their institutional and technical strength and diversity of funding sources – from both public and private sector sources. This will enable the strategic application of USAID resources and is also an indicator of the long-term sustainability of the supported institutions.

MNCHN Strategic Program Framework



Assistance provided:

1. **Technical Assistance (technical & operational)**
2. **Capacity building & institutional development**
3. **Facilitation of partnerships & exchange of experience**
4. **Applied, operations and evaluation research; analyses of existing data**
5. **Global best practices introduced**
6. **Consultation, Workshops and advocacy Events**
7. ***Implementation & operational support***

Assistance Provided:

1. **Technical assistance to programs that work at scale in MNCHN:** TA will be provided to NRHM/RCH-II, ICDS at national and state levels on all aspects of MNCHN. Other recipients of TA may include other USAID projects, NGO's and private sector partners. Such TA will depend on the assessment of need, opportunities to fill a critical gap, and the ability to have an effect at scale in India.

2. **Capacity building of Indian institutions:** Capacity building will be a hallmark of MNCHN activities. USAID will work with selected Indian institutions to build their capacity to be the technical leaders in MNCHN, achieving the long-term goal of the institutions providing services after USAID funding ends.

3. **Facilitation of partnerships and exchange of experiences:** In order for USAID activities to be relevant, it will never act in isolation. Activity priorities – from research to consultations to advocacy events – will be established with the various levels of Indian government and a wide array of important stakeholders. The objective is to establish buy-in and

ownership. Additionally, USAID will seek to support institutions and activities that have multiple channels of support (donors, private sector, and public support). USAID will chose institutions where USAID can play the greatest value-adding role.

4. **Applied, operations and evaluation research; analyses of existing data:** USAID will support improved programs and policies by providing evidence-based information. USAID will help generate this information through new research, analyzing existing data, and performing high-quality independent evaluations of existing programs. Priorities will be established with the GOI and other major stakeholders and the activities will focus on producing high-quality results in a timely manner. The information will be disseminated through reports, consultations and workshops designed to bring the information directly into the program and policy dialogue and to inform decisions.

5. **Global best practices introduced:** USAID will support programs that introduce global best practices into India's MNCHN health system. USAID and its activities will focus on selecting those practices that not only demonstrate the best approaches but also are geared to have greatest impact when implemented in India.

6. **Consultation, workshops and advocacy events:** USAID will support consultation, workshops and advocacy events that highlight, communicate and transfer the best approaches, applications and policies for addressing of MNCHN issues.

7. **Implementation and Operational Support:** Limited Implementation and operational support will be provided for select MNCHN activities – those that are essential for demonstration and learning activities.

C.1.5 USAID/India's Child Health, Maternal Health and Nutrition Efforts: Past, Present and Future

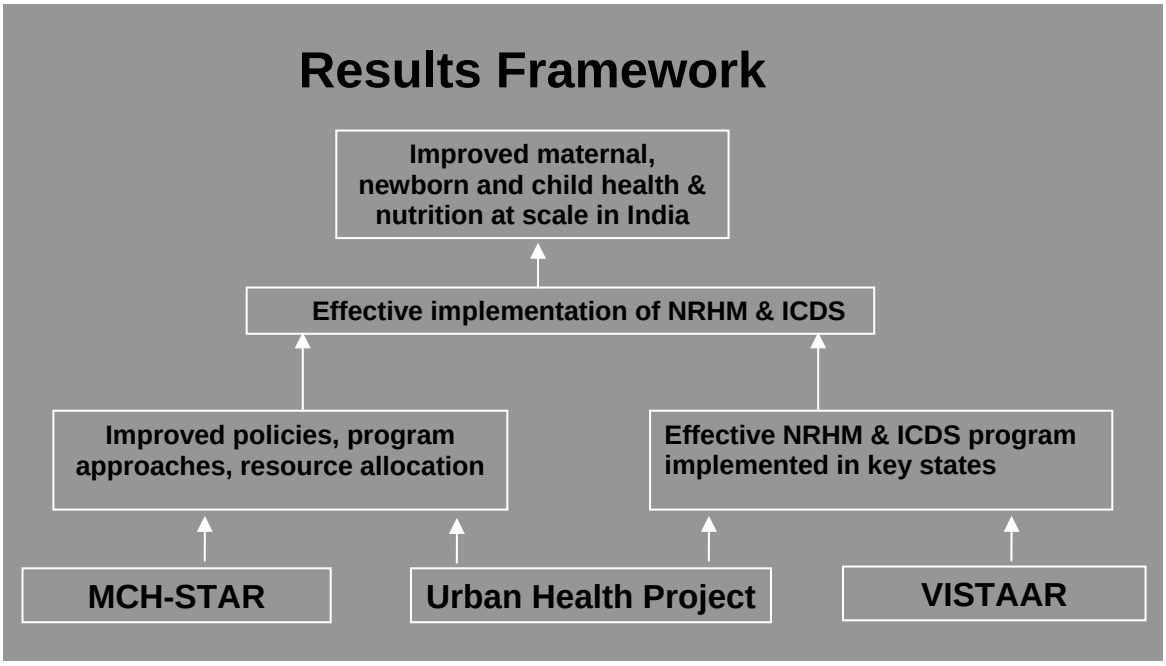
USAID's experience in MNCHN is rich, long and influential. Among the donor community in India, it is the organization with the greatest MNCHN technical assistance profile. This profile is a product of USAID's network of global projects and experience, its leading role in initiating MNCHN interventions in India, and its access to and relationships with U.S. and Indian universities. As a result, the GOI recognizes USAID as a partner in its MNCHN initiatives and an important source for MNCHN technical assistance.

USAID's experience in MNCHN also is illustrative of the larger problem of MNCHN technical assistance in India. USAID currently oversees more than ten separate MNCHN technical assistance programs. These many technical assistance activities – divided among research, micronutrients, service delivery, immunization, and others – present challenges to coordination across sectors,

are unwieldy in terms of management and do not provide for an integrated and comprehensive approach to technical assistance in MNCHN matters. Just like the national state of MNCHN, the programs' effectiveness (as demonstrated in the findings of numerous evaluations) suffers from a scattered approach to technical assistance and the lack of a dominant authority and source for the provision of comprehensive and high quality MNCHN technical assistance. Nonetheless, the USAID program for MNCHN in India has had considerable successes – contributing to positive results in its focus areas.

In anticipation of MCH-STAR, USAID's current technical assistance and research MNCHN activities are winding down or will wind down over the MCH-STAR period of performance. One benefit of MCH-STAR is that it will help the Mission consolidate its MNCHN management structure and address the findings of previous evaluations. Doing so would allow the Mission to improve its internal management of MNCHN activities and would help India fill a large gap in its approach to MNCHN. Readers of this scope of work should view this information as exposition. The eventual implementer of MCH-STAR will not be directly responsible for this aspect of USAID's internal management.

Furthermore it is important for offerers to understand the USAID's core MNCHN activities and how they relate. The figure below illustrates the three main programs that will support the MNCHN strategy and results.



USAID's Core MNCHN Programs

As USAID's current MNCHN activities are phased out or over, the Mission's MNCHN strategy will be executed by three core activities. It is important to recognize that these three programs are intended to work together in a complementary and, where possible, a synergistic manner to accomplish MNCHN results at scale in India.

The first of these activities is USAID's urban health program, implemented by the Urban Health Resource Center (UHRC). This program focuses on improving MNCHN indicators among the urban poor through technical, systems and policy interventions. *A more detailed description of the UHRC is provided in Annex - 1 of this statement of work.*

The second activity, Vistaar, was launched in October 2006 and explicitly addresses the effective implementation of NRHM and ICDS programs in two key states. It accomplishes this through demonstration, learning and support for the scale-up of proven MNCHN approaches in rural areas and small towns in the states of UP and Jharkhand. *A more detailed description of Vistaar is provided in Annex - 2 of this statement of work.*

The third project, MCH-STAR, will help India improve policies, program approaches and resource allocations via institutions that specialize in MNCHN technical leadership and services, policy analysis and advocacy.

It is easiest to think of the activities this way: Vistaar supports the identification and scale up of effective program approaches, and the successful implementation of the NRHM at the state and local levels; UHRC addresses systems and MNCHN issues specific to urban poor settings; and MCH-STAR provides high-level MNCHN technical inputs for effective policies and implementation of the NRHM.

To best achieve USAID's MNCHN objectives, a productive interaction between the three core projects will be required, and will be managed by USAID. In the case of Vistaar and URHC, both activities will benefit from MCH-STAR. For example, Vistaar and UHRC will be able to purchase technical assistance from and build alliances with the institutions MCH-STAR is strengthening. However, that does not mean MCH-STAR must be the sole provider of outside TA to these programs. Vistaar and UHRC will have the entire market of TA available to them and will be empowered to choose the TA source on the basis of best value. One example where MCH-STAR can benefit from Vistaar and UHRC include participating in key stakeholder consultations that have already been established with Vistaar and/or UHRC assistance – such as the MNCHN TAGs that have been established in UP and Jharkhand. An example of potential synergy between MCH-STAR, Vistaar and UHRC is where Vistaar and UHRC identify project priorities in operations, applied, evaluation or policy research and

MCH-STAR may provide the technical support to design, conduct and disseminate the research.

In order to optimize the interaction among these three activities, USAID will institute of process of joint quarterly reviews, annual reviews of workplans, and other means of information sharing, coordination, and co-programming as appropriate.

C.2. Detailed Technical Requirements

C.2.1 Activity Description

C.2.1.1 Project Goals, Objectives and Results

Goal:

The overall goal of MCH-STAR is to improve maternal, neonatal and child health and nutrition in India among poor and underserved populations through effective programs that address priority issues and are guided by appropriate policies.

General Objective:

Sustainable Indian institutions provide technical leadership and critical technical inputs to public and private sector programs in India in maternal, neonatal and child health and nutrition matters through technical assistance to programs, policy analyses and advocacy, and operations, applied and policy research.

Project Principles:

Among the principles guiding the MNCHN strategy and set forth in section 1.4, a few deserve special emphasis and expansion with respect to MCH-STAR.

1. Focus on the major causes of maternal, neonatal and childhood diseases and malnutrition, and their proximate determinants. This activity is meant to contribute to improved maternal, neonatal and child health and nutrition and will stay focused on these priorities.

2. Promote evidence-based programs and policies to address MNCHN needs. This activity will promote the use of scientifically sound evidence in program and policy formulation and collective decisions through the creation of new information (through operations and policy-related research), the effective dissemination and promotion of discussion and action related to new and existing information, white papers and policy analyses, and other means as appropriate.

3. Address critical gaps and constraints. Through consultation, priority setting exercises with all stakeholders and other means of identifying key gaps and constraints to programs, this activity will identify a priority agenda for operations and applied research, program and project evaluations, technical assistance and related actions that address the most critical gaps and constraints in current programs and policies.

4. Focus on poor, vulnerable and marginalized populations, including applying a gender lens to all activities and analyses. As there are sharp disparities in the health status between economic and social groups, this activity will focus on programs and policies that are designed to reach those populations with the greatest public health need. It will adopt and sharpen USAID's focus on social determinants of health status and operational issues for reaching poor, vulnerable and underserved populations. This includes ensuring that the impact of gender dynamics is properly understood and addressed in regard to these determinants and issues.

5. Focus on programs and policies that benefit populations with the worst health indicators. This includes the 200 poorest performing districts where NRHM will focus. These districts are within the critical EAG states – those eight states within NRHM where health status is poorest and progress has been slow. Among the EAG states, primary focus will be on Uttar Pradesh and Jharkhand.

6. Work with programs that will make a difference at scale in India. This activity will work with the RCH II, the NRHM and ICDS to provide support in key areas to improve program effectiveness and improve MNCHN at scale in India. These relationships of support to the national programs form the hallmark of this activity and all priorities and work will be developed through a process of close consultation and collaboration with these programs.

7. Build the capacity of Indian institutions that can provide technical leadership in MNCHN and continue to make contributions of the nature of MCH-STAR's in a sustainable fashion in India. This activity will focus on providing key MNCHN support services in the near term while building the capacity of Indian institutions to continue to provide such services in the long term.

8. Improve the coherence and management of USAID-supported MNCHN technical support activities. MCH-STAR will bring lines of work that have historically existed under many different projects under one umbrella, thus providing: increased management efficiency; financial efficiency; better coordination and realization of synergies between activities; reduction of redundancies; and improved focus on a smaller set of technical priorities developed through a rigorous process of GOI and stakeholder involvement.

9. Work closely and synergistically with other MNCHN activities and partners. MCH-STAR will work with MNCHN partners, including but not limited to those funded by USAID, to identify opportunities and priorities for the provision of technical services, to avoid overlap and unintentional duplication, and to identify critical gaps that MCH-STAR is well positioned to address.

Geographic Areas of Implementation:

MCH-STAR will provide technical services in support of the National Rural Health Mission (NRHM), Reproductive and Child Health II (RCH II) and ICDS programs, so is expected to have national influence. State specific activities and on-the-ground research activities will be focused in USAID's RCH states of UP and Jharkhand. Overall, project activities will be focused on approaches to improve MNCHN that are directly relevant in those areas of India where need is greatest - the EAG states (northern states with similar health problems and poor MNCHN indices – Madhya Pradesh, Chhattisgarh, Rajasthan, Orissa, Uttar Pradesh, Jharkhand, Uttarakhand, and Bihar).

Main Results and Key Indicators:

1. Applied, operations and policy research priorities established for maternal, neonatal and child health and nutrition in India.
    a. Consensus research priorities established at the national level for maternal health, neonatal health, child health, maternal nutrition and infant and child nutrition through a process that involves all stakeholders including the GOI.
    b. Consensus research priorities established at the state level in UP and Jharkhand.
    c. Consensus research priorities are reviewed and updated with all stakeholders annually, including reviewing progress in addressing priorities, at both the national and state levels.

2. Results of key applied, operations and policy research studies effectively disseminated to influence programs and policies.
    a. At least two major applied, operations, and/or policy research studies initiated annually.
    b. At least four small-scale applied or operations research studies initiated annually.
    c. Results documented and disseminated to all stakeholder organizations within four months of the end of field collection of study information.
    d. At least one national and one state consultation on new research findings held annually.
    e. At least one policy change annually where a major contribution of MCH-STAR research can be attributed.

3. Information and platforms for evidence-based policy development are improved.
    a. At least two policy analyses or white papers produced annually.
    b. At least one policy consultation annually addressing one or more maternal, neonatal and child health and nutrition matter convened or co-sponsored by MCH-STAR or MCH-STAR-supported institutions.

4. Programs are improved through the provision of well-informed and competent technical assistance at the national level.
    a. At least two full time equivalents of technical assistance are provided to the NHSRC.
    b. At least two MCH-STAR-supported institution members are asked to participate and contribute in each NRHM/RCH II Joint Review Mission (JRM).
    c. MOHFW and MWCD requests for specific technical assistance in MNCHN are fulfilled with timely, responsive, and high quality assistance.
    d. State level requests for specific technical assistance in MNCHN are fulfilled with timely, responsive and high quality assistance in the states of UP and Jharkhand.

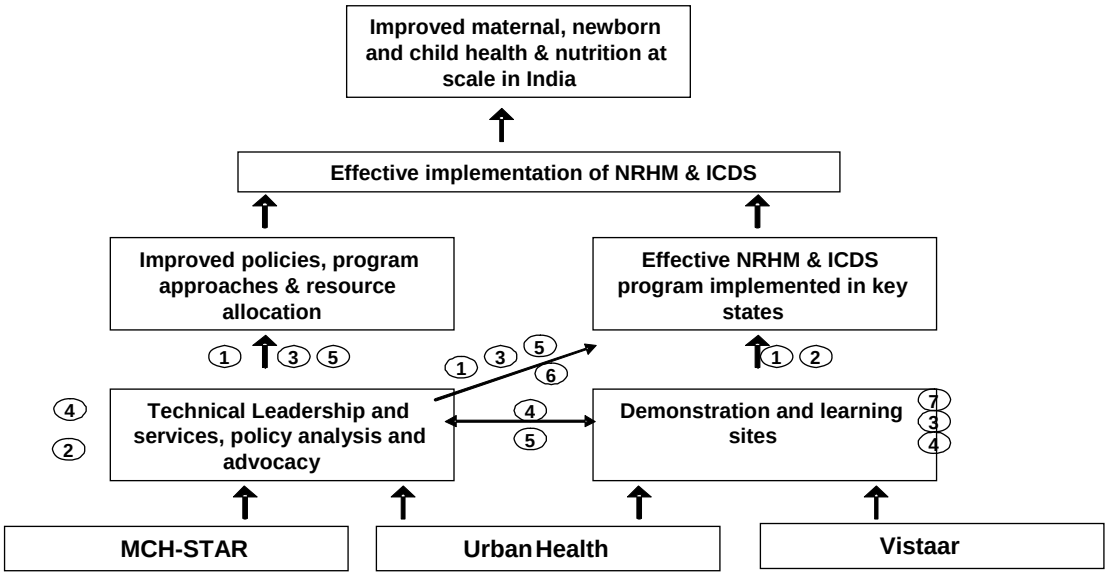
5. Programs are improved through authoritative independent evaluations.
    a. At least one major program evaluation is conducted annually by MCH-STAR-supported institutions.
    b. Evaluation scope, methodology and final interpretation of results are managed in collaboration with major stakeholders, including the GOI.
    c. Evaluation results are disseminated through a final report, peer-reviewed publication where appropriate, and a technical consultation.

6. At least two Indian institutions have the technical capacity, established relationships and financial health to provide these MNCHN technical services in a sustainable fashion.
    a. MCH-STAR-supported partners convene, co-sponsor or their institutional representatives are invited as members of national and EAG state working groups, task forces and similar convening's where maternal, neonatal and child health and nutrition are the subjects.
    b. Research reports are published in peer-reviewed publications.
    c. In the fourth year of the project, USAID funds constitute no more than one half of all funding for SSI-implemented MNCHN activities.
    d. In the fifth year of the project, no more than 10% of technical support provided through MCH-STAR will be provided from non-SSI sources.

C.2.1.2 Overall Program Strategy

MCH-STAR will support the overall MNCHN Strategic Program Framework, illustrated in the following figure:

MNCHN Strategic Program Framework

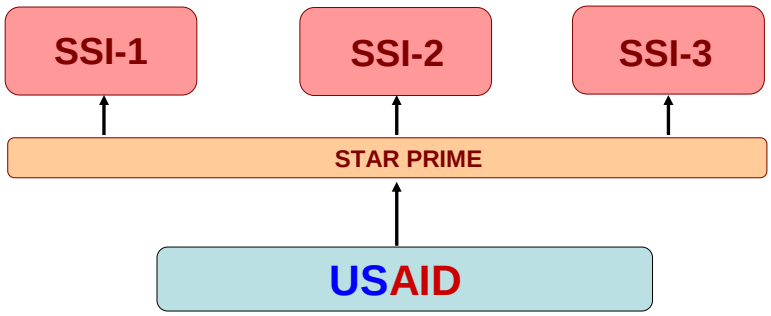


Assistance provided:

1. **Technical Assistance (technical & operational)**
2. **Capacity building & institutional development**
3. **Facilitation of partnerships & exchange of experience**
4. **Applied, operations and evaluation research; analyses of existing data**
5. **Global best practices introduced**
6. **Consultation, Workshops and advocacy Events**
7. **Implementation & operational support**

Program Approaches:

A. Capacity Building of Indian Institutions: Capacity building will be a hallmark of MCH-STAR. It will have an intensive focus on working with two or more selected Indian institutions (i.e. the STAR-supported institutions or SSIs) to build their capacity for technical leadership in MNCHN in the long term. In order to achieve this, MCH-STAR will be organized with one prime contractor or grantee supported by USAID. The prime will work directly through the selected STAR-supported institutions to provide technical services. It also will build the STAR-supported institutions' sustainable capacity to continue providing services after USAID funding ends. The relationships between USAID, the prime institution and the STAR-supported institutions are illustrated in the following figure.



SSI – STAR-supported Indian Institution

The relative roles and relationships between the MCH-STAR Prime and the STAR-supported institutions (SSI's) can be summarized as follows. The MCH-STAR Prime will have overall responsibility for project management and, as such, will have a direct relationship with USAID. The MCH-STAR Prime will be responsible for development and management of the work plan; capacity building assessments, plans and activities; developing and managing sub-agreements with the SSI's, including assuring compliance with reaching milestones and assuring deliverables. The MCH-STAR Prime also will be responsible for identifying needs for technical assistance for capacity building or for strengthening the quality of the SSIs' service MNCHN partners such as the MOHFW, MWCD and NHSRC. The Prime will have responsibility for sourcing the TA from SSI's or other sources. The MCH-STAR Prime will have final responsibility for quality control of all services and products of MCH-STAR. *The*

services of the MCH-STAR Prime are time bound and expected to end when the SSIs are sufficiently strengthened.

The SSI's will be the primary implementing agents for MCH-STAR's MNCHN activities and services. This includes: provision of technical assistance; design, approval, implementation, analysis and dissemination of operations, applied and policy-related research; design, implementation and dissemination of program evaluations; design, implementation and dissemination of policy analyses and white papers; and participation in or support or organization of forums, consultations, task forces, and working groups to build consensus for determining the research, technical service other crucial MNCHN issue priorities.

B. Technical assistance to programs that work at scale in MNCHN: TA will be provided to NRHM/RCH II and ICDS-related endeavors. Subjects for technical assistance include all aspects of maternal, neonatal, and child health and nutrition and may include operational and systems issues that impede the effective implementation of MNCHN activities. Other recipients of TA may include other USAID projects, NGO's and private sector partners. Such TA will depend on the assessment of need, opportunities to fill a critical gap, and the ability to have an effect at scale in India. Technical assistance will be provided through international projects and sources, the STAR-supported institutions themselves, or from other sources in India. Preference will be to provide TA through STAR-supported institutions. TA priorities will be determined to the greatest extent possible through the NHSRC and State HSRCs (when functional) in UP and Jharkhand. MCH-STAR will also entertain specific requests for TA and needs otherwise identified by the GOI and states, as well as other MNCHN partners. MCH-STAR will coordinate closely with the UHRC and Vistaar, under the guidance of USAID, to rationalize provision of TA, avoid overlap or duplication, and to maximize synergy among the three activities. As a general rule, MCH-STAR will receive requests, facilitate and coordinate USAID-funded TA for MNCHN matters that are outside of the specific scope of Vistaar and UHRC.

C. Operations, applied and policy-related research, analyses of existing data, and program evaluations: MCH-STAR will support improved programs and policies by providing new information through research, by re-analyzing existing data to answer key questions, and performing high-quality independent evaluations of existing programs. Priorities will be established with the GOI and other major stakeholders and the activities will focus on producing high-quality results in a timely manner. The information will be disseminated through reports, consultations and workshops designed to bring the information directly into the program and policy dialogue and to inform decisions.

D. Facilitation of partnerships and exchange of experiences: In order for the activities of MCH-STAR to be relevant, the project will never act in isolation. Activity priorities – from research to consultations to advocacy activities – will be established with the GOI and a wide array of important stakeholders in

order to establish buy-in and ownership of the end users of information thus produced. MCH-STAR will seek to support institutions and activities that have multiple donors, where USAID, through MCH-STAR, may play a strategic role in addressing specific needs and gaps, rather than creating institutional dependency on USAID.

E. Leveraging USAID resources to achieve large scale and long-term public health improvements: As noted, national GOI programs will be a key focus of the activities of MCH-STAR, with an aim to improve programs operating at scale. MCH-STAR-supported institutions will be identified based on a set of criteria that indicate their institutional and technical strength and diversity of funding sources – from both public and private sector sources. This will make it possible to strategically apply limited USAID funds on one hand, and on the other hand is an indicator of longer term sustainability of the MCH-STAR-supported institution.

What's New in MCH-STAR?

1. USAID-funded MNCHN technical assistance that historically has been spread across many projects will be coordinated under one management structure – MCH-STAR.

2. All MNCHN operations, applied and policy-related research priorities will be determined through national and state processes of priority setting that includes government and all major stakeholders.

3. Building the capacity of two or more key MCH-STAR-supported institutions to provide technical leadership in MNCHN in a long term, sustainable fashion will be a key focus and outcome of MCH-STAR.

4. Increased emphasis on nutrition integrated into all USAID-supported MNCHN activities and technical assistance.

What MCH-STAR <u>Will Not Do</u>:

1. Provide direct implementation and operational support to programs, beyond selected support required for operations and applied research activities.

2. Support investigator-driven research topics that are not the product of a consensus priority-setting exercise.

3. Focus exclusively on MNCHN technical issues without considering broader constraints to the effective implementation of MNCHN programs (e.g. social factors, management constraints, local governance issues).

4. Focus on hospital and tertiary care services, or hospital-based clinical trials.

5. Focus on improving food security.

6. Focus on supporting or monitoring ICDS or PDS food logistics and supplies.

7. Apply resources where the effects cannot be closely linked to improving MNCHN at scale in India

C.2.1.3 Technical Approach and Activities

1. Capacity Building of Indian Institutions
    a. Identify Indian institutions with potential to develop centers of excellence in MNCHN technical assistance and research. Include the Public Health Foundation of India http://www.phfi.org and IndiaCLEN http://indiaclen.org/ as SSIs.
    b. Develop a specific capacity building plan for selected institutions, where the provision of programmatically relevant, high-quality technical assistance and applied research in MNCHN matters are the capacities to be developed and measured as outcomes. Support the implementation of this capacity building plan.
    c. Strengthen the capacity of these Indian institutions by facilitating alliances and cross learning, mentoring, problem-based technical assistance to ensure the highest technical quality and the institutional development to perform MNCHN technical tasks independently in the future.

2. *Applied, Operations and Policy Research and Program Evaluation*
    a. Develop and implement a plan for STAR-supported institutions to identify with the GOI, state governments, professional associations and other stakeholders key issues where evidence is required to support policy and program decisions, and
    b. Support the development of such evidence through conducting operations, applied and policy-related research, program evaluations and evaluation research, analyses of existing data (e.g. NFHS III), or translational research of established global best practices – in all cases implemented through MCH-STAR-supported institutions and in collaboration with Indian institutions and implementing partners. USAID will fund the subset of national priorities that is most relevant to improving MNCHN in poor performing districts in EAG states.
    c. Develop and implement a system to request research proposals, both from STAR-supported institutions and from other Indian institutions where it may be advantageous for getting the best research product, and for maintaining a productively competitive environment for research awards.

3. *Policy Analyses, White papers, and advocacy*
    a. Develop and implement a plan for the STAR-supported institutions to identify with professional associations, government and other

stakeholders key issues where policy analyses, white paper, and advocacy efforts may improve the performance of the national program.

b. Support the development of priority policy analyses, white papers and advocacy events.

4. Technical Assistance

a. Develop and implement a plan for STAR-supported institutions to identify with the GOI, state governments, professional associations and other stakeholders key areas for technical assistance in MNCHN.

b. Provide such technical assistance through the STAR-supported institutions, supplemented by other sources of TA where necessary.

C.2.2 Work Requirement

2.2.1 Identify MCH-STAR Supported Institutions.

The offerer will establish requirements for institutions to qualify for selection as a MCH-STAR-supported institution.

- Minimal institutional requirements include:
  - FCRA clearance (for private organizations);
  - An articulated institutional focus or mission that includes MNCHN and/or critical matters for improving MNCHN program effectiveness;
  - History of funding from at least three sources;
  - A history of performance in some or all MCH-STAR technical-support areas (operations, applied, policy-related research; technical assistance to the NRHM, the MOHFW, state programs and MWCD/ICDS; organization and convening of national technical and policy-related meetings; and policy analyses and white papers – all aimed at improving MNCHN); and
  - An institutional focus that goes beyond narrow technical issues and includes social, behavioral, systems and community aspects of both treatment and prevention of MNCHN conditions.

- Additional selection criteria may include (but are not limited to):
  - Established credibility and track record of working in partnership with the GOI and EAG state governments;
  - Ability to influence GOI and EAG state government programs and policies;
  - Demonstrated ability to complete required approvals and clearances for research studies within a four month period (for any SSI undertaking research); and

- Indicators of fundamental institutional strength, such as presence of financial management systems, governance structures, full time, paid staff in key positions, etc.

USAID has identified two SSIs that will be included in MCH-STAR. These are the Public Health Foundation of India (PHFI) and IndiaCLEN. Following are the contact details:

Public Health Foundation of India (PHFI)
PHD House, 2nd Floor
4/2, Siri Fort Institutional Area
August Kranti Marg, New Delhi -110016, India.
Tel: + 91 11 46046000
Web site: www.phfi.org

Contact persons:
1. Ruhi Saith, Head, Research Programmes. e-mail: ruhi.saith@phfi.org

2. Krishna Dipankar Rao, Head, Health Economics and Financing. +91-9818954463 (cell); e-mail: kd.rao@phfi.org

IndiaCLEN
No. 16/8 Plot # 172
22nd Cross Street
Indira Nagar, Adayar
Chennai 600 020
Tamilnadu
India
Website- www.indiaclen.org

Contact Person:
1. Dr.Kurien Thomas MD, Professor of Medicine, President Elect IndiaCLEN
Christian Medical College, E-mail - kurien123@hotmail.com
Cell No: 094432-45487

The offerer will need to demonstrate how it would work with these institutions to meet the objectives of this project.

Offerers may identify *up to three* additional potential SSIs and demonstrate how they would work with them to meet the objectives of this project. Offerers should provide an analysis of constraints and challenges to effective MNCHN programs in India, propose priority areas where MCH-STAR may provide support to address these constraints and challenges, and justify SSI partner profile and selection based on this analysis. The focus of this analysis of constraints and challenges should be on providing justification for the approach and selection of SSIs. Offerers may identify and develop teaming agreements with specific additional SSIs, or may propose a process for selecting and finalizing additional SSIs and propose a short list of candidate SSIs. Those

proposals with greater specificity will be viewed as stronger. Specific budget allocations for individual SSI's are not required, but an overall proportion of MCH-STAR funds that will be invested in sub-contracts with SSIs should be given. SSIs may be private sector or public sector institutions, or institutions that are private sector, but have public sector interests (IndiaCLEN, where most members are public sector institutions, is an example of the latter). USAID's intention is to target MCH-STAR resources to build private sector resources that have potential to strengthen both public and private sector MNCHN programs, however USAID does not rule out the selection of public sector SSIs. SSIs may be national in scope, or may be primarily focused at the state level in UP or Jharkhand, according to the offerer's view of the best approach to achieve project objectives. All SSIs do not necessarily have to possess, or have the potential to develop, all capacities required under MCH-STAR, but, when taken overall, all MCH-STAR capacities must be represented in the group of SSI's proposed. The maximum number of SSIs that may be proposed is five; the minimum is the two named, PHFI and IndiaCLEN.

C.2.2.2 Capacity building of MCH-STAR-Supported Institutions

The offerer will propose a process for development of a detailed capacity building plan for the SSI's, and provide example plans for each proposed SSI. The capacity building plan should be closely linked to the provision of MCH-STAR technical assistance services. Specifically, respondents should focus on skills that will build an SSI's capacity to provide high-quality, responsive technical support services in MNCHN, including the range of services to be provided by MCH-STAR. It is anticipated that SSIs will be chosen that are institutionally sound, and capacity building is not expected to focus on fundamental institutional development, such as management and financial systems, leadership training, and so on. Capacity building is not expected to be training courses and international training leading to diplomas or degrees will not be supported through MCH-STAR. Capacity building is expected to include facilitation of alliances, cross learning, mentoring, and problem-based technical assistance.

C.2.2.3 Operations, Applied and Policy-related Research and Program Evaluations

- The offerer will propose a plan to identify program implementation impediments, knowledge gaps and research priorities in MNCHN with the GOI, state governments, professional associations and other stakeholders. USAID anticipates that the SSIs will take the lead in convening or facilitating this process. Where appropriate processes exist, new or competing processes will not be developed or supported under MCH-STAR. The offerers will:
    - Describe the role they see the SSIs playing in this process;
    - Describe how the offerer will support the SSIs to play this role most effectively; and

  - Describe how MCH-STAR will identify impediments, gaps and priorities most relevant to improving MNCHN in the poorest performing districts in EAG states among a (potentially) more diverse set of priorities and interests that may be generated in national consultations.

- The offerer will propose how it will work with SSIs to develop a research plan. In relation to the research plan, the offerer will propose a plan for:
  - Implementing and monitoring research activities
  - Maintaining research quality;
  - Meeting the SSIs' technical assistance needs in relation to the research; and
  - Managing the technical assistance given to the SSIs.

- Offerers will specify whether they see the need for other, non-SSI Indian institutions to lead research activities. If so, they must:
  - Explain why it is necessary.
  - Explain how these non-SSI institutions and activities will interact with SSIs.
  - Define a process for soliciting proposals and selecting the non-SSI Indian institutions.
  - Identify and address differences in the management of these research activities, when compared to those of the SSIs.

- The offerer will propose and explain a process for identifying which SSI and which office or investigator within a specific SSI will lead a given research program.

- The offerer will provide an analysis of the types of research needs and expertise required, and then specifies where key resources will be found in proposed SSIs. Such expertise is expected to include, but not necessarily be limited to the following areas: Descriptive epidemiology and observational studies, community intervention trials, program evaluations and evaluation research, design of operations and applied research studies, analysis of large demographic data sets such as NFHS, formative and qualitative research including social and behavioural determinants of health, and health systems research.

- The offerer will propose how high quality international or Indian technical assistance will be identified and procured in a reliable fashion and on a timely basis where technical assistance or mentoring is required by SSIs in any of the research areas listed above. The offerer should demonstrate experience in building the capacity of academic and technical institutions in these areas.

C.2.2.4 Policy Analyses, White Papers and Advocacy

- The offerer will propose a plan to identify key MNCHN issues where policy analyses, white papers, and advocacy efforts may lead to improvement in the performance of national MNCHN programs. The plan should work with the GOI, state governments, professional associations and other stakeholders. Again, USAID anticipates the SSIs will take the lead in convening or facilitating this process. Where appropriate processes exist, new or competing processes will not be developed or supported under MCH-STAR. Offerers will:
    - Describe the role they see the SSIs playing in this process;
    - Describe how the offerer will support the SSIs in their roles; and
    - Describe how MCH-STAR will identify priorities most relevant to improving MNCHN in the poorest performing districts in EAG states among a (potentially) more diverse set of priorities and interests that may be generated in national consultations.

- The offerer will propose a plan to support SSIs in implementing these identified policy analysis, advocacy and white paper activities. In relation to the plan, the offerer will discuss how it will:
    - Monitor the activities;
    - Maintain quality;
    - Meet the SSIs' technical assistance needs in relation to these activities; and
    - Manage the technical assistance given to the SSIs.

- Offerers will specify whether they see the need for other, non-SSI Indian institutions to lead these activities. If offerers feel TA from such resources is necessary, they must:
    - Defend why it is necessary; and
    - Explain how this non-SSI TA will interact with SSIs.

- The offerer will develop a process for selecting which SSI and which departments or individual(s) within an SSI will conduct specific policy analysis, white paper development and advocacy activities.

C.2.2.5 Technical Assistance

- The offerer will propose a plan to identify MNCHN technical assistance needs with the GOI, state governments, and other stakeholders. Where appropriate processes exist, new or competing processes will not be developed or supported under MCH-STAR;

- The offerer will propose a plan to identify the MNCHN technical assistance needs of the SSIs; and

- The offerer will propose a plan for prioritizing and processing ad hoc requests for MNCHN-related TA from the GOI and others.

In relation to each of these three points, the offerer will:

- Describe the process to identify and to respond to TA needs;
- Describe the process for deciding whether TA requests can be met by a SSI;
- Describe the process for selecting which SSI and which departments or individual within an SSI will provide the TA; and
- Describe the process for selecting non-SSI TA resources when SSIs are unable to meet TA needs.

- The offerer must demonstrate it has the means to quickly procure TA from non-SSI sources (in India or on the international market) where the price and quality is competitive with that provided through USAID's US-based technical projects.

- In the case of TA procured from non-SSIs, the offerer will demonstrate how this TA will interact with the SSIs and contribute to SSI capacity development.

- The offerer will propose a plan to support SSIs in implementing these technical assistance activities. In relation to the plan, the offerer will discuss how it will:
  - Monitor and evaluate SSI performance
  - Maintain quality;
  - Meet the SSIs' technical assistance needs to ensure quality, timeliness and to build capacity; and
  - Manage any such technical assistance given to the SSIs.

The offerer will provide an analysis of the types of technical assistance needs and expertises required, and then specify where key resources will be found in proposed SSIs. Such expertise is expected to include, but not necessarily be limited to following areas: Infant and young child nutrition and growth promotion, diarrheal diseases, acute respiratory illnesses, skilled birth attendance and safe delivery, neonatal health, maternal nutrition and related health systems issues. Technical assistance will be focused on MNCHN issues at the household and community level, with selected intervention at the primary care and first referral levels of facilities.

Enclosures:

1. AID Form 1420-17
2. OIC Certification
3. Disclosure of Lobbying Activities
4. Certification regarding Drug-free Workplace
5. Contract Pricing Proposal
6. VISTAR (Resource Document)
7. UHRC (Resource Document)

Section D - Attachments

Required Certifications and Other Information and Resource Documents:
1. Biographical Data Sheets (Form AID 1420-17) to support salary information for the proposed personnel, containing salary history for the previous three years. (Bio-data forms must be properly certified and signed by both employee and contractor in the appropriate spaces with all blocks completed, as appropriate.)

2. A signed Organizational Conflict of Interest Representation form. See Attachment 2.

3. A certification that no AID employee has recommended the use of an individual for use under the proposed delivery order who was not initially located and identified by your organization.

The proposal must be submitted in this RFTOP and received no later than the date and time indicated on the solicitation.

The authorized geographic code for procurement of goods and services for this Task Order 935

In your cost proposal please provide your Data Universal Numbering System (DUNS) and Tax Identification Number (TIN).

Certifications:

Lobbying Certification.

Certification Regarding a Drug-Free workplace.

A certification that no USAID employee has recommended an individual for use under the proposed task order who was not initially located and identified by your organization.

A statement as to the relationship of the proposed individual(s) to the contractor (e.g., employee, consultant, subcontractor employee).

As an attachment to the technical proposal, the contractor must explain in specific detail its process for conducting the background/reference checks on personnel proposed and the results of those checks.

Certification of Organizational Conflict of Interest for Offeror and their subcontractors (copy below).

CERTIFICATION REGARDING A DRUG-FREE WORKPLACE (JUL 1990)

(a) Definitions. As used in this provision,

"Controlled substance" means a controlled substance in schedules I through V of section 202 of the Controlled Substances Act (21 U.S.C. 812)and as further defined in regulation at 21 CFR 1308.11 - 1308.15.

"Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes.

"Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, possession or use of any controlled substance.

"Drug-free workplace" means the site(s) for the performance of work done by the Contractor in connection with a specific contract at which employees of the Contractor are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance.

"Employee" means an employee of a Contractor directly engaged in the performance of work under a Government contract.

"Directly engaged" is defined to include all direct cost
employees and any other Contractor employee who has other than a minimal impact or involvement in contract performance.

"Individual" means an offeror/contractor that has no more than one employee including the offeror/contractor.

(b) By submission of its offer, the offeror, if other than an individual, who is making an offer that equals or exceeds $25,000, certifies and agrees, that with respect to all employees of the offeror to be employed under a contract resulting from this solicitation, that, it will-- no later than 30 calendar days after contract award (unless a longer period is agreed to in writing), for contracts of 30 calendar days or more performance duration; or as soon as possible for contracts of less than 30 calendar days performance duration, but in any case, by a date
prior to when performance is expected to be completed--

(1) Publish a statement notifying such employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;

(2) Establish an ongoing drug-free awareness program to inform such employees about--

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

(ii) The Contractor's policy of maintaining a drug-free workplace;

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

(iv) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(3) Provide all employees engaged in performance of the contract with a copy of the statement required by subparagraph (b)(1)of this provision;

(4) Notify such employees in writing in the statement required by subparagraph (b)(1) of this provision, that as a condition of continued employment on the contract resulting from this solicitation, the employee will--(i) Abide by the terms of the statement; and (ii) Notify the employer in writing of the employee's conviction under a criminal drug statute for a violation occurring in the workplace no later than 5 calendar days after such conviction;

(5) Notify the Contracting Officer in writing within 10 calendar days after receiving notice under subdivision (b)(4)(ii)of this provision, from an employee or otherwise receiving actual notice of such conviction. The notice shall include the position title of the employee; and

(6) Within 30 calendar days after receiving notice under subdivision (b)(4)(ii) of this provision of a conviction, take one of the following actions with respect to any employee who is convicted of a drug abuse violation occurring in the workplace:

(i) Take appropriate personnel action against such employee, up to and including termination; or

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

(7) Make a good faith effort to maintain a drug-free workplace through implementation of subparagraphs (b)(1) through (b)(6) of this provision.

(c) By submission of its offer, the offeror, if an individual who is making an offer of any dollar value, certifies and agrees that the offeror will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in the performance of the contract resulting from this solicitation.

(d) Failure of the offeror to provide the certification required by paragraphs (b) or (c) of this provision, renders the offeror unqualified and ineligible for award. (See FAR 9.104-1(g) and 19.602-1(a)(2)(i).)

(e) In addition to other remedies available to the Government, the certification in paragraphs (b) or (c) of this provision concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

By signature hereon, or on an offer incorporating these Representations, Certifications, and Other Statements of Offerors, the offeror certifies that they are accurate, current, and complete, and that the offeror is aware of the penalty prescribed in 18 U.S.C. 1001 for making false statements in offers.

Date of Offer_____

Name of Offeror_____

Typed Name and Title_____

Signature_____

Date_____

CONTRACT PRICING PROPOSAL COVER SHEET	1. SOLICITATION/CONTRACT/MODIFICATION NO.	FORM APPROVED OMB NO. 9003-0013

NOTE: Form is used in contract actions if submission of cost or pricing data is req. *(See far 15.804-6(b))*

2. NAME AND ADDRESS OF OFFEROR *(Include Zip Code)*	3A. NAME AND TITLE OF OFFEROR'S POINT OF CONTACT	3B. TELEPHONE NO

4. TYPE OF CONTRACT *(Check)*

☐ A. NEW CONTRACT	☐ D. LETTER CONTRACT
☐ B. CHANGE ORDER	☐ E. UNPRICED ORDER
☐ C. PRICE REVISION/ REDETERMINATION	☐ F. OTHER *(Specify)*

5. TYPE OF CONTRACT *(Check)*

☐ FFP ☐ CPFF ☐ CPIF ☐ CPAF
☐ FPI ☐ OTHER *(Specify)*

6. PROPOSED COST *(A+B=C)*

A. COST	B. PROFIT/FEE	C. TOTAL
$	$	$

7. PLACE(S) AND PERIOD(S) OF PERFORMANCE

8. List and reference the identification, quantity and total price proposed for each contract line item. A line item cost breakdown supporting this recap is required unless otherwise specified by the Contracting Officer. *(Continue on reverse, and then plain paper, if necessary. Use same headings.)*

A. LINE ITEM NO	B. IDENTIFICATION	C. QUANTITY	D. TOTAL PRICE	E. REF

9. PROVIDE NAME, ADDRESS, AND TELEPHONE NUMBER FOR THE FOLLOWING *(If available)*

A. CONTRACT ADMINISTRATION OFFICE	B. AUDIT OFFICE

10. WILL YOU REQUIRE THE USE OF ANY GOVERNMENT PROPERTY IN THE PERFORMANCE OF THIS WORK? *(If 'Yes', identify)* ☐YES ☐NO	11A. DO YOU REQUIRE GOVERNMENT CONTRACT FINANCING TO PERFORM THIS PROPOSED CONTRACT? *(If 'Yes', complete 11B.)* ☐YES ☐NO	11B. TYPE OF FINANCING ☐ ADVANCE PAYMENTS ☐ PROGRESS PAYMENTS ☐ GUARANTEED LOANS
12. HAVE YOU BEEN AWARDED ANY CONTRACTS OR SUBCONTRACTS FOR THE SAME OR SIMLAR ITEMS WITHIN THE PAST 3 YEARS? *(If 'Yes', identify item(s), customer(s) and contract number(s))* ☐YES ☐NO	13. IS THIS PROPOSAL CONSISTENT WITH YOUR ESTABLISHED ESTIMATING AND ACCOUNTING PRACTICES AND PROCEDURES AND FAR PART 31 COST PRINCIPLES? *(If 'No', explain)* ☐YES ☐NO	

14. COST ACCOUNTING STANDARDS BOARD (CASB) DATA *(Public Law 91-379 as amended and FAR PART 30)*

A. WILL THIS CONTRACT ACTION BE SUBJECT TO CASB REGULATIONS? *(If 'No', explain in proposal)* ☐YES ☐NO	B. HAVE YOU SUBMITTED A CASB DISCLOSURE STATMENT *(CASB DS-1 or 2)? (If 'Yes', specify in proposal the office to which submitted and if determined to be adequate)* ☐YES ☐NO
C. HAVE YOU BEEN NOTIFIED THAT YOU ARE OR MAY BE IN NONCOMPLIANCE WITH YOUR DISCLOSURE STATEMENT OR COST ACCOUNTING STANDARDS? *(If 'Yes', explain in proposal)* ☐YES ☐NO	D. IS ANY ASPECT OF THIS PROPOSAL INCONSISTENT WITH YOUR DISCLOSED PRACTICES OR APPLICABLE COST ACCOUNTING STANDARDS? *(If 'Yes', explain in proposal)* ☐YES ☐NO

This proposal is submitted in response to the RFP, contract modification, etc. in item 1 and reflects our best estimates and/or actual costs as of this date and conforms with the instructions in FAR 15.804-6(b) (2),Table 15-2. By submitting this proposal, the offeror, if selected for negotiation, grants the contracting officer or an authorized representative the right to examine, at any time before award, those books, records, documents and other types of factual information, regardless of form or whether such supporting information is specifically referenced or included in the proposal as the basis for pricing, that will permit an adequate evaluation of the proposed price.

15. NAME AND TITLE *(Type)*	16. NAME OF FIRM

17. SIGNATURE	18. DATE OF SUBMISSION

ORGANIZATIONAL CONFLICTS OF INTEREST REPRESENTATION

1. (a) The contractor represents, to the best of its knowledge and belief, that the award to it of this Task Order to provide support services under the Task Proposal for _____, under Contract# _____ does ( ) or does not ( ) involve an organizational conflict of interest:

(b) The term "organizational conflict of interest" means that a relationship exists whereby an offeror or a contractor (including its chief executives, directors, proposed consultants or subcontractors) has interest which (A) may diminish its capacity to give impartial, technically sound, objective assistance and advice or may otherwise result in a biased work product, or (B) may result in an unfair competitive advantage: It does not include the normal flow of benefits from the performance of a contract.

(c) The term "Contractor" means any person, firm unincorporated association, joint venture, partnership, corporation or affiliate thereof, which is a party to a contract with the United States of America. As used in this definition, the term "affiliate" has the same meaning as provided in FAR 19.101.

2. If the contractor indicates that there are organizational conflicts of interest in the "Organizational Conflicts of Interest Representation", the contractor shall provide a statement which describes in a concise manner all relevant facts concerning any present or current planned interest (financial, contractual, organizational, or otherwise) relating to the work to be performed in the proposed Contract bearing on whether the contractor has a possible organizational conflict of interest with respect to being able to render impartial, technically sound; and objective assistance or advice, or bring given an unfair competitive advantage. The contractor may also provide relevant facts that show how its organizational structure and/or management systems limit its knowledge of possible organizational conflicts of interest relating to other divisions or sections of interest of the organization and how that structure or system would eliminate or neutralize such organizational conflict.

Firm:_____.

Signature:_____

Name:_____

OMB Control No. 0412-0520; Expiration Date: 08/31/2000

CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET

1. Name (Last, First, Middle)		**2. Contractor's Name**	
3. Employee's Address (include ZIP code)		**4. Contract Number**	**5. Position Under Contract**
		6. Proposed Salary	**7. Duration of Assignment**
8. Telephone Number (include area code)	**9. Place of Birth**	**10. Citizenship (*If non-U.S. citizen, give visa status)***	

1. Names, Ages, and Relationship of Dependents to Accompany Individual to Country of Assignment

12. EDUCATION (include all college or university degrees)				**13. LANGUAGE PROFICIENCY**		
NAME AND LOCATION OF INSTITUTION	MAJOR	DECREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading

14. EMPLOYMENT HISTORY

1. Give lasts three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.
2. Salary definition – basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions consultant fees, extra or overtime work payments, overseas differential or quarters, cost of living or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (mm/dd/yyyy)		Annual Salary
		From	To	Dollars/Local Currency

15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (mm/dd/yyyy)		Days at Rate	Daily Rate Dollars/Local Currency
		From	To		

16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.

Signature of Employee	Date

Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts

Signature of Contractor's Representative	Date

INSTRUCTIONS

1. Indicate your language proficiency in block 13 using the following numeric interagency Language Roundtable levels
(Foreign Service Institute levels). Also, the following provides brief descriptions of proficiency levels 2, 3, 4, and 5. "S" indicates speaking ability and "R" indicates reading ability. For more in-depth description of the levels refer to USAID Handbook 28.

2. Limited working proficiency

   S Able to satisfy routine social demands and limited work requirements.

   R Sufficient comprehension to read simple, authentic written material in a form equivalent to usual printing or
   typescript on familiar subjects.

3. General professional proficiency

   S Able to speak the language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations.

   R Able to read within a normal range of speed and with almost complete comprehension.

4. Advanced professional proficiency

   S Able to use the language fluently and accurately on all levels.

   R Nearly native ability to read and understand extremely difficult or abstract prose, colloquialisms and slang.

5. Functional native proficiency

   S Speaking proficiency is functionally equivalent to that of a highly articulate well-educated native speaker.

   R Reading proficiency is functionally equivalent to that of the well-educated native reader.

PAPERWORK REDUCTION ACT INFORMATION

The information requested by this form is necessary for prudent management and administration of public funds under USAID contracts. The information helps USAID estimate overseas logistic support and allowances; the educational information provides an indication of qualifications; the salary information is used as a means of cost monitoring and to help determine reasonableness of proposed salary.

PAPERWORK REDUCTION ACT NOTICE

Public reporting burden for this collection of information is estimated to average thirty minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to:

United States Agency for International Development
Procurement Policy Division (M/OP/P)
Washington, DC 20523-1435;
and
Office of Management and Budget
Paperwork Reduction Project (0412-0520)
Washington, DC 20503

Annex I

Urban Health Resource Centre (formerly EHP-India)
Agreement Type: ***Grant Agreement***
Duration: ***October 2005-February 2008***
Geographic Scope: ***All India***
Technical Assistance Agencies: ***GSM***
Implementing Agency: ***NGOs (BGMS, BNS, IDSSS, CECOEDECON, and PFHTP in Indore; FPAI, NIRPHAD, and SNBS in Agra; MUSKAAN in Bhopal), National and State RCH Programs***

DESCRIPTION:

Urban Health Resource Centre works to bring about sustainable improvements in maternal and child health conditions among the urban poor through a consultative and knowledge sharing approach in partnership with National and State Governments, NGOs, public and private sector health providers, the corporate sector and communities. UHRC strives to increase and improve accessibility of urban health knowledge; advocates and networks to promote better and increased resources allocated for urban health.

The Environmental Health Project – India office was incorporated as the Urban Health Resource Centre (UHRC), a non-profit Indian institution on October 31st 2005. UHRC continues the urban health activities of EHP through continued USAID support.

OBJECTIVES:

- Develop innovative Urban Health programs in diverse cities of different states which can be replicated by government and non-government agencies;
- Document and disseminate the learnings from these innovative programs for influencing other public health programs in country
- Improve urban health programming approaches and capacities available at different levels among government and non-government partners;
- Enhance attention to the 'health of urban poor' among government and non-government agencies and academic institutions through increased dissemination of urban poor specific information.

STRATEGIES:

UHRC works in partnership with national, state governments and municipalities, NGOs, CBOs, public and private sector health providers, the corporate sector and communities to contribute towards improved health of children and families living in underserved urban settlements. Strategies include:

- Applying scientific methods for situation specific urban health program planning
- Developing and testing effective urban health programming approaches in diverse settings

- Facilitating adaptation and replication of these approaches through development of tools and guides
- Capacity Development of urban grass root institutions to bring about and sustain health improvements
- Utilizing operations research for generating evidence on best practices and promoting them for better urban health programs
- Sharing lessons with stakeholders through study tours, workshops and documents
- Providing technical assistance to government, nongovernmental, and corporate private sector institutions for developing urban health program strategies
- Promotion of functional partnerships among public sector, civil society and corporate sector agencies for improving urban health
- Bridging the knowledge gaps on health of the urban poor and program experiences
- Advocacy at different forums to shape policies and set priorities for improving health of the urban poor

KEY ACTIVITIES:

- Provide Technical Assistance to strengthen Urban Health programming and capacities of functionaries at different levels and among government (such as RCH II/NRHM) and Non-Government partners to enhance reach to underserved settlements.
- Provide City Level Technical Assistance, develop demonstration programs and carry out research activities in diverse cities focusing on improving health of the urban poor, to facilitate utilization of learning from these sites in government and non-government programs.
- Generate, compile and disseminate urban health information to address knowledge gaps and utilize such urban poor specific information to enhance attention on 'health of the urban poor' among government and non-government stakeholders and academic institutions through advocacy efforts.

KEY ACHIEVEMENTS:

- Demonstration city programs fully functional in Indore and Agra.
- Evolved into a nodal technical assistance agency to Urban Health component of national RCH program of GOI.
- Provided technical assistance for the development of model urban health proposals (for RCH II) for 3 cities (Dehradun, Haridwar and Haldwani) in Uttaranchal, Bally (West Bengal), Agra (UP), Shahdara North and Narela (Delhi).
- Provided TA to development of National Guidelines for Developing City level Slum Health programmes and organized regional dissemination meetings.
- Supported Govt. of India in facilitating the National Task Force to advise NRHM on strategies for urban health care and compilation of its recommendations.
- Assisted State Governments of Bihar, Delhi, Jharkhand, Rajasthan, Madhya Pradesh, Maharashtra, Uttarakhand and Uttar Pradesh in developing and implementing Urban Health plans under RCH -2.
- Reanalysis of NFHS 2 (DHS) data by Standard of Living Index has provided insights into the health conditions of the urban poor
- Prepared 'State of Urban Health' reports for Uttar Pradesh, Madhya Pradesh and Rajasthan for better informing programmers and policy makers about health of the urban poor in the respective states.

- Published eleven articles on urban health in 'Indian Pediatrics', a respected peer-reviewed journal in collaboration with Indian Academy of Pediatrics.
- Advocated for increased attention to health of the urban poor through over 40 presentations at various international and national conferences/seminars.
- Developed Urban Health Gateway, a compilation of articles, reports, on health of the urban poor and other related subjects with focus on India. (see http://uhrc.in/uhgateway/home/index.php)
- Also developed Global Network for Urban Health, an informal alliance of implementing organizations, technical resource agencies and research and teaching institutions with a focus on improving health of the urban poor (see http://urbanhealthnet.org/)

CONTACT INFORMATION:

Dr. Siddharth Agarwal, Executive Director, UHRC, F 9/4 Vasant Vihar, New Delhi – 110057; Tel: 91-11- 26149771, fax: 91-11- 51669281
e-mail: siddharth@uhrc.in Web-site: www.uhrc.in

Annex II

The Vistaar Project: From Knowledge to Practice

Duration:	*October 2006-September 2011*
Geographic Scope:	*UP, Jharkhand and activities at national level*
Technical Assistance Agencies:	*IntraHealth International, Inc. (lead agency), Abt Associates, Catholic Relief Services, Johns Hopkins University- Centre for Communications Program*

DESCRIPTION:
This ***technical assistance*** project is designed to support the National Rural Health Mission (NRHM) in taking knowledge to practice. The NRHM encompasses the GOI Reproductive and Child Health Program (RCH II), the Universalization of ICDS, and the Eleventh Five Year Plan and is expected to contribute to the achievement of the Millennium Development Goals for maternal and child health. The project objective is:

To strengthen the capacity of the National Rural Health Mission
(Government of India and State Governments of Jharkhand and UP)
to take maternal, newborn, and child health and nutrition (MNCHN) knowledge to practice

KEY ACTIVITIES:
The project works in consultation and collaboration with the Governments of India, UP and Jharkhand in four major activity areas:

- Facilitating evidence reviews of MNCHN interventions, which will be conducted by recognized public and private sector experts (see the selected themes for these reviews for year one, listed below).
- Based on the recommendations from these expert reviews, supporting demonstration and learning projects (action research) to fill critical knowledge gaps in that theme area working at district level with government and other Indian organizations
- Promoting recommended models for adoption within NRHM (models that are effective, sustainable, scalable and that reach the most vulnerable)
- Building Capacity of the government and its partners to support the adoption of the recommended models at scale

These activities will be conducted for six technical themes over the first year of the project. These themes have been selected in consultation with the Government and a wide group of stakeholders:

- Growth Promotion and Complementary Feeding
- Anemia Prevention and Treatment
- Newborn Care and Skilled Birth Attendance

- Delay of Marriage and First Birth
- Performance Improvement and Support to Community Health Functionaries
- Village Health Planning and Monitoring

Important cross cutting themes for the project will be knowledge generation and sharing, facilitating collaboration and convergence and promoting interventions with a strong equity focus, including gender equity.

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