USAID/PAKISTAN

FROM THE AMERICAN PEOPLE

RFTOP Number: **391-07-011**
RFTOP Issuance Date: March 2, 2007
RFTOP Closing Date: April 6, 2007 (10:00 am Pakistan Standard Time)

To: **TASC III IQC Holders**

Subject: **Request for Competitive Task Order Proposal No. 391-07-011, Strengthening Health Systems in Pakistan Activity for USAID/Pakistan**

USAID/Pakistan is soliciting for technical services to implement the **Strengthening Health Systems in Pakistan Activity** which is described in the attached statement of work.

This Request for Task Order Proposals (RFTOP) consists of the following sections:

A Proposal Preparation Instructions
B Evaluation Criteria
C Statement of Work
D Attachments

USAID plans to award a **Cost Plus Fixed Fee (CPFF)** completion task order with a total estimated cost between $9 - $11 million covering a two (2) year period, subject to availability of funds and the approval of USAID/Pakistan's Operational Plan. Revealing the cost range for the task order does not mean that Offerors should necessarily strive to meet the maximum amount. The Offeror must propose costs that it believes are realistic and reasonable for the work. If Offerors bid as a consortium, one firm must take the lead and serve as prime.

You are requested to provide this office with a technical and cost proposal for achieving the results set forth in the attached Statement of Work by the above mentioned closing date. Please submit the proposals via email to pkcontract@usaid.gov.

Any questions concerning this RFP should be addressed to Nadeem Yusuf, via email nyusuf@usaid.gov or fax (92)51-2870310. This letter in no way obligates USAID to award the proposed Task Order, not does it commit USAID to pay any costs incurred in the preparation and submission of the requested information. **Please acknowledge receipt of this letter via e-mail preferably.**

Sincerely,

Karin Kolstrom
Contracting Officer
USAID/Pakistan

USAID/Islamabad
Office of Acquisition and Assistance
Embassy of the United States of America
Diplomatic Enclave, Ramna 5
Islamabad, Pakistan
Tel: 92-51-2082636 FAX: 92-51-2870310

Section A - Proposal Preparation Instructions

A.1 Instructions to Offerors

Proposals shall be submitted in two separate volumes: (a) technical, and (b) cost. Offerors shall submit an original and three (3) hard copies of the technical proposal and an original and one (1) hard copy of the cost proposal in addition to the email submission.

Submission of Applications by Email: Preferred software for email attachments: Microsoft Word (for narrative text) or Excel (for tables). Please convert your documents to one of these software programs before sending them to USAID. Zipped files cannot be accepted due to firewall restrictions; however, PDF files (for all files except budgets) are acceptable. Offerors are responsible for confirming that their complete applications were received electronically by USAID.

Deadline for questions: The deadline for submitting questions regarding this RFTOP is March 19, 2007. Offerors must propose all questions in writing and submit them to pkcontract@usaid.gov. Questions that would benefit all Offerors will be issued as an amendment to this RFTOP.

A.2 Technical Proposal instructions:

The technical proposal must be divided into nine sections, separated by tabs, as shown below.

Technical approach	(20 pages)
Gender analysis	(one page)
Implementation Plan	(5 pages)
Management Approach	(4 pages)
Curriculum Vitae (CVs) of key personnel	(no page limit)
Institutional Capability	(2 pages)
Past performance information	(no page limit)
Award monitoring plan	(3 pages)
Branding Implementation Plan (BIP)	(no page limit)
Annexes	(no page limit)

a. Technical Approach

The activity consists of four distinct and different components, with overarching factors attributable to each. The Offeror must show, when appropriate, effective integration of each component. The Offeror must show that the strategies and approaches, design and technical focus for each component is appropriate and sound. The Offeror must demonstrate knowledge of the current and past socio-economic and political situation in Pakistan for each component. The technical proposal should demonstrate responsiveness to the current status of devolution in Pakistan, the urban/rural split, as well as the public/private sector challenges that are well-entrenched in this country. Specifically, in relation to the grants program, the Offeror must provide a clear plan for proposed application selection process for grant applications which ensures fairness and independence of the screening process as well as a plan for mentoring grantees when necessary and monitoring the progress of the grants.

b. Gender Analysis

It is important to note that USAID is committed to gender equality. In one page, the proposal should outline the most significant gender issues related to health systems strengthening in Pakistan by reflecting on the following questions: (i) are men and women involved or affected differently by the context or work to be undertaken? (ii) If so, how will this difference be addressed through managing for sustainable impact?

c. Implementation Plan

Offerors shall submit an implementation plan for the entire period of performance which should clearly outline links between the proposed results, conceptual approach, performance milestones, and a realistic timeline for achieving the semi-annual, annual, and end-of-program results. The implementation plan serves several purposes including a guide to program implementation, a demonstration of links between activities, strategic objectives and intended results, a basis for budget estimates and the foundation for the monitoring and evaluation plan.

The implementation plan, at a minimum, shall include:

- Brief situation analysis in the context of what other donors and implementing partners and host-country governments are contributing.
- Life-of-program results.
- Milestones (or benchmarks) toward achieving those results over the duration of the program.
- Partner involvement and contributions to achieving the results.
- Timeline.

d. Management Approach

Offerors must submit a detailed Management Approach for USAID's review. Management Approaches must, as a minimum, address the following:

- Staffing plan with organogram for the project, identifying personnel/positions from each partner organization.
- Placement of the program team within the larger organization(s).
- Identification of key personnel, including their technical and managerial roles and responsibilities.
- A clear chain of authority on the project/program team, including sub-partner staff.
- A clear line of communication and reporting which allows for early identification and proposed resolution of problems by the prime awardee and provision of related information to USAID.
- A clear, regular, and concrete means of communication between program staff in the field and their backstop officers in the headquarters office that functions without creating unnecessary overlap.
- A clear, regular, and concrete means of communication between the prime contractor and its sub-partners which ensures a cohesive working relationship and achievement of results.
- How the Offeror intends to manage the operational partnerships in order to maximize the input and utility of all sub-partners collaboratively and effectively.
- How the Offeror will ensure efficiencies in operational and financial management.

- A use of both international and Pakistani expertise, with attention to gender balance, and the development of indigenous Pakistani capacity.
- Demonstrated capacity of the Offeror to procure equipment for this project in a timely manner and remain compliant with geographic code 000 requirements.
- The method of identifying sub-contractors/sub-awardees, and the tasks/functions they will be performing. Offerors shall state whether or not they have existing relationships with these other organizations and the nature of the relationship (e.g., sub-grantee, sub-contractor, partnership. etc) and shall discuss the technical resources and expertise of proposed sub-contract/sub-recipient organizations.
- A regular means of communication with the Cognizant Technical Officer (CTO), in addition to the required programmatic and financial reporting.

Program organizational charts with linkages to the key staff's parent organization are recommended.

Offerors are encouraged to describe specific instances in which the proposed management approach has had demonstrated success.

e. Key Personnel

Offerors must specify the qualifications and abilities of proposed key personnel relevant to successful implementation of the proposed technical approach. The Chief of Party should have a proven track record of managing such programs. The Offeror shall also include, in section 4, CVs for all key personnel candidates. Each CV shall have work experience listed in chronological order starting with the most recent experience. Each CV shall be accompanied by a SIGNED letter of commitment from each candidate indicating his/her: (a) availability to serve in the stated position, in terms of days after award; (b) intention to serve for a stated term of the service; and (c) agreement to the compensation levels which correspond to the levels set forth in the cost application. As references may be checked for all proposed long-term personnel, a minimum of four references for each proposed long-term person is required. Offerors should provide current phone, fax and email address for each reference contact.

f. Institutional Capability

Offerors must provide evidence of their technical and managerial resources and expertise (or their ability to obtain such) in program management, grants management and training, as well as their experience in managing similar programs in the past. Information in this section should include (but is not limited to) the following:

- Brief description of organizational history/expertise.
- Past experience and examples of accomplishments in developing and implementing similar programs.
- Relevant experience with proposed approaches.
- Institutional strength as represented by breadth and depth of experienced personnel in project relevant disciplines/areas.
- Sub-awardee or sub-contractor capabilities and expertise.
- Financial controls.

g. Past Performance

The proposal must include, for the prime and each of the major sub-contractors, a list of the ten most recent U.S. Government and/or privately-funded contracts, grants, cooperative agreements, etc., and the name, address, email address and telephone number of the Project Officer, activity manager or other contact person. Include the following for each award:

- Name of awarding organization or agency.
- Address of awarding organization or agency.
- Place of performance of services or program.
- Award number.
- Amount of award.
- Term of award (begin and end dates of services/program).
- Name, current telephone number, current fax number, and email address (if one is available) of a responsible technical representative of the awarding agency.
- Brief description of the program.

Note: do NOT send completed NIH Contractor Performance reports.

h. Award Monitoring Plan (AMP)

As part of its proposal, Offerors must submit a detailed Award Monitoring Plan (AMP) for USAID's review. The award monitoring plan (AMP) must include the Offeror's complete and considered strategy for monitoring progress towards indicators and targets included in the award. The strategy constituting the AMP must include, as a minimum, the following:

- Description of the established system within which the particular AMP operates. The system refers to:
    - Organization-wide policies and procedures for monitoring and their relation to the particular AMP, including the roles of different implementing partners.
    - Organizational staffing/expertise, roles, and responsibilities and how the staffing and expertise is to be used in the particular AMP.
    - Automated and other methods to gather, store, manipulate, summarize, analyze, and/or report performance data.
    - Procedures for regular communication with USAID regarding the status of monitoring activities, including protocol for notifying USAID in the event of significant obstacles or issues of immediate concern.
    - Means of addressing a discovered lack of progress or success. Procedures should focus on learning from mistakes, analyzing them, and ascertaining the reasons for missteps.
    - Procedures for monitoring prime and sub-partner compliance with statutory requirements implemented in the resulting award, such as anti-terrorism and restrictions on family planning activities (i.e. Tiahrt, PD3, Mexico City policy).

- Information about all activities to be monitored under the AMP. The list of activities should be provided in a results framework which:
    - Links activities to required task order results both those required by USAID in the task order and lower level or complementary results contained in the Offeror's approach.

- Describes assumptions being made about the relationship of the activity to the award result.
- Identifies the indicators against which progress is to be measured.
- Describes the methods to be used for monitoring. Methods for monitoring vary according to what it is being monitored. Some activities can be observed easily and costs and outputs can be measured against the original targets and timetable. Other activities are less easy to monitor in terms of quantitative achievements, especially such intangible effects as awareness and empowerment and their direct link to program interventions. Indirect or proxy indicators may have to be identified, even if these cannot be verified. By considering these factors at the planning stage, expected results can be kept realistic and cost-effective and the recipient can recognize that not all available and useful indicators are 'objectively verifiable'.
- Provides an illustrative schedule for discrete monitoring activities tied to the overall project/program implementation plan.
- Includes a mechanism for oversight and verification of monitoring conducted by field staff.

i. Branding Implementation Plan (BIP)

The branding strategy for this activity is as follows:

Program or project name:
USAID's Strengthening Health Systems in Pakistan Program
How the materials and communications will be positioned:
Jointly sponsored by USAID and the Government of Pakistan (GOP).
Desired level of visibility:
High.
Any other organizations to be acknowledged:
Nursing Council and the Midwifery Association of Pakistan.

Offerors are required to submit a branding implementation plan (BIP) in accordance with Automated Directives System (ADS) 320.3.2.2. The BIP will not be evaluated and scored, but will be reviewed and is subject to discussion and modification after award.

j. Annexes

Offerors shall include signed "letters of commitment" from key personnel and sub-awardees in this section. Offerors shall also submit signed letters of commitment and/or collaboration from the Ministry of Health (MOH) and the Ministry of Population Welfare (MOPW) at national and provincial levels.

A.3 Cost proposal Submission Instructions

Cost information shall be submitted as follows:

a. Development Focused budget (DFB) - Summary

Offerors are required to summarize cost data using development-focused budgeting (DFB) in cost proposals submitted in response to this RFTOP. DFB is a customer-based, performance-driven, results-oriented budget system underpinned by outcome management. Outcome management is a management approach that focuses on the development results achieved by providing a service. DFB involves summarizing cost data corresponding to development results/outcomes. Cost data must be summarized into DFB categories. If an input serves multiple development results, the Offeror must allocate the input across the corresponding results and provide a rationale in the budget narrative for the method used for each allocated input.

A summary budget shall be presented in the format shown below. Vertical columns represent development results. The development results shown in the table are illustrative examples.

Input Categories	**Capacity Building**	**Targeted Health Information**	**Grants Program**	**Strengthening of Essential Drugs and Contraceptives Logistical System**	Total
Labor					
Fringe Benefits					
Travel					
Equipment					
Grants					
Other Direct Costs					
Sub-total					
Overhead					
Fee					
G&A					
Total					

The summary budget shall be supported by spreadsheets which detail the inputs in each category above, and shall be accompanied by budget notes that explain and justify the reasonability of the proposed costs. The spreadsheet and budget notes shall be detailed enough to support:

- The breakdown of all costs according to each partner organization (or sub-awardee) involved in the program, in the format described herein.
- The costs associated with home office, expatriate, and local in-country labor, i.e. identification of positions, daily or hourly compensation, hours/days to be worked, etc. AID form 1420, biographical data sheet, shall be submitted for all key personnel.
- Breakdown of all other direct costs to include cost elements (communications, office supplies, printer, vehicle, office rent, etc), unit of measure (monthly estimate, cost per unit), number of units, basis of the estimate and programmatic need for the expenditure. (Details of travel, per diem and other transportation expenses to include number of international trips, expected itineraries, cost of travel, number of per diem days and per diem rates.)
- Indirect costs budgeted in accordance with the rates set forth in the basic IQC and/or most current NICRA.
- Fee (if applicable).

b. Development Focused budget (DFB) – Activity Cost

In addition, Offerors shall submit the following development based budget information that is activity specific for each development result, as shown in the example below:

Development result: *Strengthening of Essential Drugs and Contraceptives Logistical System.*

(Note: the estimates below are NOT to be treated as Government estimates; however Offerors are instructed to separately estimate the costs of administration as well as monitoring and evaluation.)

Activity Description	Units	Unit Cost	Total Estimated Amount
Conduct a review of the existing information system;	5	$ 5000	$ 25000
Based on results of the review, develop a plan for computerizing the system at all levels;	1	$10,000	$ 10,000
Supply computers at the provincial and national levels after an assessment of the Ministries' current available hardware;	1	$100,000	$100,000
Administrative staff, facilities, etc needed to achieve this result (cost of field offices, portion of home office staff and time, Islamabad office share, etc)	2	Years	$2,000,000
Monitoring and evaluation of this development result	2	years	$200,000

c. Cost Considerations

- The authorized geographic code for this award will be 000.
- Title to property/non-expendable equipment purchased under the resulting award shall vest in the Cooperating Country.
- Labor costs for Pakistani and Third Country Nationals shall not exceed the thresholds in the local employee compensation plan (LECP). A copy is included with this RFTOP.
- At this time, Pakistan is an unaccompanied post for US direct hire employees. For security reasons, family members of US direct hire employees are not permitted to travel to or reside at post with the employee at government expense. Under the resulting task order, while USAID cannot expressly forbid a Contractor employee from bringing family members to post at personal expense, it is not encouraged or desired. Under no circumstances will costs related to dependents be considered allowable costs to the resulting award including but not limited to housing, transportation, education, and per

diem. Separate maintenance allowance (SMA) would be allowable if in accordance with the standardized regulations and the Offeror's policies and practices.

SECTION B - EVALUATION CRITERIA

B.1. Best Value Selection

Proposals will be evaluated using the tradeoff process and award will be made to the Offeror whose proposal represents the Best Value for the US Government. If the Contracting Officer determines that competing technical proposals are essentially equal, cost/price factors may become the determining factor in source selection. Conversely, if the Contracting Officer determines that competing cost/price proposals are essentially equal, technical factors may become the determining factor in source selection. Further, the Contracting Officer may award to a higher priced Offeror if a determination is made that the higher technical evaluation of that Offeror merits the additional cost/price.

B.2 Technical Evaluation

B.2.1 Summary

Technical Proposals for this activity will be evaluated based on numerical ranking for overall proposal and each section of the proposal, respectively. The following ratings will be used in assessing the criteria set forth.

91-100 points: The proposal fully meets the RFTOP's requirements and the expectations of USAID. The Offeror has convincingly demonstrated that the requirements have been analyzed, evaluated, and should result in an outstanding, effective, and economical performance.

81-90 points: The proposal demonstrates a level of effort that substantially meets the RFTOP's requirements and the expectations of USAID. The proposal specified performance or capability requirements necessary for acceptable performance and could produce results which should prove to be substantially beneficial.

71-80 points: The proposal does not meet some specified performance or capability requirements necessary for acceptable performance, but inadequacies are correctable. The proposal demonstrates good understanding and ability to fulfill the requirements and weaknesses and should not seriously affect the Offeror's performance if measures are taken to correct them.

0-70 points: The proposal fails to meet specified minimum performance and capability requirements and contains major deficiencies. It is incomplete and vague and deficiencies are uncorrectable without a major revision of the proposal. Proposals scoring within this range will not be considered for award.

B.2.2 Specifics

The following are the point values for each evaluation category:

Technical Approach 40 points

- Gender issues addressed and integrated into overall strategic design. 2

- Soundness of strategies and approaches, the overall design and technical focus, demonstrating full understanding of local issues and challenges, and clear articulation of how results will be achieved (note: the implementation plan will be evaluated as part of the "technical approach.")

    - *Component One – Capacity Building* 12
    - *Component Two – Targeted Health Information* 8
    - *Component Three – Grants under Contracts*
        - ✓ Technical soundness and feasibility of proposed selection process for grant applications which ensures fairness and independence of the screening process 4
        - ✓ Appropriateness of proposed methodologies for monitoring and mentoring grantees 2

    - *Component Four - Strengthening of Logistical System* 12

Award Monitoring Plan 15 points

The AMP will be evaluated based upon the following.

- A clear description of the Awardee's established system within which the particular AMP operates including:
    - The organization-wide policy and procedures for monitoring and evaluation.
    - Roles and responsibilities of sub-partners in monitoring and evaluation.
    - A description of the system which will address lack of progress or success.
- Information on activities to be monitored under the AMP including:
    - For each component, how activities are linked to achieving required rresults and how performance will be monitored.
    - Assumptions being made about the relationship of each activity to the results.
    - For each component, proposed indicators which track progress over the life of the task order with annual targets for each indicator.
    - Methods to be used for monitoring activities and collecting data for results reporting.
    - An illustrative schedule for monitoring activities.
    - A mechanism for oversight and verification of monitoring conducted by field staff.
- A realistic plan to monitor the project and proposed sub-grantees to ensure adherence to the US Government and USAID regulations, such as anti-terrorism and restrictions on family planning (i.e. Tiahrt, PD3, Mexico City policy).

- Detailed description of proposed evaluation plan including:
    - The evaluation methodology.
    - A proposed time line.
    - Indicators which track impact over the life of the activity (with targets).

Key Personnel 20 points

- Qualifications, skills and experience of proposed Chief of Party. 10
- Qualifications, skills and appropriate experience of other key personnel. 10

Management Approach 15 points

- Soundness of performance management plan, with clear articulation of labor and responsibilities with proposed sub-partners and understanding of necessity of local partnerships and coordination with other projects and stakeholders. 5
- Clear delegation of authority of overall management plan to the field personnel. 5
- Overall staffing plan with clear roles and responsibilities for key staff, lines of management and technical authority. 5

Past Performance and Institutional Capability 10 points

- Demonstrated capability of prime contractor to plan, implement and monitor similar projects in similar settings 5
- Demonstrated capability of proposed sub-cooperating agency(ies) to plan, implement and monitor similar projects in similar settings 5

B.3 Cost Evaluation

(a) Cost proposals will not be assigned a numerical score, but will evaluated for cost realism, completeness, and reasonableness.

(b) Cost realism is an assessment of accuracy with which proposed costs represent the most probable cost of performance, within each Offeror's technical and management approach. A cost realism evaluation shall be performed as part of the evaluation process as follows:

- Verify the Offeror's understanding of the requirements.
- Assess the degree to which the Task Order Cost Proposals accurately reflect the technical and management approach as well as the risk that the Offeror will provide the supplies or services for the costs proposed.
- Assess the degree to which the costs included in the Task Order Cost Proposals accurately represent the work effort included in the respective Task Order Technical Proposals.

(c) The results of the cost realism analysis will be used as part of the Agency's best value/tradeoff analysis. Although technical evaluation criteria are significantly more important than cost, the closer the technical evaluation scores of the various proposals are to one another, the more important cost considerations will become. Therefore, the evaluation of costs proposed may become a determining factor in making the award.

Section C – Statement of Work

I. TITLE

Strengthening Health Systems in Pakistan

II. PURPOSE

The purpose of this Task Order is to improve the effectiveness, quality and accessibility of health services in Pakistan through strengthening targeted systems that support the public and private health care delivery sectors throughout the country. The USAID Mission seeks to support the Government of Pakistan's (GOP)) goals of providing accessible and affordable health care for all, with an emphasis on making preventive and curative health services efficient, equitable and effective. The objective of this program is to improve the health of Pakistani people by providing high quality technical assistance to both the public and private health care delivery systems in the areas of capacity building and mobilization around targeted health interventions. The program will target a variety of key health system areas that are essential to service access and quality to achieve maximum impact over the life of the program. The program will have a sub-grants component to fund innovative, pilot-level interventions and activities targeted at service provision through either public/private partnerships or specifically with the private sector.

III. BACKGROUND

Population. Pakistan is a poor country characterized by low life expectancy (63.0), and high maternal (500 per 100,000 live births), infant (72 per 1000 live births) and under-five mortality rates (108 per 1000 live births). It is also the sixth most populous country in the world with an estimated population of 167 million. The population growth rate remains high at 2% with a total fertility rate of 4.1. This high growth rate and relatively large proportion of the population under 15 years of age will continue to contribute to the increasing demand for health services, further challenging the GOP's health systems and resources.[1, 2]

Health Services. It is widely agreed that in Pakistan, the root cause of poor performance in the public sector is a weak public health system. The public health sector faces significant challenges first and foremost because it is large and complex with a fragmented and highly vertical infrastructure.

Private sector health services, which are largely unregulated, account for a large but unknown amount of primary and hospital care in Pakistan. The sector is broad and includes a variety of service providers, from doctors, nurses and midwives to traditional healers, shopkeepers and unqualified practitioners.[3] There are few standards for facilities, staffing, infrastructure or fees. Licensing or certification does exist for physicians, nurses, midwives, pharmacists, and related categories of workers as well as for drug manufacturers but there is no functioning system in

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[1] United States Agency for International Development, Pakistan Country Health Statistical Report, June 2006. Retrieved August, 2006 from http://dolphn.aimglobalhealth.org/pdf/Pakistan.pdf.

[2] Note: A USAID-financed Demographic and Health Survey (DHS) and Maternal Mortality Study is underway in 2006/2007.

[3] Nishtar, S. The Gateway Paper; Health Systems in Pakistan - a Way Forward. Islamabad, Pakistan: Pakistan's Health Policy Forum and Heartfile; 2006. Retrieved September 2006 from http://www.heartfile.org/

place to monitor compliance. Malpractice, in the form of excessive medication and unnecessary procedures, is thought to be fairly common with little or no recourse for those harmed.

Health Sector Goals. Despite the many challenges in the health sector, the GOP is fully committed to improving health outcomes. The GOP has agreed to the Millennium Development Goals (MDGs), along with the other United Nations member states, and has accepted the MDG framework for measuring progress. Pakistan has adopted eight MDG goals to be achieved by 2015, while identifying "eradication of extreme poverty and hunger" as its highest priority. Among the eight goals, three are directly related to achieving better health outcomes: Goal 4 targets reducing child mortality (under-five mortality rate) by two thirds between 1990 and 2015, while Goal 5 aims to reduce the maternal mortality ratio by three-quarters during the same time frame. Finally, Goal 6 seeks to combat HIV/AIDS, malaria and other diseases by halting and eventually reversing the spread of these diseases by 2015.

Health Infrastructure and Workforce. While largely under-utilized, the public health infrastructure of facilities and staff is vast and reaches out to the most remote rural areas in Pakistan. Two government ministries are responsible for the oversight and delivery of public services, the Ministry of Health (MOH) and the Ministry of Population Welfare (MOPW).

At the grassroots level, there are numerous health houses attached to or near homes of Lady Health Workers (LHWs), as well as health posts and dispensaries that provide services through the MOH. Basic Health Units (BHUs) and Rural Health Centers (RHCs) are located at the primary care level. There is at least one BHU in each Union Council which is the smallest administrative unit in local governments, covering a population of about 10,000-15,000. Four to five BHUs are attached to each RHC. RHCs are intended to provide preventive and primary-level curative services to catchment areas of 50,000-100,000. There are also about 20 beds in each RHC. At the secondary level, Tehsil Headquarters Hospitals (THQs) are located in towns and provide inpatient care with 20-50 beds. Finally, there are District Headquarters Hospitals (DHQs) located at the centers of the districts. Most of the specialties are present at the THQs and DHQs, though with more sophistication at the DHQ level. Teaching hospitals, found in large cities, provide tertiary care and serve as referral centers. In addition to this extensive public network providing health services, thousands of private clinics and hospitals exist, though largely in urban areas.

The cornerstone of the MOPW program is the Family Welfare Center (FWC) of which there were 2,270 in 2005. Given that the FWCs are in rented space, the GOP has recently mandated they be combined into the RHCs under the MOH. Reproductive Health Service- A and B Centers are the hospital-based service delivery units established by the MOPW. These centers, if not already located in THQs or DHQs, are being combined into these MOH facilities. The MOPW also has 14 training centers located in teaching hospitals to train medical staff on how to manage and provide quality reproductive health services. Finally, there are 204 Mobile Service Units which provide reproductive health services to populations in remote villages and hamlets. Under the MOPW, the Family Welfare Workers (FWW) comprise a significant cadre that provides family planning and maternal and child health services out of the MOPW service centers.

Several decade-long investments to provide culturally appropriate and trained healthcare providers resulted in the growth of a non-physician workforce made up of several cadres of workers. These cadres include Traditional Birth Attendants (TBAs), FWWs, Lady Health Visitors (LHVs), LHWs, and most recently Community Midwives. The majority of TBAs lack

adequate training and skills to offer safe deliveries; nevertheless, they assist at the vast majority of home births. LHVs receive formal training to provide maternal and child health services including deliveries, but they are few in number. FWW also receive 18 months of formal training to provide family planning and maternal and child health services but their course has been increased by six months to include training in safe delivery services. The LHWs, who number 90,000, receive 18 months of training and are then assigned to their indigenous communities to provide basic healthcare, health education and referrals. The newest cadre, Community Midwives, receive 18 months of training and are expected to work under the MOH for four years in their indigenous communities before being allowed to work anywhere in the country. Many of the public providers cited above also provide services during their off duty hours in the private sector.

Physicians play a relatively limited role in the provision of primary healthcare. The majority of newly graduated physicians begin public service at district or tehsil headquarters hospitals after completing medical school. A Family Medicine curriculum is only taught through optional postgraduate training, allowing doctors to practice without formal training in family practice or primary care. Although there is a mandatory service requirement for newly graduated physicians to work in rural areas, this legislation is rarely enforced. Most physicians work simultaneously for the public and private sectors, as doctors employed by the government will use public facilities and time to maintain private practices.

The public health system has made progress in many areas but the rate of improvement is slow as policy makers and managers continue to struggle with issues of both access and quality. While the GOP and donors have made substantial investments in building the health infrastructure, access is not uniform and the overall quality of health services, particularly for essential clinical and public health services such as maternal and child health and reproductive health, remains very poor. Exacerbating the problem is the inability of the federal government to clearly define the role of the MOPW since the ministry has been de-federalized.

As a consequence of overall dissatisfaction with public health care services, an estimated 70% of the population seek care through the unregulated private sector and non-governmental organization (NGO) health care providers. Although Pakistan remains one of the few countries without an organized system for producing National Health Accounts (NHA), a rough estimate is that out of pocket private expenditures constitute 77% of overall health expenditures per capita.[4] This level of private expenditure is higher than most other developing countries and ability to pay is clearly associated with the utilization of services, creating gross inequalities in access to quality healthcare. The level of out of pocket private expenditure was found to be approximately the same whether services were obtained from the public or private sector. Private medical practices are frequently stand-alone clinics operated by individual providers whose concern is often focused on maximizing profits, at the expense of providing quality services.[5]

National Public Health Programs. Starting in the early 1980s, the MOH began developing seven vertical programs to combat critical public health problems with significant funding from several donor agencies. These programs are now financed and managed at the federal level; however, the degree of delegation from the federal to provincial and district levels varies among each program. This variance at times undermines the ability of local district-level health

[4] Center for Research and Poverty Reduction and Income Distribution (CRPDID) 2003. Pakistan Health and Population Welfare Facilities Atlas.
[5] Nishtar, S. The Gateway Paper; Health Systems in Pakistan- a Way Forward. Islamabad, Pakistan: Pakistan's Health Policy Forum and Heartfile; 2006.

managers and administrators to integrate services and to manage public resources effectively and efficiently. A summary of the seven national public health programs follows.

The *National Program for Family Planning and Primary Healthcare* is one of the oldest national programs. Paid LHWs hired by the program provide basic primary healthcare services to communities where they live. The LHWs are multipurpose workers intended to function in an integrated service delivery model to identify and refer complex cases, and provide essential health education and basic preventive and curative care. *The Population Welfare Program* is another national program initiated several years ago by the MOPW with the similar purpose of expanding family planning services. *The Expanded Program on Immunization* (EPI) was also established many decades ago to immunize children against seven infectious diseases. *The National Tuberculosis Control Program* (NTCP) was initiated more recently, when tuberculosis (TB) was declared a national emergency due to the fact that Pakistan ranked sixth (currently seventh) among high-burden TB countries. The program continues implementing the Directly Observed Therapy, Short–Course (DOTS) strategy and has achieved significant increases in DOTS coverage since its inception. The *Malaria Control Program* is also one of the older programs, but has not achieved significant impact. A *National AIDS Control Program* was launched with the purpose of maintaining the low HIV/AIDS prevalence rate in Pakistan. Finally, a *National Micronutrient Program* was approved three years ago for the control of vitamin and mineral deficiencies.

Devolution Process and its Implications on Health. Under the centralized system which was initiated with the establishment of the Pakistani state in 1947, the planning, administering and monitoring of social sector programs was top-down with minimal involvement of community members and leaders. The centralized approach led to widespread inefficiencies in the provision of social services and thus the GOP put forward an elaborate devolution and decentralization plan along with the creation of local governments in 2001. Devolution applies to all four provinces of Pakistan, but not to the Federally Administered Tribal Areas or to Azad Jammu and Kashmir. Devolution covers decentralization of political power and administrative authority as well as de-concentration of management functions and allocation of resources to the district level. The intent of devolution is to decentralize political power and administrative and financial authorities to local governments for improved governance, efficient delivery of services and transparent decision-making through participation of its citizens at the grassroots levels. Devolution led to the replacement of existing municipal bodies with a new tier of local government at three levels noted in descending order: districts; tehsils; and union councils. Local government elections held in 2001 placed locally elected leaders in lieu of assigned civil servants.

The establishment of district governments has had major implications for all social sectors including health. Devolution of authority and responsibility to the district level offered a renewed opportunity as well as a challenge for strengthening the district health system and the delivery of healthcare services. Devolution was expected to achieve more effective and efficient service delivery as locally elected leaders were given the ability to match services provided within the health sector with the preferences and needs of the district's constituency. Devolution, however, remains in a transitional period and the challenges in transferring power continue to create tensions among both provincial and local government officials.

Under Devolution, public–private partnerships in the provision of healthcare have become more popular as the government continues to search for better, more efficient ways of addressing the health needs of the population. The term 'public-private' currently refers to the partnering of the

state with local and international NGOs for the sharing of investment, risk, responsibility and reward.[6] Numerous models of such partnerships have been implemented throughout the country with mixed results in terms of utilization, quality of care and facility management.

USAID/PAKISTAN STRATEGY AND PROGRAM: The overall goal of USAID/Pakistan's Interim Strategic Plan, May 2003-September 2007 is to "promote quality, stability, economic growth and improved well-being of Pakistani families."[7] USAID's Strengthening Health Systems in Pakistan program will contribute to the achievement of Strategic Objective 7: *Improved health in vulnerable populations in Pakistan* and specifically, to Intermediate Result (IR) 7.1: *Improved quality and use of maternal, newborn, and child health and reproductive services* and IR7.2: *Improved administrative and financial management of primary health care programs.* This Task Order directly supports IRs 7.1 and 7.2 by providing technical assistance to the public and private health sectors to improve health service delivery with particular focus on maternal, reproductive, and child health.

USAID/Pakistan's current health program is designed to achieve the above Strategic Objective 7, in addition to improving reproductive, maternal and child health services and preventing major infectious diseases. The program is nationally focused, working in all four provinces. Initiatives relevant to health systems that USAID/Pakistan supports include:

- *Improving Reproductive Health and Family Planning:* Support is provided to increase use of modern contraceptive methods and expand the contribution of the private commercial sector through improving reproductive health services and social marketing of contraceptives. (Implementing Partners: Constella/Futures Group & Greenstar)
- *Maternal and Newborn Health:* The Pakistan Initiative for Mothers and Newborns (PAIMAN) is USAID's flagship project designed to reduce maternal and neonatal mortality. The project is being implemented in 10 districts in all four provinces of Pakistan. (Implementing Partner: John Snow Incorporated)
- *HIV/AIDS Program:* USAID provides grants to seven local NGOs to increase HIV/AIDS awareness, promote healthy behaviors in high risk groups, and offer care and support to people living with HIV/AIDS. (Implementing Partner: Research Triangle Institute)
- *Strengthening TB Control:* USAID assists the GOP to ensure complete treatment of TB patients in both the public and private sectors. (Implementing Partner: World Health Organization (WHO))
- *Polio Eradication:* USAID provides assistance to national polio immunization campaigns and surveillance to eliminate polio from Pakistan. (Implementing Partners: WHO and the United Nations Children's Fund)
- *Demographic and Health Survey (DHS):* USAID provides funding and technical assistance for the Pakistan DHS and Maternal Mortality Study. (Implementing Partners: Macro International and National Institute of Population Studies)
- *Disease Surveillance and Response:* USAID supports the design of a National Integrated Disease Surveillance and Response Program and a Field Epidemiology and Laboratory Training Program. (Implementing Partner: U.S. Centers for Disease Control and Prevention)

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[6] Review of Public-Private Partnership Models. Pakistan Initiative for Mothers and Newborns, USAID/Pakistan; 2006.

[7] USAID/Washington approved the extension of The Interim Strategic Plan from September 2006 through September 2007.

- *Child Health in the Federally-Administered Tribal Areas (FATA) of Pakistan:* USAID is working to improve the availability, quality and demand for child health services throughout the FATA. (Implementing Partner: Save the Children, USA)
- *Safe Drinking Water and Hygiene Promotion:* USAID is providing technical assistance in hygiene and sanitation promotion and community mobilization along with extensive capacity building in 31 districts in order to complement the GOP's installation of water treatment facilities nationwide. (Implementing Partner: Abt Associates)
- *Primary Health Care Revitalization, Integration and Decentralization (PRIDE)* in *Earthquake-Affected Areas*: Under the Earthquake Reconstruction Strategic Objective, USAID is constructing 15 health care facilities in Bagh and improving access and quality of health services for families in Bagh and Mansehra. (Implementing Partner: International Rescue Committee)
- *Districts That Work (DTW)* is a USAID program, under the Democracy and Governance Strategic Objective, designed to provide elected and administrative district officials with the necessary skills and tools for effective governance across multiple sectors including health. The goal of the program is to encourage these officials to focus their efforts on achieving the results desired and needed by their citizens. (Implementing Partner: Urban Institute)

IV SCOPE OF WORK

A. Component 1 – Capacity Building. The purpose of this component is to build institutional capacity, increase sustainability, and improve the performance of services provided by selected organizations whose role in the health sector is critical to improved health outcomes for low income and vulnerable populations.

A.1 Developing the Capacity of the Nursing Council and Midwifery Association.

A.1.1 Background: The *Nursing Council* is an autonomous body legally established under Parliamentary legislation and is responsible for all nursing education in Pakistan. The Council conducts examination boards, verifies current licensure to international employers, and provides guidance to the GOP on administrative matters such as appropriate salaries and patient-nurse ratios. It also licenses nurses, midwives, LHVs and community midwives, with more than 41,000 currently registered. The Nursing Council conducts many in-service training workshops throughout the country; although there is no system for ensuring that skills are actually improving as a result of these trainings. Continued licensure for nurses is not dependent on continuing education. The Council does conduct inspection/oversight but the scope and effectiveness of this program faces staffing and financial constraints.

The *Midwifery Association of Pakistan* was officially constituted in June 2006 and currently has 274 members. The Association represents its members in a variety of fora to lobby for a proper career structure and better working conditions for midwives. It aims to work with the Pakistan Nursing Council to develop a human resource plan for training and utilization of midwives, to improve standards of midwifery training in both the public and private sectors and to ensure training of specialized midwifery teachers. (Currently there are five-post graduate colleges of nursing but none offers a specialization in midwifery or in the teaching of midwifery.) With the Nursing Council, the Association works to ensure a licensing and registration system for trained midwives, to safeguard the rights of licensed midwives to practice their profession in a health facility or in the community, and to ensure that midwifery practice in Pakistan meets agreed

practice standards. The Association also works to ensure the rights of all Pakistani women to have safe maternity services.

Despite the well established system of licensing individual practitioners and accrediting training schools, most health care providers and institutions are not regulated in Pakistan. The Contractor will work with the Nursing Council and the Midwifery Association and other relevant midwifery bodies such as provincial associations to 1) strengthen their administrative and governing capacity to establish and enforce accreditation, licensing and registration standards and assist them to clarify their various roles and responsibilities in this process; 2) expand the scope and quality of in-service training for all nursing cadres[8] in both the public and private sectors; and 3) improve the pre- and in-service education for midwives.

A.1.2 Result, Indicators and Activities

A.1.2.a Administrative and Governing Capacity

Result: Overall management and financial sustainability of the Nursing Council and Midwifery Association are improved; nursing and midwifery regulatory systems for licensure/registration and accreditation of teaching institutions are strengthened nationwide; and efforts to advocate for the needs of nurses and nursing/midwives and midwifery are increased.

Indicators:

- Revenues through services provided by the Nursing Council and the Midwifery. Association to members increased by 20 percent.
- Revised monitoring systems to measure licensing/registration and accreditation standards adopted and implemented by end of project.
- Number of institutions monitored using new standards.
- Number of institutions sanctioned for failing to meet standards.

Activities:

The Contractor shall work with the Nursing Council and the Midwifery Association to build their administrative and governing capacity and shall undertake the following activities:

- Current professional licensing and registration systems for nurses/midwives and teaching institution accreditation assessed, improvements identified, implementation plan. developed for enacting recommendations, and assistance provided to obtain approval.
- Online nursing/midwifery registration system developed.
- Public relations plan designed and enacted to promote to the Pakistani public the value of nurses/midwives to their health status and wellbeing.
- Emerging nurse/midwife leaders identified and involved in advocacy and governance activities.
- Outcome-oriented learning opportunities provided to emerging nursing/midwifery leaders through study tours to developing countries with strong functioning nursing/midwifery associations.
- Financial and incentive package to increase midwife retention designed and advocated.

[8] For purposes of this program, "nurses" may refer to one or more of the various cadres of providers receiving oversight through the Nurses Association: nurses, midwives, LHVs, FWW, community midwives.

- Career ladder structure designed and advocated that includes and links Lady Health Workers, Family Welfare Workers, Lady Health Visitors, Community Midwives and Registered Nurses.

A.1.2.b Midwife, Lady Health Visitor and Nurse Training

Result: Scope and quality of in-service education for all nursing cadres improved.

Indicators:

- In-service nursing and LHV courses designed/redesigned to incorporate competency-based maternal and child health and reproductive health skills along with supervised clinical practice; trainers trained and 1,000 nurses/LHVs trained in USAID focus districts.
- Standards for required continuing education for nurses/midwives developed, agreed and enacted by Nursing Council and Midwifery Association.

Activities:

The Contractor shall work with the Nursing Council and the Midwifery Association to expand the scope and quality of in-service education for all nursing cadres and shall undertake the following in-service training activities:

- Set standards for continuing education required to maintain nursing/midwifery licensure/registration.
- Prepare in-service nursing and LHV courses in maternal and child health and reproductive health and retrain 1,000 nurses/LHVs
- Assist the Nursing Council and Midwifery Association to expand coverage of continuing education training workshops and seminars to include providers in both public and private practice, and those in rural areas and/or hard-to-reach districts. The Contractor shall make all efforts to introduce multiple, creative ways of providing training such as on-site, team training, on-the-job and distance learning, etc; minimizing the time that providers are away from their stations.
- Develop and institutionalize a monitoring and evaluation program to determine the effectiveness of in-service trainings in improving practice skills among nurses/midwives.
- Design small business courses for developing private midwifery practices, train trainers, and assist the Midwifery Association to provide the course to 400 trained midwives.

A.1.2.c Pre-service education for midwives

Result: Pre-service education of midwives improved.

Indicators:

- Standards for preparing midwifery tutors developed and approved.
- Number of qualified long- and short-term midwifery instructors prepared for post-graduate teacher training colleges.

Activities:

The Contractor shall work with the Nursing Council and the Midwifery Association to strengthen the pre-service training of midwives and shall undertake the following activities:

- Set standard qualifications for midwifery tutor education including theoretical training and supervised clinical practice experience.
- Increase the number of long- and short-term qualified instructors for midwifery programs.
    - The Contractor shall support the Nursing Council and the Midwifery Association in advocating for a specialization course in teaching midwifery to address long-term tutor development.
    - The Contractor shall also engage in partnerships or twinning with accredited midwifery organizations, such as the American College of Nurse Midwives, International Confederation of Midwives, or a midwifery department in a college or university to engage short-term instructors for training of trainers to prepare midwife tutors to meet immediate and long-term needs.

A.2 Developing Government Capacity in Health Systems Development and Administration

A.2.1 Background: USAID/Pakistan is currently supporting the GOP as they continue to engage in health sector reform. To assist the GOP and to ensure the successful implementation of this activity and other USAID health systems efforts, it is anticipated that the Mission will need rapid access to high quality technical assistance throughout the duration of the task order.

A.2.2 Result, Indicators and Activities

Result:
Short-term consultants on health systems issues are available to address the GOP expressed needs in a timely fashion.

Indicator:
Ninety percent of consultants requested for technical assistance identified and on the ground within six weeks of request or on the date requested, should the required assistance be more than six weeks from the date of the request.

A.2.3 Activities:

The contractor shall provide an estimated 260 days of quality, mid- to senior- level expatriate consultations for short term (average consultancy of three to four weeks) health systems technical assistance in response to GOP requests and as directed by the mission in the following disciplines: human resource planning and management, performance improvement and training, health management information systems (HMIS), sector planning, policy development, health care financing, pharmaceutical management, logistics, research and other systems essential to service access and quality at all levels.

B. Component 2 – Targeted Health Information - The purpose of this component is to raise citizens' awareness and encourage them to hold government administrations and the private

sector accountable for providing quality health services by applying modern approaches to communication and information dissemination.

B.1.1 Background: Pakistan is a country rich with data, yet leaders at all levels of society need to begin using this information to advocate for better health service delivery and to mobilize communities around preventive and timely health seeking behavior. USAID is currently supporting a Demographic and Health Survey (DHS) through the Pakistan National Institute of Population Studies (NIPS). This GOP-supported organization is responsible for all the DHS data collection and analysis, and will be a key partner under Component 2. Preliminary DHS results are expected in early 2007.

B.1.2. Result, Indicators, and Activities

Result: Increased public health advocacy activities carried out by societal leaders.

Indicators:

- Number of individuals provided with technical assistance for strategic information activities (m/f).
- Number of government officials attending awareness training.
- Number of public health events for constituents led by government officials who attended awareness training on key public health issues.
- Number of journalists trained in public health reporting.
- Number of public health stories published by trained journalists.

Activities:

The Contractor shall initiate activities promoting a culture of information, fully utilizing existing data and the anticipated DHS results, among citizens and leaders including, but not limited to: Parliamentarians, local GOP officials, Nazims, journalists, women's groups, NGOs, health managers, and community-based organizations. The Contractor will promote leadership among these key members of society to encourage counterparts to be open to facts and use available information to set priorities and plan a response; advocating for the provision of quality health care throughout the public and private sectors. The contractor shall create health communication and information dissemination capacity in the partner organization using best practices and providing skills transfer. Activities at the district level will be focused where USAID health programs are underway. The contractor shall undertake the following activities:

- Develop fact sheets and other tools, in collaboration with the NIPS, to train in data for decision making. Foster advocacy for key public health issues using targeted federal, provincial and district data from the DHS and HMIS to inform and educate key members of society.
- Facilitate GOP legislator buy-in through awareness trainings and seminars targeting specific public health issues affecting the health status of their constituents. Provide comparative data between constituencies and organize fora for discussions, exploring ways to cultivate friendly rivalry and competition between representative GOP officials.
- Encourage provincial, district, tehsil and union council legislators to initiate constituent events (festivals, contests, competitions, etc.) focused on specific health

themes such as "Happy, Healthy Children", facilitating advocacy and discussions around such topics as maternal and child health, birth spacing and good nutrition for healthy mothers and children.

- Engage and educate journalists and other key members of society on key health issues to improve the frequency and accuracy of responsible reporting.

C. **Component 3 – Grants Program.** The purpose of this component is to address health systems' challenges in the public, private, or commercial sectors which can be resolved with modest grant assistance within a period of one year by concerted local effort of sub-grantees.

C.1.1. Initial Focus and Themes of Grants: The majority of the population in Pakistan seeks care through the private sector. To reach this critical section of the health care system, the Contractor will establish and implement a grants program which in the first year of grant-making provides grants as seed money for innovative ways of delivering quality, family friendly preventive health care services through either public/private partnerships or through the private sector alone. In order to build on the momentum of other USAID funded activities, the grants program will target the twenty districts covered under USAID's new family planning activity.

The Contractor shall award and administer sub-grants to Pakistani NGOs in accordance with Automated Directives Systems (ADS) 303 and the clause of this task order entitled "Grants Under Contracts." When necessary, the contractor shall also mentor awardees.

The grants program shall be funded at $1,000,000 for the life of the task order, and each individual grant shall not exceed $100,000 without prior approval of the Contracting Officer. A minimum contribution of 15 % of each grant is required from the grantee as cost sharing. USAID will participate in the selection of sub-grantees and will approve the final selections. Prior to the solicitation and award of any grants, the Contracting Officer shall approve the Contractor's grants manual.

In their proposals, grantees shall identify the public health problem the grant will address, what approaches will be applied, what outcomes are expected and how these will be monitored and reported. Grants shall not be for major equipment purchases or construction.

No later than the end of the first year, the Contractor shall propose for USAID approval the focus and themes for the second year's grants competition.

C.1.2. Result, Indicators and Activities

Result: A minimum of 10 grants awarded.

Indicators:

- Number of local organizations provided with technical assistance for institutional capacity building and/or in technical areas.
- Number of new service delivery approaches successfully introduced through grants program.
- Amount of in-country public and private financial resources leveraged by grants program.

Activities:

- Grants program initiated within six months of task order award.
- Service delivery innovations evaluated for efficacy.

D. Component 4 – Strengthening of Essential Drugs and Contraceptives Logistical System.

The purpose of this component is to strengthen the logistical system of essential medicines and contraceptives in the public sector at the national, provincial and district levels to ensure their availability throughout the country.

D.1.1. Scope: Under this component, the contractor will be expected to work with both the MOPW and the MOH in all of the geographic areas that will be covered under a new family planning award being competed and to coordinate closely with the grantee of the new family planning activity that will be responsible for strengthening the logistics at delivery points below the district level in facilities (RHC, BHU, FWC) and with lady health worker supervisors.

** A study was recently conducted of the logistic system and is included in section D of this RFTOP.

The contractor shall provide technical assistance in four specific areas: 1) developing a computerized system to manage all aspects of drug and contraceptive supplies from the national to the district level; (2) upgrading the current system for managing inventory; (3) strengthening the storage of supplies throughout all levels of the health system; and (4) establishing a system and providing training on forecasting supply needs.

Result: A fully functional contraceptive and essential drug logistics system within the twenty targeted districts

Indicators:

- Monthly reports available showing stock status at district level.
- Number of districts within the catchment areas experiencing stock outs of contraceptives.

D.1. Developing a Computerized System to Manage Essential Drugs and Contraceptive Supplies

The Contractor shall develop a computerized system to manage all aspects of drug and contraceptive supplies for the MOPW and the MOH. The contractor shall implement this system beginning in year one of this task order and work with the ministries to correct software bugs, etc. and train users during the second year of this task order. The system shall be operational and fully functional (free of bugs) and in use by the end of year two.

Activities:

The contractor shall:

- Conduct a review of the existing information system.

- Based on results of the review, develop a plan for computerizing the system at all levels.
- Supply computers at the provincial and national levels after an assessment of the ministries' current available hardware.
- Develop module(s) and test system.
- Conduct training of appropriate staff.
- Ensure the computerized system becomes functional at all appropriate facilities within both the MOPW and the MOH.

D.2 Upgrade the Current System for Managing Inventory of Contraceptives

The contractor shall:

- Initiate computerized inventory management systems at the Karachi Central Warehouse, and federal, provincial and district levels of MOPW and MOH.
- Implement inventory control procedures at each level.
- Provide training to appropriate staff to ensure functionality of the system.

D.3 Strengthen the Storage of Contraceptive and Essential Drug Supplies throughout all Levels of the Health System

Under this component, the contractor shall:

- Conduct an assessment of warehouses and stores at all levels: national, provincial and district.
- Utilize the assessment recommendations to implement drug storage improvements.

D.4 Establish a System and Provide Training on Forecasting Supply Needs for Contraceptives and Essential Drugs.

The contractor shall:

- Improve the procedure for forecasting at all levels (central, provincial, district). This will require developing procedures and training staff.
- Develop a long-term (5-year) forecast for contraceptives and essential drugs in collaboration with all appropriate parties.

V. SPECIAL CONSIDERATIONS

A. **Cultural and Provincial Considerations.** Pakistan is a complex and culturally rich country, all of which can impact the successful implementation of programs. The Contractor is expected to demonstrate sensitivity and flexibility when taking into account the different provinces and their cultures, population size, geographical makeup and general ways of doing business. Activities and approaches must be properly tailored to meet these challenges.

B. **Role of GOP and Local Governments.** USAID/Pakistan seeks to support the GOP's goals of providing accessible and affordable health care for all. Support and commitment from the GOP is essential to the success of this program and the Contractor shall develop and maintain collaborative relationships to ensure ownership and support throughout all phases of program planning, implementation and monitoring and evaluation.

C. **Coordination.** The Contractor shall ensure that program interventions are carefully coordinated and linked with local organizations, other USAID partners' and donors' activities focused on systems strengthening to leverage the investment and resources where and when appropriate, and to prevent duplication of efforts.

D. **Building Human Resources and Sustainability**. The Contractor shall implement measures to develop competencies for decision-making among an increased number of Pakistan counterparts at all levels to develop long-term sustainability. The Contractor shall ensure that counterparts will increasingly be in a position to take senior management and technical roles, authorities and responsibilities in the areas of health systems strengthening. The Contractor's own human resource base, particularly Pakistani, at senior, middle and entry level should be developed through specific planning and professional development activities.

E. **Gender.** Gender differences and discrimination play a significant role in determining the health status of women and girls in Pakistan. The Contractor shall take into consideration the impact of gender and ensure that equity concerns will be an integral element of all program activities. Appropriate internal and external management structures and personnel processes are required to demonstrate that issues of gender are incorporated into all program interventions.

F. **Development Alliances.** USAID strongly encourages public-private alliances in implementing its programs, as illustrated in USAID's Global Development Alliance (GDA). The Contractor is encouraged to look for opportunities for public-private partnerships under the GDA mechanism. More information on the GDA can be found at http://www.usaid.gov/our_work/global_partnerships/gda/ .

VI. KEY PERSONNEL

The Key Personnel positions under this Task Order shall include the following: Chief of Party, Director of Administration and Financial Management, Monitoring and Evaluation Advisor and Senior Technical Advisors with experience in multiple aspects of health systems strengthening. Key personnel can be expatriates, Pakistani citizens or some combination of the two. USAID must approve all Key Personnel and any changes to the Key Personnel under this Task Order. Required qualifications and functions for Key Personnel include the following:

A. **Chief of Party (COP).** The COP shall be responsible for the overall management and implementation of the program and report directly to the designated USAID CTO. S/he shall supervise project implementation, serve as the principal interlocutor with USAID and the GOP and ensure the program meets stated goals and reporting requirements. The COP shall have an advanced degree (master's degree or equivalent) in a relevant field from an accredited university. The COP shall have at least 10 years of experience in managing and implementing health systems programs in developing countries and specifically in the areas outlined above. S/he shall have demonstrated exemplary diplomatic and interpersonal skills to ensure internal coherence amongst diverse team members as well as relations with the GOP, donors and the international community. The

COP shall possess excellent English writing skills. The COP shall be in-country two weeks after the task order is signed.

The Chief of Party serves as the representative of the Program including any sub-contractors[9], if any, and will be the point of contact in Pakistan for all purposes of this project, unless delegations of authority are presented to and agreed by the Mission CTO.

B. **Director of Administration and Financial Management.** The Director of Administration and Financial Management shall be responsible for overseeing the administrative and financial management and accountability requirement of the program. Additional responsibilities would include the administration and management of the grants program. S/he shall have an earned graduate degree in accounting or business administration from an accredited university and at least five years of experience in project administration.

C. **Monitoring and Evaluation Advisor.** The Monitoring and Evaluation Advisor shall be responsible for coordinating the development of a performance management plan for the project, including performance monitoring criteria. The Advisor is required to hold an earned degree from an accredited university in a relevant field. S/he shall have at least five years of relevant experience working in developing country settings. S/he shall have excellent writing skills in English.

D. **Senior Technical Advisors.** The technical team shall be composed of two experienced and well-qualified health systems advisors/specialists with at least five years of demonstrated expertise in their particular fields in a developing country. Special focus shall be given to experience in capacity building with nursing/midwifery educational institutions and professional associations, in logistics management, and in communications and public relations. All technical team members shall have excellent writing skills in English.

VII. ADDITIONAL ORGANIZATIONAL CONSIDERATIONS

The Contractor shall provide office space for all program staff, regardless of institutional affiliation, co-located in the program head office or in program satellite offices in order to maintain one identity for the program and to facilitate teamwork and coordination among prime- and sub-contracting agencies (if any). Short term technical assistance advisors may, with CTO concurrence, be seconded to other offices.

The project will seek to co-locate with government or non-governmental partners in the provinces and territories. The staffing pattern proposed for non-key staff should describe how additional expertise and skill mix might be obtained while attending to the necessity of cost-containment and avoiding unnecessary staffing.

The Contractor shall ensure that all project staff create and maintain effective working relationships with the communities and local and provincial governments, USAID and other donor organizations; and work in a collaborative and inclusive team oriented manner. USAID

[9] "Sub-contractors" refers to those organizational entities that have proposed to partner with the prime contractor in responding to this Task Order.

places a high value on the Contractor's ability to develop partnerships and promote teamwork and on its responsiveness to the varied needs of the Mission.

The task order shall be managed in-country with all management decisions and administrative responsibilities delegated to the main field office in Islamabad. The prime Contractor's home office shall provide managerial oversight and administrative backstopping, and technical assistance as needed.

VIII. REPORTING REQUIREMENTS

The Contractor shall adhere to all reporting requirements listed below. All reports shall be submitted within 30 days after the end of each reporting period. Additional reports requiring review and clearances, when necessary, are listed under each requirement. The exact format for preparation of all reports will be jointly determined between the Contractor and the CTO.

The Contractor shall provide timely responses to any and all requests pertaining to the annual submission of the newly instituted joint USAID and State Department Operational Plan, and subsequent semi- and annual reports. The Contractor shall also adapt internal systems, primarily financial and monitoring and evaluation systems, to the needs and requirements under the new regulations from the U.S. State Department Office of the Director of Foreign Assistance.

A. **Quarterly Financial Reports.** The Contractor shall submit to USAID, through the CTO, a quarterly financial report that specifically includes line item budgets, expenditures and accruals and a pipeline (balance remaining). This table with expenditures and accruals shall be submitted to the CTO no less than 15 days before the end of each (USAID) fiscal year quarter through the life of the project.

B. **Performance Management Reports**. The Contractor shall submit reports to the USAID CTO as described below. The exact format for preparation of all reports shall be proposed by the Contractor and concurred by the CTO.

B.1. **Award Monitoring Plan** (2 hard copies + electronic copy). Sixty days after award, the Contractor, in consultation with sub-partners and USAID, shall submit the final version of the performance monitoring plan (PMP) for the project, including final selection of indicators, baseline data needs and establishment of program targets. This will be the finalization of the draft PMP version submitted with the RFTOP. In addition to internal project impact and monitoring indicators for the Contractor's use, USAID may require the collection of data on a set of core indicators to be finalized during PMP development.

B.2. **Annual Implementation Plan** (2 hard copies + electronic copy). The first implementation plan is due two (2) months after the contract is awarded. The second annual implementation plan is due in month 13 of the activity. The first annual implementation plan will cover the 12 month period following mobilization. The implementation plan serves several purposes including a guide to program implementation, a demonstration of links between activities, strategic objectives and intended results, a basis for budget estimates and the foundation for the monitoring and evaluation plan.

Implementation plans shall be organized to clearly link activities to the expected results. The work plans shall be jointly determined between the Contractor, the CTO and in consultation with the GOP. Implementation plan budgets shall delineate an overall budget and the budget per activity in the Development Focused Budgeting (DFB) format.

The implementation plan, at a minimum, shall include:

- Brief situation analysis in the context of what other donors and implementing partners and host-country governments are contributing.
- Life-of-program results.
- Milestones (or benchmarks) toward achieving those results over the duration of the program.
- Partner involvement and contributions to achieving the results.
- Development Focused Budget (DFB).
- Timeline.

B.3. **Quarterly Performance Monitoring Reports** (2 hard copies + electronic copy). Quarterly performance monitoring reports shall be submitted to the CTO, in coordination with Mission internal reviews. Reports should briefly document actual accomplishments toward the program objectives, intermediate results and milestones, including conformance with environmental guidelines. Quarterly reports should not exceed 30 pages. The last performance monitoring report of the year shall be a summation of the results and progress toward results made during that year. Key indicators shall be tracked against pre-defined targets and reported in table or graph format as agreed upon by the CTO. The reports must also include the following:

- Explanation of quantifiable output of the programs or projects, if appropriate and applicable.
- Reasons why established goals were not met, if appropriate.
- Analysis and explanation of any cost overruns or high unit costs. (Contractors must immediately notify USAID of developments that have a significant impact on award-supported activities).

Notification must be provided to the CTO in a timely manner in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the award. These notifications must include a statement of the action taken or contemplated, and any assistance needed to resolve the situation.

B.4. **End of Program Report** (3 hard copies + electronic copy). The Contractor shall submit a final report 90 days after the completion date of this Contract which includes: an executive summary of the Contractor's accomplishments in achieving results and conclusions about areas in need of future assistance; an overall description of the Contractor's activities and attainment of results during the life of the Contract; an assessment of progress made toward achieving results under the Strategic Objective 7; significance of these activities; important research findings, if any; comments and recommendations; and a fiscal report that describes how the Contractor's funds were used.

The Contractor shall submit an original and two copies of the final report to the CTO and one copy to the USAID Development Experience Clearinghouse: E-mail (the preferred means of submission) is: docsubmit@dec.cdie.org. The mailing address via U.S. Postal Service is: Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910.

C. **Distribution of Reports.** Reports required as described in this section will be sent to the CTO. Reports and intellectual products required above will also be submitted to the USAID Development Experience Clearinghouse either electronically via e-mail (the preferred means of submission) to docsubmit@dec.cdie.org or in hard copy via U.S. Postal Service to Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910.

Section D – Attachments

1. Study on the logistic system. (Attached as separate document. The attachment is in two parts.)

2. Locally Employed Compensation Plan (Attached as separated document)

[End of RFTOP 391-07-011]