Issuance Date: December 21, 2006
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***SUBJECT: RFTOP 521-07-004 IQC* TASK ORDER FOR BIDDING ON "QUALITY BASIC HEALTH SERVICES SUPORT TO HAITI"**

Dear TASC3-Global Health Contractors,

The United States Government (USG), represented by the U.S. Agency for International Development's Mission in Haiti (USAID/Haiti), has been requested by the Mission's Health Office to negotiate a Task Order (TO) under the Technical Assistance and Support Contract (TASC 3-Global Health) IQC, as more specifically described in the rest of this Request for Task Order Proposal (RFTOP).

It is anticipated that a three year, (estimated), Cost Plus Fixed Fee Task Order (TO) will be awarded for these services. Please note, follow-on activity may result from this Task Order should the USAID's strategy be extended and additional funds approved. This work is to implement USAID's new bilateral health activity with 5 program elements: 1) HIV/AIDS; 2) Tuberculosis; 3) Maternal Health; 4) Child Health; and 5) Family Planning. This work will build on previous USAID/Haiti investments in health to support decentralization, strengthen public sector capacity in service delivery and support NGO service delivery by leveraging other donor funding.

The total estimated value of USAID's share of this procurement over three years (2007-2010) is $43 million comprised of funding for maternal and child health including population and HIV/AIDS services. The Offeror is expected to provide a minimum of a 20% match in private sector funding (which can include in-kind and non-profit funding) annually. The 20% matching funds cannot include host government matching funds or matching funds from proposed sub-contract or sub-grant implementing partners.

If your organization is interested in submitting a Proposal in response to this RFTOP, please carefully review this letter and the contents of this request, which include:

Section	Title
Section A	Statement of Work
Section B	Instructions for Preparation of the Technical Proposal
Section C	Evaluation Criteria

It is requested that questions regarding this RFTOP be submitted by e-mail to Stephane Bright (sbright@usaid.gov), while proposals should be sent directly to me.

Annette Tuebner, Contracts Officer
USAID/Haiti
atuebner@usaid.gov
fax: 011 (509) 229-3201

Proposals are due **January 31, 2007**. See Section B for details.

Issuance of this RFTOP does not constitute an award commitment on the part of the U.S. Government, nor does it commit the U.S. Government to pay for costs incurred in the preparation and submission of proposals. Further, the U.S. Government reserves the right to reject any or all proposals received.

In addition, award of the Task Order contemplated by this RFTOP cannot be made until funds have been appropriated, allocated and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for the award. Proposals are submitted at the risk of the Offeror.

Proposals should be prepared in accordance with the instructions set forth in Section B, and with Section F.9(b)(2)(i) of the basic IQC.

Thank you for your consideration of this USAID initiative. We look forward to your organization's participation.

Sincerely,

Anne Quinlan
Contracts Officer

SECTION A – STATEMENT OF WORK

I. Overview & Background

The *New Strategic Framework for U.S. Foreign Assistance* concentrates U.S. foreign assistance on five priority objectives to meet the goal of "Helping to build and sustain democratic, well-governed states that will respond to the needs of their people and conduct themselves responsibly in the international system". These areas are:

- *Peace and Security*: recognizing these as platforms for further political, economic and social progress;
- *Governing Justly and Democratically*: recognizing that effective, accountable, democratic governance is a vital foundation for sustainable progress;
- *Investing in People*: recognizing that human capacity must be strengthened in order to promote and sustain success;
- *Economic Growth*: recognizing that economic progress and poverty reduction are critical underpinnings of sustainable development; and
- *Humanitarian Assistance*: recognizing the United States' commitment to alleviate human suffering and respond to destabilizing humanitarian disasters.

The USAID country strategy 2006 – 2009 for Haiti builds on over 40 years of United States Government (USG) humanitarian relief, health and development experience. It focuses development assistance through the analytic lens provided in the *New Strategic Framework for Foreign Assistance.* This Task Order is consistent with this new framework and focuses resources on a defined set of program areas investing in lives of people for "Rebuilding Countries" (i.e. states in or emerging from and rebuilding after internal or external conflict.) (Refer to www.http://f.state.gov for extensive information and details on the new Foreign Assistance Framework, program elements and sub-elements).

This Task Order addresses the Health Program Area under the category, "Investing in People", and the specific program elements are:

- Program element 1.1: HIV/AIDS
- Program element 1.2: Tuberculosis
- Program element 1.6: Maternal and Child Health
- Program element 1.7 : Family Planning

As a cross cutting theme across these elements, the contractor will support strengthening the executive function of the Ministry of Public Health and Population (MSPP). The overall goal of this Task Order is to improve the quality of lives of vulnerable populations in Haiti to enable them to have more productive livelihoods to contribute to Haiti's overall economic growth and development. Specifically, this Task Order aims to increase the use of basic health care services that are currently available to approximately 50% of the Haitian population through both non-governmental (NGO) and public sector

clinics in targeted geographical areas. The public sector sites are referred to as *Zones Ciblees.* The Zones Ciblees represent marginalized segments of the population which have little or no access to health services and have been strategically selected by the Government of Haiti as priority public sector sites to receive USAID health sector assistance. (See list of tables and maps in the electronic document section of this Task Order, which clearly indicate geographical focus areas for implementation of assistance under this Task Order.)

This document provides an overview of the major health and development issues in Haiti and describes the requirements and performance standards under this Task Order to be accomplished that contribute to USAID's strategic objective (SO)12, Increased Access to Quality Basic Social Services under USAID's country strategy 2006-2009. Applicable documents are referenced throughout this document describing in detail the efforts that USAID and other stakeholders have pursued in the last several years to improve access to primary health care services, which has laid a strong foundation for the technical assistance to be delivered under this Task Order.

The installation of the Government of Haiti (GOH) Préval administration in June 2006 marked the resumption of constitutional governance in Haiti. The USAID strategy recognizes that it will take time for the legitimacy and effectiveness of state institutions to improve. There will be setbacks as well as progress, and stability will be uneven and not easily achieved. The strategy is flexible so that USAID may respond to evolving political, social, and economic realities.

USAID will help Haiti reduce internal conflict and provide the basis to rebuild by addressing key sources of stress and conflict in social, economic and political spheres, notably through creating employment and rebuilding assets for sustainable livelihoods (economic), increasing access to primary health services and basic education (social), and fostering improved rule of law and responsive governance (political). All interventions will be undertaken to achieve short-term visible and measurable results while still developing the capacity of Haitian institutions to sustain results beyond the life of this strategy.

Informed by the analyses summarized above, the new strategy has greater demographic and geographic focus than the past. There are three vulnerable demographic target groups: 1) children and youth under 25; 2) women and; 3) special concerns groups, such as persons living with HIV/AIDS (PLWAs), tuberculosis (TB) patients and trafficked persons. All strategic objectives (SOs) address at-risk youth, with different interventions geared to different age cohorts, sexes, residence (urban, rural), and expressed interests. All SOs target women as participants and beneficiaries, and identify creative ways to address and respond to violence against women in their respective spheres.

The USAID country strategy 2006-2009 has three broad geographic target areas: 1) conflict-vulnerable areas, especially the cities and rural sending areas and the hotspots they surround; 2) targeted watersheds, which will stabilize environmental conditions, mitigate the impact of natural disasters, and create assets and employment; and 3) other

locations that are self-targeting by activity (e.g., regional and district courts, departmental health offices, mango processing centers) or provide particular opportunities for impact, such as food insecure and vulnerable populations. Under this Task Order, assistance will be targeted in all 10 departments of Haiti through approximately 100 service delivery sites managed either by NGOs or by the Government of Haiti (i.e. Zones Ciblees) that provide access to approximately 50% of the population of Haiti. The geographic target area includes the USAID-identified "hotspots" - *Petit Goave, Port-au-Prince, St. Marc, Gonaives, Cap Haitian and Les Cayes.* See list of tables and maps in the electronic document section which clearly indicate geographical focus areas under this Task Order.

II. Summary of USAID Country Strategy 2006-2009 Assessments

a) The **2006 Haiti Conflict Mitigation and Management (CMM) Assessment** was fundamental to defining a strategic direction that incorporates a multi-sectoral approach to address the root causes of conflict. The CMM Assessment identified the violent culture and anarchy found in several urban hotspots as a key driver of Haitian instability. It also highlighted a key strategic demographic target, at-risk youth, and emphasized the need to focus on women as particularly vulnerable to conflict. Consistent with the assessment recommendations, USAID strategically targets resources to support stabilization of urban hotspots and other conflict-vulnerable areas; works to strengthen institutions across Haitian society; and creates jobs and economic opportunities. Resources will be directed to reinforce government leadership and effectiveness in improving the conditions that affect daily life such as social services and access to justice. Institution-building support will be targeted to key decision-making entities as well as incorporated into sector programs. The strategy also addresses inclusiveness, including the need to engage youth and women in community decision-making, and it will develop avenues for consensus-building among critical sectors of society while promoting the rule of law. For health, this Task Order focuses interventions on key vulnerable groups, i.e. children and youth under 25, women and special concerns groups, such as persons living with HIV/AIDS (PLWAs), TB patients and out-of-school youth.

The initial focus will be on creating space in which programs can operate by building citizen confidence and trust through quick, visible community-identified small projects. These will capitalize on a convergence of interest among historically antagonistic groups by responding to community-identified needs. As secure space broadens within the hotspots, and in other areas where security is adequate, USAID will support programs that provide income and productive work through short-term jobs, while building the foundation for longer-term improvements through extensive public works. Programs will work closely with local and national government entities to build their capacity to provide and oversee critical services while reinforcing accountability to citizens. These public works programs will also serve to facilitate an expansion of education, health, justice, democracy, training and economic growth programs. Transforming unstable hotspots will be uneven and require an increase or decrease in activities in a given hotspot based on opportunity and potential to enhance stability. Across all activities in conflict-vulnerable areas, the strategy will work to expand the reach of government and local authorities in providing basic services, including, where appropriate, public-private

partnerships. The institution-building elements will further stability and citizen confidence.

b) USAID also conducted a literature review and undertook an **Assessment of Governance, Decentralization & Deconcentration** in past USAID and other donor projects in Haiti. A key finding is that the legal framework for decentralization is absent. In the absence of the GOH passing the legal framework for decentralization, USAID should carefully evaluate undertaking a new program and consider supporting only those authorities committed to democratic principles and the development of their areas with active citizen participation. Key recommendations include the need to take the differing authorities and responsibilities of deconcentrated and decentralized government functions into account. A second key finding is the need to reinforce the legitimacy of elected local government officials and central government staff in deconcentrated ministry offices to expand the reach of government. Steps will be taken to avoid creating project-specific committees to serve as rubber stamps for external partners and project management structures that supplant legitimate local authorities. USAID will foster collaboration between local government agencies and local non-governmental organizations (NGOs), community based organizations (CBOs), and private commercial actors. The findings of the assessment will be applied in USAID's targeted urban conflict-vulnerable areas; the rural watersheds; and in other locations that are self-targeting by activity.

c) The Corruption Assessment played an important role in the strategy development process. The assessment highlighted the fact that Haiti's corruption is endemic and systemic and is a major impediment to USAID's objectives of assisting Haiti to achieve economic, social and institutional stability. The assessment recognized that some progress has been made but emphasized that in order for USAID to achieve its strategic objectives, anti-corruption efforts must be given high priority and work across strategic objectives. Approaches to dealing with corruption generally fall into two categories: (a) enforcement and prosecution, and (b) prevention and education. While acknowledging that both are important, the assessment recommends that the anti-corruption efforts in Haiti be focused on the latter because vigorous law enforcement, investigation and prosecution are not likely to be successful due to the GOH's lack of resources and capacity to undertake these activities. In addition, this process would be extremely vulnerable to political manipulation. The strategy will reinforce activities that promote greater transparency and accountability in the public sector, reduce opportunities for corruption, and expand civil society capacity for oversight and monitoring. A primary focus will be on improving capacity for transparent management of resources within targeted government entities.

d) The 2006 Haiti Gender Assessment was fundamental to strategy development, highlighting seven key areas for increased attention: 1) violence against women; 2) legal reform; 3) judicial reform; 4) overall governance; 5) jobs and livelihoods; 6) women's groups; and 7) inter-program and donor synergy. Given women's importance to the economic and social domains in particular, women are considered one key demographic target group for the new strategy.

e) The new **Environmental Threats and Opportunities Assessment (ETOA) and related Section 118/119 (Tropical Forest and Biodiversity)** analyses were key to development of the USAID's approach to Haiti's environmental fragility and consequent vulnerability to natural disasters, notably floods. These analyses formed the basis for the USAID's selection of degraded, but potentially productive, watersheds as a second key geographic focus. Haiti's forests and biodiversity remain extremely degraded. Protected forest areas account for just 21,000 hectares (0.7% of land area). The Section 118/119 analysis concluded that the greatest threat to the remaining biodiversity is continued clearing of lands for agriculture, resulting from poverty and depleted soils. The ETOA notes that the primary reasons for environmental degradation are not land tenure insecurity or charcoal production, but 1) the sheer pressure of mountain farmers and their reliance on the production of annual food crops that cause erosion, 2) extensive de-capitalization of the rural sector, and 3) the overall absence of viable production or livelihood alternatives. Additional environmental threats to populations and stability are caused by overcrowded slum areas which are often located in flood plains. Opportunities to address these issues include the use of market-based incentives that connect soil and water conservation measures to improvements in farmer incomes at a scale large enough (e.g., within a major watershed) to have measurable positive impact.

III. Summary of USAID Country Strategy 2006-2009 Expected Results

USAID will pursue its vision of *Stability* through activities to achieve three strategic objectives (SOs) that are directly linked to reducing internal conflict, increasing the availability of essential social services, and making initial progress to create policies and strengthen institutions upon which future progress will rest. The three SOs are: *More Employment and Sustainable Livelihoods ("Livelihoods SO"), Increased Access to Quality Basic Social Services ("Services SO"), and Improved Rule of Law and Responsive Governance ("Governance SO").* These SOs form the broad results that USAID plans to achieve between 2006-2009. By 2010, Haiti will be more stable and less prone to violent conflict. The provision of basic health and education services will be increased for Haitian citizens through the government's improved use of donor resources and deconcentration. There will be more responsive and accountable executive, legislative, and judicial institutions of government providing increasingly effective governance. In sum, more Haitians will be able to support themselves and their families, and they will have increased access to primary health services, basic education and strengthened rule of law and community institutions. For additional information on USAID's Country Strategy 2006-2009, refer to the country strategy in the electronic document section of this Task Order.

IV. Summary of Strategic Objective "Increased Access to Quality Basic Social Services"

The Social Services SO is comprised of 6 main components:

1) Improve Child Survival, Health and Nutrition
2) Improve Maternal Health and Nutrition

3) Support Family Planning
4) Prevent and Control Diseases of Major Importance
5) Improve Equitable Access to Quality Basic Education
6) Strengthen Public Sector Executive Function

For the purposes of this Task Order, the Offeror will address components 1- 4, as well as component 6 as it relates to strengthening the MSPP. The food assistance provided under the PL480 Title II food program is a part of the Social Services SO, but is not part of this Task Order. However, the maternal and child health assistance implemented as part of this Task Order should be linked to the PL480 food and nutrition activities. In addition, the Offeror should identify ways to complement and create synergies with component 5. Lastly, where appropriate, the Offeror should identify and link proposed health activities to USAID's Livelihoods and Governance strategic objectives.

V. Overview of Health Sector Issues and Prior USAID Assistance to Provide Quality Health Services to the Haitian Population

Summary Description of Problem

Haiti occupies one third of the Hispaniola Island it shares with the Dominican Republic. The population density is 300 inhabitants per square kilometer. In certain areas of Port-au-Prince this density reaches 2,500. Haiti's GNP per capita in 2003 was $332, down from $632 in 1980, a decline of 90% over 23 years, whereas at the same time the GNP per capita for the Latin America and Caribbean region for 2005 was $3,580. Two-thirds of Haiti's population lives in abject poverty. Life expectancy at birth is 50.0 years, compared to 70.5 years in the LAC region, and the infant mortality rate is 63.2 per 1,000 (31.2 per 1,000 in the LAC region). Fifty percent of the population is below 24 years of age, and over 50% of them have never attended or did not complete primary school. UNESCO 2005 data indicate that only 66.2 % of youth 15 to 24 years of age are literate, compared to 95.5% for LAC.

Nearly 40% of Haitians have no access to basic primary health care. Haiti's health indicators reveal that the country's health system is weak. Haiti has the highest under-five mortality in the Western Hemisphere with approximately 12.5% of children dying before reaching the age of 5 years, followed by Bolivia with 9.0%. Haiti's has the highest maternal mortality rate in the region at approximately 523 deaths/ 100,000 live births—close the maternal mortality rates in Africa. While the recent 2005 Demographic Health Survey (DHS 2005) suggests that trends in mortality and morbidity are going down, they are still worrisome. For a detailed summary of DHS 2005 results, refer to Section VIII below.

The dismal state of key health indicators is a result of lack of access to quality health care services and to potable water and chronic food insecurity. Access to quality health care across the country is challenged due to poor health infrastructure and disruption of services (notably within the capital of Port-au-Prince, which has struggled with insecurity and violence in several neighborhoods over the last several years). Insecurity and

violence in particular areas have caused even further deterioration of services. This has resulted in a lack of equipment, inadequately trained staff, and poor management of health facilities, especially by the public sector. Although there is engagement of communities and civil society, notably NGO support, to participate in addressing health issues, both the supply and demand sides of health services need to be strengthened in both the public and non-public health care delivery sectors.

Prior USAID Health Sector Assistance

USAID has been engaged for over forty years in the health, education and food security sectors. Conditions of basic services in both sectors have deteriorated badly over the past two decades. The bulk of Haiti's population is chronically food insecure, with decreases in food production making the situation increasingly fragile, as Haiti teeters on the brink of becoming a chronic food deficit country. This paradigm of decline across sectors is due to government mismanagement and corruption, political and economic instability and natural disasters. Despite these obstacles, USAID's health sector assistance during the past several years has continued to achieve results. The following provides a summary of USAID assistance in the health sector as it relates specifically to this Task Order. For a recent summary of all of USAID's health sector assistance refer to the electronic document section for a draft of USAID's health sector annual report of results achieved between October 2005-September 2006.

In the early 1980's, USAID funded two major bilateral projects implemented by two different partners focusing separately on Maternal Child Health (MCH) and Family Planning (FP). In 1999, USAID focused assistance on the delivery of integrated basic health care services through one project called Haiti Santé (HS) 2004, which was implemented from 2000-2004. This was followed by HS2007, which is scheduled to end in September 2007.

During the last several years of health sector assistance, USAID's direct engagement with the public sector has been limited by Haiti's protracted political insecurity, resulting in a weak central MSPP. As a way to ensure continuity in health care services in USAID geographic target areas, USAID supported the delivery of basic health care through NGOs in 100 clinics in all 10 departments in Haiti. Over the last three years, USAID re-engaged the MSPP in an effort to strengthen GOH decentralization efforts in the health sector and improve public sector health care delivery. USAID supported the development of departmental health plans in the 10 geographic departments to strengthen coordination and planning among donors, enhance MSPP oversight of the delivery of health services and strengthen the partnership between public and private health providers. In April 2006, USAID assistance identified 30 public sector health care clinics in hard to reach areas, referred to as "*Zones Ciblees"*, to support the MSPP to re-start or strengthen public sector service delivery. Some of these *Zones Ciblees* are in 4 of the 6 USAID-identified "hot spots". The two remaining "hot spots"—Petit Goave and St. Marc-- will be included as part of the geographical focus of this Task Order. Currently, with USAID health sector assistance, 47% of the Haitian population has access to basic health care services through approximately 100 NGO clinics and 30 public sector *"Zones Ciblees"* clinics.

In July 2006, *Haiti Santé 2004 and Haiti Sante 2007* were evaluated. In spite of a fragile government, weak infrastructure, security problems and natural disasters, *Haiti Santé 2004 & 2007* achieved considerable results, largely in part due to flexible and innovative implementation of assistance. Section X below summarizes the findings of the evaluation. Refer to the electronic document section for the complete evaluation report. Among the achievements were:

1. Contraceptive Prevalence rose to 29.5% in the USAID target areas compared to 24.8% in the rest of the country.
2. Vaccination coverage rose to 82% in the USAID target areas compared to a national average of 41.3%.
3. Births attended by trained personnel were 63% in USAID target areas vs. 60% in non-project areas.
4. 50.7% of women in USAID target areas received three pre-natal visits compared to 15.4% nationally.
5. The project introduced an innovative performance-based mechanism for linking health performance to financing NGO program efforts.
6. A community-based approach strengthened referral linkages between the community and the health service delivery points, thus improving continuity of care.

VI. How the Health component of Social Services Strategic Objective Responds to Government of Haiti Priorities

USAID health sector assistance aims to support the GOH priorities to strengthen governance and health service delivery capacity in order to respond to the needs of its citizens. With this in mind, USAID has worked closely with GOH to develop the health component of the Social Services Strategic Objective and to ensure that it is fully supportive of GOH priorities.

In November 2005, the MSPP published its "*Plan Stratégique National pour la Reform du Secteur de la Santé"*, which lay out the Ministry's new approach toward integration of health services and its strategy to deliver a basic minimum package of health services closer to the people (refer to the electronic document section for a copy of this strategic plan). The Prime Minister further outlined major government priorities in a speech before the Haitian Parliament in June 2006. As a major long-term goal, he emphasized the modernization of the State and the deployment of State functions to all regions of Haiti, i.e., deconcentration and decentralization of State functions and services. Over the USAID country strategy period, the health component of the Social Services Strategic Objective has identified the need to maintain and increase access to basic health services by progressively enhancing direct service delivery capacity in both the public and NGO sector and strengthening public sector oversight of and norm setting for service provision. Areas of assistance include: a) enhancing MSPP executive and normative policy functions in service delivery; b) continuing quality service delivery through non-public sector groups with gradual increase in MSPP oversight to improve quality, accountability

and transparency; c) strengthening public and private sector cooperation in quality service delivery; d) progressively increasing public sector service delivery capacity and, e) improving training of primary health care professionals. The priorities outlined above for the health component of the Social Services Strategic Objective are consistent and supportive of the priorities outlined in the MSPP strategic plan and those stated in the Prime Minister's speech for deconcentration and decentralization.

These same priorities have been repeated in recent GOH statements and venues. The GOH clarified its economic and social development priorities in a general policy document presented at the July 25, 2006, Donors' Conference for Economic and Social Development in Haiti. In the health sector, the GOH clearly articulated four key objectives in support of expanded access to basic services: a) ensuring maternal and infant health such as nutrition, vaccinations, and infectious diseases, including HIV/AIDS; b) ensuring national and equitable coverage; c) decentralization of services targeting the most difficult to reach; and d) improving sustainability by training personnel, improving infrastructure, access to potable water and sanitation. The activities described in the USAID Activity Approval Document (AAD) (refer to the electronic document section) are directly responsive to these priorities. USAID health sector assistance will support management training and placement of technical advisors to strengthen executive functions at the MSPP, e.g. planning, monitoring and delivering social services. Activities will support decentralization by strengthening the MSPP departmental offices through strategic planning, financial management and anti-corruption measures, technical assistance, training and material support.

VII. Other Donors in Health

The United States is the single largest donor in the health sector with Canada, the Global Fund for HIV/AIDS, Tuberculosis and Malaria, and the Inter-American Development Bank (IDB) making substantial investments in Haiti's health sector. USG health sector assistance under the three-year country strategy includes approximately $20 million annually in child survival and family planning funding; $35 million annually in PL480 Title II funding; and $50 million annually in PEPFAR (HIV/AIDS) funding. The Global Fund is the second largest HIV/AIDS donor ($20 million per year) and a major donor in Haiti for tuberculosis and malaria providing about $6 million dollars for both annually. The current Global Fund program will continue through 2011. Canada and Brazil provide significant resources to the MSPP for immunization. Canada recently launched a five-year $100 million program in four departments which supports public sector services, university training in public health, and pilot projects in commune-level service delivery with reference hospitals. The IDB funds a four-year $38 million health project with the MSPP which will end in 2008 to construct, renovate and equip 60 hospitals and train staff. The WHO/PAHO, UNICEF, French Cooperation, and the EU are providing technical assistance and commodities in selected departments and equipment support to the public sector.

While all donors are providing major inputs to the national health system, little investment is being made to ensure adequate drugs and consumable supplies. USAID is

the major supplier of contraceptives and supports the logistics and distribution of these contraceptives to USAID target areas. UNFPA also provides commodities, which includes primarily condoms. In addition, USAID through PEPFAR (co-implemented by CDC and USAID) purchases anti-retroviral drugs, HIV/AIDS commodities, laboratory supplies, test kits and drugs for opportunistic infections for Haiti and provides technical assistance to strengthen commodities logistics and distribution for these HIV commodities in each of the 10 departments.

VIII. Preliminary Findings of the 2005 Demographic Health Survey (DHS) and Future Direction of USAID Health Sector Assistance

Child Survival: Although the infant and child mortality rate has decreased slightly, almost the full range of indicators underlying the rate has either stagnated or worsened over the last five years. The levels of breastfeeding have fallen to unacceptably low levels. Exclusive breastfeeding has fallen from 40.7% in 2000 to 2% in 2005 while levels of bottle feeding have risen from a low of 3.9% to 22.5% during the same period. Immunizations range from 10% to 40% nationwide. The incidence of diarrhea and acute respiratory infections (ARI) have held steady, but rates of treatment of ARI have been nearly halved. In 2000, 39.5% of children were treated for ARI at a health center, but this percentage drops to 20.4% in 2005. Nutritional status data are not yet available and the departmental level data required to make recommendations for geographical targeting will only be available following the secondary DHS analysis due to be completed in February 2007.

At 41.3 %, full immunization rates are the worst in the Western Hemisphere and well below the internationally accepted rates of 85% or higher nationwide critical in reducing the threat of epidemics. The immunization challenge is to identify and reach the 10.6 % of children who receive no immunizations and ensure follow-up for the 30% who get the first immunization but drop out before the third. Once the secondary DHS analysis is completed, it will be possible to make recommendations for geographical targeting for immunization, ARI, diarrheal disease, and child nutrition programs, including better targeting of rural areas and urban hot spots.

The 2005 DHS data on malnutrition are presently being analyzed. However, data from the 2000 DHS reveal that 23% for children 5 and under suffered from chronic malnutrition (low height for age), 17% were low weight for age and 4.5% suffered from low weight for height. Pregnant women who are underweight are at higher risk of maternal mortality and poor pre-natal nutrition. This is the primary factor underlying chronic malnutrition in children and low-birth weight infants and contributes to infant mortality.

Maternal Health: Maternal mortality rates are being analyzed under the 2005 DHS. There is evidence to suggest that high levels of maternal malnutrition and high rates of unsupervised births contribute to poor maternal health and maternal death. Twelve percent of Haitian women are considered to suffer from chronic energy deficiency as measured by body mass index. While many births occur at home and are attended by

matrons, traditional birth attendants (TBAs), they often have had little or no formal training. The system of identifying and referring high risk pregnant women to a health facility prior to the birth is weak. Given the limited ability to predict high risks births, a community based approach to emergency obstetrical care (EOC) should be considered in rural areas. Initial DHS data on pre-natal care visits show care is dropping in urban areas (78% in 2000 vs. 71.5% in 2005) while pre-natal care rates are increasing in rural areas (50% vs. 52.6%).

USAID assistance will support the MSPP to strengthen maternal health services in three key areas: pre-natal; post-natal and prevention of HIV from mother to child transmission (PMTCT) Pre-natal and maternity care aims to continue providing at least three pre-natal check-ups at the service delivery point where pregnant women receive medical care. These services include health education, nutrition during pregnancy, and family planning and birth spacing to protect the health of the mother and her newborn. The "Safe Delivery" intervention focuses on having a trained health provider present during childbirth and paying attention to the "critical delays" in accessing care. Post-natal care is critical to ensure the health of the baby as well as that of the mother in the post delivery period. Ideally a trained TBA should visit the woman at home within the first 24 hours of delivery. At a minimum, the woman should be encouraged to visit the health facility six weeks after delivery and TBAs should play an important role to ensure that the visit takes place. The major thrust of the PMTCT component is to reduce mother-to-child-transmission of HIV/AIDS through testing, diagnosis and treatment of pregnant women. Administration of anti-retroviral drugs (ARVs) is used to reduce by two-thirds the number of HIV positive women who transmit the virus to their newborn infants. Emphasis will be placed on informing HIV-positive mothers about breastfeeding options to reduce vertical transmission to their newborn, assisting them with dietary and nutritional assessments for themselves and their young children, and educating them on optimal feeding and weaning practices for their newborn.

Family Planning: The 2005 DHS concluded that the fertility rate (the average number of children per woman of reproductive age) fell from 4.7 children per woman in 2000 to an average of 4 children per women. The rapidly dropping rates of fertility do not correspond with the stagnant levels of contraceptive use. The contraceptive prevalence rate, or the numbers of women of reproductive age using contraception (all methods) increased slightly from 22% in 2000 to 24.8% in 2006—one of the lowest rates in the Western Hemisphere. Contraceptive prevalence in USAID-supported sites is approximately 30%. The data suggest use of modern contraceptive methods nationwide is stagnant and that new users are choosing less reliable traditional methods as often as or more often than modern. Nevertheless, unmet need for family planning in Haiti increased from an extremely high level of 56% in 2000 to almost six in ten women in 2005 (57.3%). Over 82% of Haitian women surveyed either do not want a child in the coming two years (30.4%) or do not want any more children (51.7%). These data confirm that quality contraceptive products and services are in high demand and are presently a "missed opportunity". However, weak commodities management and logistics systems continue to present challenges in meeting client needs for modern contraception. Stock

outs in contraceptive supplies and an in adequate method mix has contributed to lack luster performance and stagnation in contraception use for several years.

Following a year of policy and advocacy by USAID, a national committee was established at the MSPP to outline the essential requirements to reposition family planning as a primary component of reducing maternal mortality and improving child survival. The MSPP determined it would engage community decision makers and partners that deliver services to work together to re-launch family planning in their programs. Departmental committees have been formed to oversee and plan strategically for the re-introduction of family planning as a necessary component of maternal health. Demonstrating the importance of the family planning program to the GOH, in late 2006, the Prime Minister and US Ambassador will open a national conference, *Repositionnment Du Planning Familial en Haiti.* The goal of this initiative is for MSPP is to strive to provide universal access to family planning for all women and men of reproductive age who want `to space or limit their families. USAID assistance will support a broader mix of family planning methods including natural family planning, long lasting methods and permanent surgical contraceptives. Assistance will also be provided to support treatment and diagnosis of STIs and other sexually transmitted infections among those at risk for unintended pregnancy and disease. Although the MSPP's objective is to increase the contraceptive prevalence rate from 22% in 2005 to 40% in the next five years is overly ambitious, it does however speak to the importance the MSPP has placed on reinvigorating family planning services. In order to achieve this, attention to clinical methods for men and women will be a major component of Haiti's Repositioning FP initiative. With the renewed interest by the new government and strong commitment among NGO and civil society groups, this initiative presents an opportunity to revamp family planning in Haiti. (For more information, see electronic background documents and analyses on the repositioning family planning initiative).

HIV/AIDS: Haiti's HIV epidemic is the most severe in the Caribbean region. According to the 2005 DHS, Haiti has a sero-prevalence rate of 2.2%. Although new infections are probably being driven by the most-at-risk populations of commercial sex workers, mobile working men and out of school youth engaging in unprotected transactional sex, there are now indications that some transmissions are being driven by the general population. A close look at age-specific rates in the 2005 DHS paints an alarming picture of an epidemic that is not only infecting women at greater rates than men, but one in which young people are at particular risk. The sero-prevalence rate in young women age 20-24 (2.4%) exceeds the national average and is double the rate in young men (1.2%). Knowledge of AIDS increased substantially for men and women between 2000 and 2005; however, significant behavior change associated with this knowledge did not occur. USAID assistance will be provided through the Presidential Emergency Plan for AIDS Relief (PEPFAR). The intent of USAID's assistance is to provide an integrated package of treatment services in selected sites, a comprehensive approach to promoting prevention through abstinence, being faithful and correct and consistent condom use, and establishing a continuum of services from prevention to care.

USAID will continue to provide treatment and care through its network of NGO partners and the MSPP to people infected with HIV. Under this Task Order, a subset of the approximately 100 NGOs and 30 MSPP *Zones Cibleés*, plan to reach approximately 15% of the population who will be in need of ARVs. In order to provide a comprehensive approach, the Offeror will integrate HIV/AIDS prevention, care and treatment with TB, STI, family planning and maternal health and child survival (MCH) services. Assistance will support treatment, care and prevention services to vulnerable groups who are either at risk or have been affected by HIV/AIDS—either directly or indirectly. Maternal health services will be available to pregnant women who request counseling and testing (CT) for HIV. With PEPFAR funding, CT services will be provided at some 90 sites throughout Haiti. Palliative care to PLWAs will also be expanded under the Task Order to reach about 25% of the estimated numbers of PLWAs who will need treatment through the NGO and MSPP *Zones Cibleés* health facilities. Clinical skills of health personnel, especially nurses, will be improved to provide anti retroviral therapy (ART). Psychologists and social workers will be trained to provide counseling, psycho-social support and education to those infected and affected by HIV. Assistance will also be provided to orphans and vulnerable children (OVC) infected and affected by HIV with counseling, care and treatment as well as community support.

Tuberculosis: Haiti has the highest TB incidence rate in the Latin America and Caribbean (LAC) Region with an estimated incidence of 306/100,000 population in 2004. There is still a considerable way to go to achieve the national and global targets of 70% case detection and 85% treatment success. Only 55% of the country is covered by the Directly Observed Therapy-short course (DOTS). DOTS case detection is only 49% and only 78% of cases detected were successfully treated. There is a 40% co-infection rate for HIV and TB and the lack of integrated detection and treatment programs hinders care and treatment. USAID assistance under this Task Order will increase case detection and treatment in the USAID financed target areas and better integrates TB and HIV programming.

Gender. Gender is an important consideration in this new procurement. Attention will focus on the linkages between violence against women and maternal health and health pregnancy outcomes. Analysis of the 2005 Demographic and Health Survey (DHS) revealed that more than one in three women (35.2%) reported have been a victim of physical violence since the age of 15, with 15.4% of women having suffered domestic violence in the previous year, and 7% reporting violence during pregnancy.

DHS data reveal that improving men's knowledge of family planning and encouraging positive health seeking behavior are important considerations in improving the health of women. Data from the DHS also indicate that men are engaging in much higher levels of risky behavior than women, warranting a focus on male behavior in order to reduce multiple partnerships, reduce occurrence of high-risk sex, and increase condom use. The DHS also suggests that family planning information be targeted to males to encourage higher condom use and to involve them in family planning decision making with their partners. In addition, since prevention of HIV transmission is a personal matter, information about prevention must include messages on personal risk assessment and

development of personal prevention plans linked to behavior change. USAID health assistance will include gender considerations.

IX. Youth at Risk

According to the Haitian Child Institute, over 61% of Haiti's population is age 24 or under. There are an estimated 2.7 million young people in the 10-24 age group. The age of sexual debut (average age at first sex) continues to fall for both young men and women. Age at first sex for young women has decreased by more than a year over the past five years, falling to 17.8 years in 2005. Twenty-eight percent (28%) of young women have sex before the age of 15. For young men, the age of debut has dropped by 1.5 years to 15.3 years in 2005. Sixty-two percent (62%) of boys have sex before the age of 15. Twenty-one per cent (21%) of young people age 15 to 24 report they have had non-consensual or forced sex. A recent study reported that 17% of boys and 5% of girls in this same age group have had sex for money or other favors.

Rates of high-risk sex in young women and men are double the average rates in all adults 15-49 years of age: 47.1% of young women and 91.1% of young men under the age of 24 have had unprotected sex in the past year. While only 2.2 % of young women report having two or more partners in the past year, nearly one third (32.1%) of young men report having two ore more partner during the same period. Women report 1.9 lifetime partners; among men 15-24 years of age the mean number of partners in the past year is 5.8. Focus group discussions also indicate that many younger women are having sex with older men. Young women 15-24 suffer from sexually transmitted infections (STIs) at rates much higher than the national average, making them more at risk for HIV transmission.

For example, 47.1% of young women and 91.1% of young men age 15-24, and 98% and 99.3% of never-married women and men report having had high-risk sex in the past year. Another way to describe the risk associated with this unprotected sex is as follows: on average, a person having unprotected sex in Haiti has a 1 in 25 chance that the sex will be with an individual who is sero-positive. For a young woman in the 20-24 year age group having sex with a young man in the same age group, there is a 1 in 16 chance of having sex with an infected partner. For a young woman in the 20-24 year age group having sex with a man in the 40-44 year age group, there is a 1 in 12 chance that the sex is with an infected partner. The DHS data suggest that USAID assistance needs to directly address the reproductive health issues and high risk behavior among youth in order to affect behavior change, reduce risky behavior and slow down HIV transmission among youth, especially, among young women.

X. Strategic Priorities in Health for the Increased Access to the Quality Basic Social Services Program

In preparation for developing this Task Order, USAID conducted various technical evaluations and analyses including an analysis of the 2000 DHS and the preliminary data from the 2005 DHS. These data have provided data sets and charts that show trends in

child survival, family planning, maternal health and HIV/AIDS and allowed USAID to identify strategic interventions for USAID assistance in the health sector.

To promote synergies among complementary initiatives, in August 2006 the activities of the Health, Education and Food Security and Humanitarian Assistance Offices were combined to form one SO. This step complemented the evaluation recommendations of the *Haiti Santé* 2004-2007. The new Social Services Strategic Objective will strengthen the links between health and nutrition and reach youth both in and out of school. There may also be opportunities to explore links between the Livelihood SO and the Governance SO to address gender violence as a factor of poor pregnancy outcomes and maternal mortality.

As mentioned briefly Section V above, an external evaluation of the *Haiti Santé* (HS) Haiti Health 2004-2007 was undertaken which outlined the major successes, gaps and lessons learned to date, and made recommendations for future USAID assistance. The evaluation looked at all elements of the existing health project including: overall management; financial management; local capacity building; integrated service delivery; maternal and neonatal health; child survival, nutrition and growth monitoring; acute respiratory infections; diarrhea control and oral rehydration therapy; and reproductive health and family planning. The evaluation team looked at several initiatives currently funded under PEPFAR in order to understand the synergies between the two health programs and where HS 2007 and PEPFAR complemented each other and identified opportunities for further collaboration.

The evaluation was generally positive about the contributions that USAID's prime contractor made to the MSPP's overall health program. The evaluation acknowledged the challenging environment in which HS 2004-2007 has been, and is being, implemented. Furthermore, the evaluation concluded that the prime contractor was able to mobilize international partners and local service delivery NGOs to overcome a wide variety of challenges to deliver the results expected by USAID. The contractor's ability to adapt quickly to the evolving, often volatile, circumstances in Haiti, and to the shifting priorities of USAID, was critical to achieving success. This implementation strategy resulted in improved health status of the Haitian population served by a consortium of NGOs. This network of NGO partners was able to fill the void created by the near collapse of the GOH and the inability of the MSPP to provide health services.

The evaluation finding and various analyses undertaken by USAID, reaffirm that the components of the on-going primary health care portfolio for the Basic Social Services SO be continued. The basic package of services include: support for integrated management of childhood illnesses, prevention and treatment of diarrheal diseases and acute respiratory infections, breastfeeding promotion and targeted feeding); maternal health interventions--emergency obstetric care services, pre and post natal care services; family planning; and reproductive health services, including treatment of sexually transmitted diseases; TB and HIV/AIDS care, treatment and prevention services. The analyses also highlight the need to reposition family planning services to protect maternal and child health and ensure that a wider variety of methods are available, especially

clinical methods, to respond to the high levels of unmet demand for theses services. More attention is also needed to address youth between the ages of 15 and 24 with a wide variety of reproductive health, HIV/AIDS, and social service programs.

The analyses have consistently identified the weak leadership and the centralization of authority within the MSPP at the national level as major constraints to the provision of health services and commend the HS2007 for addressing these problems. Further, it encourages continued assistance to the MSPP, at all levels, to build on the foundation of what has been accomplished to date by assisting the MSPP to implement its decentralization plan. Under this Task Order, support will be provided to the MSPP in adapting to its new role of policy development, articulation of technical norms and standards, as well as the standardization of program guidelines for management, implementation and supervision of services. This assistance will continue the performance based incentive program with the NGO service providers, and encourage the new contract to experiment with a similar program with the public sector sites in the *Zones Cibleés* in reaching hard to reach underserved rural areas and urban hot spots. Additionally, it is acknowledged that a strategy must be developed to wean some of the stronger NGOs away from 100 per cent funding by USAID to a cost sharing model by which the secure funding from other donors (local and international), other USG entities or by developing sliding scales of fee for service for their clients who could pay a nominal amount for quality services.

Several analyses address the need for further training of various cadres of personnel and that linkages be further explored and developed between Haitian health training institutions and universities or teaching hospitals in the United States. Several U.S. institutions and universities already collaborate with Haitian NGOs and Universities. Harvard University collaborates with Partners in Health; March Hospital is linked with Tulane University; *Hopital Justinien of Cap-Haitian* is linked with the University of Miami, to name a few. Discussions with colleagues inside and exterior to USAID suggest these linkages be expanded to provide additional opportunities in the areas of continuing education for doctors, nurses, and auxiliary health personnel. Transfers of new technology and training in the provision of quality of care should take place in Haiti, where possible. In order to establish formal linkages, separate support will be provided through USAID's Higher Education Program to strengthen partnerships between Haiti and the US for training health personnel.

XI. Grants Under Contract Mechanism

In an effort to promote innovative, creative and flexible development approaches, a small "grants under contract" (GUC) mechanism will be introduced as part of the awarded contract. The GUC mechanism is estimated at a maximum of $3 million for the life of the contract, but will not exceed more than $1 million per year. This GUC mechanism may be used to bring in new partnerships or establish coalitions with local community based organizations (CBOs), faith-based organizations (FBOs) and other civil society groups to support decentralization of health care services. For example, a women's organization that is working on micro-finance activities for women may be interested in

adding a family planning component to their program or an out-of school youth education program may be interested in adding an HIV/AIDS education component to their curriculum. The GUC mechanism may be a useful and flexible tool to provide health sector assistance in USAID-identified "hot spots". Prior to implementation, criteria for the GUC mechanism would be developed in collaboration with USAID.

XII. Global Development Alliance or Other Private Sector Partnerships & Contributions

USAID's Global Development Alliance (GDA) works to enhance development impact by mobilizing ideas, efforts and resources of the public sector with those of the private sector, NGOs and foundations. An "alliance" is a formal agreement between two or more parties created to jointly define and address a development problem. Alliance partners combine resources, risks and rewards in pursuit of common objectives. It is believed that such an alliance will promote public-private partnerships that will bring new resources, new ideas, new technologies and/or new partners to address the health problems facing Haiti. Potential public-private partnerships will likely focus on strengthening alliances among local stake holders, international and local foundations, the Haitian *Diaspora*, represented in part by the Haitian Association of Private Health Care Organizations and the Association of Haitian Medical Doctors and the communities from which they originate, neighborhood organizations, education and student groups. These alliances may play an important role as proponents of participatory and democratic mechanisms for decision-making at the local level. To encourage creativity and promotion of private sector partnerships with USAID health sector assistance, Offerors are required to provide a minimum of 20% of matching private sector (which includes non-profit and in-kind) funding as part of the Offeror's proposed budget. The 20% matching funds cannot include MSPP matching funds or matching funds from proposed sub-contract or sub-grant implementing partners who will be responsible for implementation of health care services at the department or community level.

XIII. Cross-Cutting Themes

Assistance under this Task Order will focus interventions in and around the approximate 100 NGO and 30 *Zones Ciblees* public sector service delivery points in all 10 departments. Health services will be targeted in USAID's underserved rural areas, the two water sheds in the North and West Departments, conflict-prone areas or the six "hot-spots" of Petit Goave, Port-au-Prince, St. Marc, Gonaives, Cap Haitian, and Les Cayes. The activities also focus on demographic targets of concern, principally children, youth, women and vulnerable groups, such as orphans and TB/HIV+ people in need of care. All program elements under the Task Order address the cross-cutting concern of involving civil society and local community based NGOs, CBOs and faith-based organizations (FBOs). This assistance will also enhance public sector accountability and transparency and promote civil society participation. In addition, support will focus on strengthening the MSPP capacity in policy formulation, development of technical guidelines and improving their monitoring and supervision of health services. Support to the MSPP and

NGOs will deepen public private partnerships in the delivery of health services at the departmental level to underserved groups.

Bringing health messages and services to groups that are already targeted for assistance provide opportunities to link the health activities of the Social Services SO to activities in USAID's Livelihoods and Governance strategic objectives. For example research around the world has shown that men are as interested in family planning messages as women. Linking health messages or services to livelihood assistance provide a unique opportunity to reach out to men and out-of- school youth, as well as women, in their places of work. Provision of food and nutrition support near or in health clinics, provide an incentive for women to enter the health system. Likewise, health messages that are behavior change focused and stress avoidance of high risk behaviors could be incorporated into curricula (print and radio) for out-of -school youth and other high risk groups. School children are another well-defined sub-group who can be reached with messages about nutrition and the importance of detection and treatment of TB as well as messages about sexuality and associated health risks.

Under this Task Order, another cross-cutting theme that will continue to receive assistance is decentralization, deconcentration and executive leadership support of the MSPP. This assistance will strengthen local executive leadership by placing more responsibility on the Department Health Directors in the 10 regions and their staff, municipal entities and individuals in both the private and public sectors. These efforts in turn, support the governance initiatives, and will increase transparency and accountability in the delivery of critical health services while at the same time bringing government services closer to the people.

XIV. Title

"Quality Basic Health Services Assistance to Haiti"

Note that this is a generic name given to this solicitation. Offerors may propose a unique name for their proposed program in their proposal submission.

XV. Objective

Under this Task Order, the objective is to improve the health status of vulnerable populations so that they can become more productive members of society to promote stability within their communities and participate in the economic and social development of Haiti. Specifically, the technical assistance delivered under this Task Order targets approximately 50% of the Haitian population and aims to increase their use of an integrated package of basic health services that includes maternal and child health care, family planning services and prevention and control of diseases of major importance, including HIV/AIDS. Both public (*Zones Ciblees*) and private (non-profit) sector health care delivery will be strengthened as well as the MSPP's ability to carry out their executive function role at the central and department level. In this regard, at the end of the contract, the MSPP will have significantly improved its ability to lead and

strategically manage decentralized health care delivery in Haiti. A special focus of technical assistance under this Task Order will be to support the improvement of stability in "hot spots" as identified by USAID.

XVI. Statement of Work

Period of Performance: Under this Task Order, the contractor will begin work as soon as the contract is awarded. The initial activities under this Task Order will overlap and complement those of the current USAID health sector assistance that is ending on or before September 2007. To ensure a smooth and cost-efficient transition, USAID will to the extent feasible facilitate the transfer of equipment, vehicles, and office space from the current contractor to the new contractor. (Please refer to USAID documents "List of Equipment & Vehicles"). The period of performance is three years from the start of the contract. Offerors are reminded that USAID may chose to extend the contract for up to an additional two years through two one-year extensions of the awarded contract. For multi-year planning, extension possibilities will be determined towards the end of year two of the contract.

Geographic Focus: Initially and at a minimum during year one, assistance under this Task Order will continue to target approximately 50% of the population and maintain service delivery in approximately 100 NGO service delivery sites and 30 MSPP *Zones Cibleés* service delivery sites that have received assistance in the past year from USAID. In years two and three, the contractor may propose changes to service delivery sites and geographical focus; however any final changes in geographic focus will be approved by USAID. In addition, as part of this geographic focus, the contractor will ensure that assistance is delivered in the six USAID-identified "hot spots" - Petit Goave, Port-au-Prince, Gonaives, St. Marc, Cap Haitian and Les Cayes, and the two "watershed" zones in the North and West Departments. Finalization of the type of and specific geographical location of assistance in the "hot spots" and two watersheds will be determined during the first 30 to 60 days of the awarded contract in partnership with other USAID implementing partners also directed to work in these same geographical areas. Flexibility of assistance delivery and site selection within identified "hot spots" will be required throughout the entire time period of the contact in order to enable USAID to meet the most pressing needs within these hotspots. As indicated earlier, all USAID implementing partners working in the six "hot spots" and two "watersheds" will be required to work in a coordinated approach to maximize and leverage USAID funding. See list of tables and maps in the electronic document section of this Task Order, which clearly indicate the geographical target area (service delivery sites) and the type of services to be delivered at each site. Note that not all services (i.e. HIV and TB services) will be delivered in all service delivery sites.

Other USAID Health Sector Assistance: Under the health component of the Social Services SO, there are other USAID health sector assistance activities that are being implemented by other USAID implementing partners. These activities support the technical assistance to be implemented under this Task Order but are not a part of this Task Order. The awarded contractor for this Task Order will need to work in partnership

with these other implementing partners. The most critical of these other assistance activities includes USAID's direct procurement of family planning and HIV/AIDS commodities that are used within several of the service delivery sites that are the geographic focus of this Task Order.

Funding: The estimated value of this procurement over three years (2007-2010) is $43 million with the following illustrative budget. The Offeror is expected to provide a 20% match in private sector funding.

Illustrative Budget

Program Funding Source	**FY 2007 (000)**	**FY 2008 (000)**	**FY 2009 (000)**
Child Survival Maternal Health	$ 4,500	$ 5,500	$ 5,500
Support Family Planning	$ 4,000	$ 5,000	$ 5,000
TB	$ 500	$ 500	$ 500
PEPFAR/HIV/AIDS	$ 3,550	$ 4,000	$ 4,000
Total IQC Contract	**$13,550**	**$15,000**	**$15,000**
Offeror 20% Match	**$ 2,710**	**$ 3,000**	**$ 3,000**
Total	**$16,250**	**$18,000**	**$18,000**

Important note on PEPFAR Funding: For the purpose of the Task Order, the Offeror should assume that the PEPFAR budget will be straight lined at $4 million in FY08 in the categories listed below. Although FY08 is the last year of PEPFAR funding, it is assumed that USAID will continue to receive HIV/AIDS funding in FY09 at approximately the previous year's levels.

PEPFAR FY07 proposed funding is broken down as follows:

PEPFAR	**Amount ($000)**
PMTCT	$ 350
Prevention Abstinence be Faithful	$ 440
Condoms, other prevention	$ 340
TB/HIV	$ 100
Counseling and Testing	$ 250
ARV Services	$1,875
Palliative Care	200
Total	**$3,555**

XVII. Applicable Supporting Background Documents

The following documents are available electronically at http://www.hausaid.info/index.jsp and form a part of this Task Order.

A. USAID Documents

1. HIV/AIDS Behavior Survey Summary Report (USAID, FHI, Center for Evaluation and Applied Research and Haitian Child Health Institute) 2003.
2. Activity Approval Document for SO Increased Access to Quality Social Services, September 8, 2006.
3. Demographic and Health Survey for Haiti (DHS) 2000 power point presentation.
4. Demographic and Health Survey for Haiti (DHS) 2005-2006, Preliminary Report, July 2006.
5. Demographic and Health Survey for Haiti (DHS) 2005-2006 power point presentation.
6. Demographic and Health Survey (DHS) 2005-2006, slide HIV/AIDS prevalence by geographic department.
7. Executive Summary for Next Steps in Planning the New PHN Health Strategy, USAID/Haiti PHN Office, January 2006.
8. Gender Assessment for USAID/Haiti Country Strategy, Draft June 2006
9. Haiti Health Project, Haiti Santé HS2004-2007 Evaluation, Media Link, July 2006
10. Haiti Health Sector Summit, June 2003, Summit Proceedings.
11. PEPFAR Country Operational Plans (executive summaries) 2005 and 2006
12. *Repositionnement Du Planning Familial En Haïti,* Issakha Diallo, July 2006.
13. Synthesis of Bilateral Health Project Evaluation, Eilene Oldwine, September, 2006.
14. USAID/Haiti ARV Treatment and Care sites, June, 2006.
15. USAID/Haiti Strategy Statement FY 2007-2009, July 5, 2006. Public Version
16. USAID/Haiti Quality Basic Social Services Strategy (SO 12) Power Point Presentation, October 2006.
17. USAID/Haiti Map of Geographic Coverage by NGOs Service Delivery Points. August 2006
18. USAID/Haiti Map of Geographic Coverage of Services Offered at Service MSPP *Zones Cibleés* Delivery Points, August 2006.
19. USAID/Haiti List of NGO and *Zones Cibleés* Service Delivery Points, December *2006.*
20. USG Haiti PEPFAR- List of HIV/AIDS Sites and Services, 2006
21 USAID/Haiti Infectious Diseases Strategy 2006-2009.
22. USAID/Haiti PEPFAR Behavior Change Communications Map, August, 2006.
23. USAID/Haiti Summary Annual Report, November, 2006
24. USAID/Haiti "*HS2007 Performance Based Financing Mode1"* Fact sheet, *2005*
25. USAID/Haiti "Virtual Leadership Development & Management" Fact sheet, 2006
26. Abstinence, Being Faithful and Condoms (ABC) Guidelines, Office of Global AIDS Coordinator (OGAC), 2005. See www.pepfar.state.gov for more details related to PEPFAR requirements.
27. List of equipment and vehicles which could be transferred to the new project.

B. Government of Haïti Documents

1. *République d'Haïti, Conférence Internationale pour le Développement Economique et Sociale d'Haïti, July 2006.*

2. *République d'Haïti, Une Fenêtre D'Opportunité Pour Haïti, Stratégie Intérimaire pour la Réduction de la Pauvreté (DSRP-1),* Septembre 27, 2006

3. *Ministre de la Santé Publique, Plan Stratégique National pour la Reforme du Secteur de la Santé,* Novembre, 2005.

4. *Ministre de la Santé Publique, Manuel de Gestion Financière et Comptable, 2006.*

5. *"Declaration de Politique General",* Speech to the Haitian Senate by Prime Minister Jacques Edouard Alexis, June 2006.

XVIII. Performance Requirements

The performance requirements below incorporate the program elements and indicators of the "Investing in People" Objective of new USG Foreign Assistance Strategy Framework. Upon award of the contract, final indicators and requirements in line with the new guidance from the Director of Foreign Assistance will be provided to the contractor. Given that the guidance from the Director of Foreign Assistance is evolving, the contractor and USAID may need to make changes to indicators and development assistance terminology and approach during the time period of the contract.

The contractor is responsible for tasks and achievement of results outlined below over the period of performance. USAID has multi-year data on the approximate 100 NGO service delivery sites and one-year data on the 30 *Zones Ciblees* service delivery sites identified as the geographic target area for this Task Order. Upon award of the Task Order, in consultation with USAID, the contractor will analyze this data and establish baselines and targets based on this data. (See list of tables and maps in the electronic document section of this Task Order, which clearly indicate geographical focus areas for implementation of technical assistance under this Task Order.)

Program Element Result #1 HIV/AIDS: This element has three key components: 1) HIV treatment services; 2) palliative care; and 3) prevention services, including voluntary counseling and testing (VCT) and prevention of mother to child transmission (PMTCT).

HIV/AIDS Result Summary. By 2010, USAID expects that ART treatment, palliative care and prevention services will be made more widely available. Under this Task Order, the contractor will maintain HIV/AIDS services in 42 designated existing sites that are part of the geographic target area. Of these 42 sites, 5 offer the complete package ARV, PMTCT, TB/HIV Palliative care and voluntary testing and services. Nineteen sites offer only PMTCT, TB/HIV Palliative care, and VCT services. Twenty-four sites offer only TB/HIV and VCT Services. The remaining 18 sites offer only VCT services. See table

in the electronic document section of this Task Order that indicates the exact geographic target areas and which type of service(s) to be delivered in each service delivery site). In Years 2 and 3, expansion of HIV/AIDS services beyond this identified geographical target area will be considered pending the availability of funding. The contractor will link this element with all other elements for TB, Maternal and Child Health and Family Planning integrate HIV into on-going health services.

Indicators:

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful.	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of individuals trained annually to promote HIV/AIDS prevention through abstinence and/or being faithful.	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of individuals trained annually to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of individuals who received counseling and testing for HIV and received their test results annually.	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of health workers trained annually in counseling and testing for HIV according to national and international standards.	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of individuals provided with HIV-related palliative care (including TB/HIV)	Actual 2006 Target 2007 Target 2008 Target 2009 Target 2010	TBD TBD TBD TBD TBD
Number of individuals receiving ARV therapy at the end of the reporting period.	Actual 2006 Target 2007	TBD TBD

	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of health workers trained annually to deliver ARV therapy services, according to national and international guidelines.	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of service delivery sites providing ARV therapy	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of individuals trained in the provision of laboratory-related activities	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of individuals trained in HIV-related stigma and discrimination reduction	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD
Number of individuals trained in HIV-related community mobilization for prevention, care and/or treatment	Actual 2006	TBD
	Target 2007	TBD
	Target 2008	TBD
	Target 2009	TBD
	Target 2010	TBD

Performance Requirements for Result #1 HIV/AIDS: Building on USG PEPFAR investments in HIV, the contractor will provide a HIV/AIDS treatment, care and prevention in the above identified geographical target area with a focus on integrating these services into maternal and child health, family planning and STI health care services. Special attention will be given to increasing HIV services in the "hot spots" of Petit Goave, Port-au-Prince, St. Marc, Gonaives, Cap Haitian, and Les Cayes and in the two "watershed" areas. The USG Haiti PEPFAR program funds a variety of HIV/AIDS

activities primarily channeled through USAID and CDC. CDC provides support for clinical services for treatment and care and strengthening the laboratories used to detect infectious diseases. USAID focuses on prevention of new cases, integrated HIV and basic health service delivery and care at the community level. The contractor will collaborate with other PEPFAR funded partners to avoid duplication or double counting of results within the same organization. Refer to Result #3 for detailed PMTCT performance requirements.

HIV treatment. The contractor will maintain HIV treatment services in the above identified geographical target area annually. The contractor will continue to provide HIV testing and ARV treatment to HIV/AIDS infected patients. Also, the contractor will provide refresher training of health personnel in ARV service delivery, patient compliance, lab services, and modest infrastructure improvements to assure the quality of ARV care. The contractor will promote integration of HIV and TB to ensure a comprehensive approach to treatment of patients co-infected by both. USAID is providing ARV drugs, lab supplies and test kits through a separate centrally funded supply chain management mechanism. The contractor will collaborate with the supply chain management partner in acquiring drugs and supplies for HIV testing and treatment, including drugs for opportunistic infections.

Palliative Care. The contractor will provide palliative care services to approximately 15,000 PLWHAs within the above identified geographical target areas. Linkages will also be created with ARV clinical sites in order to provide a continuum of HIV care and treatment services. Physicians, nurses, social workers, and community workers will be trained in psycho-social counseling techniques in order provide a complete package of social support services. The contractor will ensure that this package includes home based care services, where community workers will conduct home visits and provide health and hygiene education, pain management, water purification products for safe water, malaria prevention and nutrition. The contractor will collaborate with other PEPFAR partners to ensure uniform training and adherence to national guidelines for the provision of palliative care. The contractor will also work with the supply change management partner to secure drugs and supplies for treatment of opportunistic infections and palliative care.

Prevention. While HIV prevalence is on a downward trend, there are still pockets of prevalence which are higher than the national average (2.2%) according to the 2005 DHS. Within the above identified geographical target areas, the contractor will deepen prevention interventions including VCT in departments with some of the highest HIV rates, such as the Nippes and North Department (3%) and Northeast Department (2.7%) The contractor will work with a subset of NGO partners who are currently providing health services at the community level to strengthen prevention efforts. The contractor will undertake community based mobilization and the promotion of messages encouraging a comprehensive ABC approach—abstinence, being faithful and condoms. (See OGAC *ABC Prevention* Guidelines in electronic document section of this Task Order.) Training of youth and adult educators will be undertaken to target their peers with age appropriate prevention messages. Youth 10-14 not yet sexually active, will be

targeted with abstinence only messages. Those older sexually active youth, adults, couples and most at risk groups such as mobile populations, commercial sex workers and men in uniform will be targeted with risk reduction messages, including correct and consistent condom use. The contractor will ensure linkages for counseling and testing for most –at- risk- groups to reduce high risk behavior and transmission of HIV.

Performance Standards for Result #1 HIV/AIDS: At a minimum

1.1 Establish Year 1 baseline and annual targets for indicators under this program element.
1.2 Maintain an integrated package of ARV treatment, palliative care, and PMTCT and VCT services in the above identified geographic target area at a minimum in Year 1.
1.3 Meet the targets for ARV, HIV/TB palliative care and prevention services as determined by USAID and the contractor.
1.4 Pending funding availability, expand integrated ARV treatment and care services to additional sites by Year 2 and Year 3.
1.5 Pending funding availability expand pediatric HIV care and treatment services in above identified geographic target area in consultation with USAID.
1.6. Annually and as needed, train 200 health professionals in ART service provision and train 400 in HIV-related palliative care.
1.7 Annually, establish HIV/AIDS peer educator programs targeting youth and adults with age-appropriate behavior change prevention messages with approximately 15 NGOs and expand in subsequent years pending funding availability.
1.8 Annually, train 600 youth and adult peer educators in HIV/AIDS prevention messages.
1.9 Establish 15 NGO advocacy programs with community leaders to promote positive health behaviors with respect to disease prevention and expand in subsequent years pending funding availability.

Program Element Result #2 Tuberculosis: This element has two key components: 1) detection of new cases and 2) treatment of TB cases.

Tuberculosis Result Summary: By 2010, USAID expects that TB case detection and treatment will increase in 20 sites operated by the two key TB NGO partners--the International Child Care (ICC) and Centre pour le Development de la Sante *(CDS)* in six departments. See table in the electronic document section of this Task Order that indicates the exact geographic target areas and which type of service(s) to be delivered. This element is closely linked with the above Program Element Result #1: HIV/AIDS.

Indicators:

Percentage of the Estimated Number of New Smear –positive TB cases that were detected under DOTS	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Percent of all registered TB patients who are tested for HIV	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Percent of laboratories performing TB microscopy with over 95% correct microscopy results	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of people (medical personnel, health workers, community workers, etc.) trained in DOTS	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Performance Requirements for Result # 2 Tuberculosis: Building on USAID investments, the contractor will work with and support the two main TB NGO partners ICC and CDS to continue and/or initiate TB case detection and treatment in the above identified geographic target area. The number of TB patients being screened and treated is expected to increase and the contractor will expand the use of the Directly Observed Therapy Strategy (DOTS) throughout the 20 sites.

Detection of TB cases: Detection of cases will be done routinely at the clinics for every patient with signs and symptoms of TB according to MSPP/WHO guidelines and protocols. To improve case detection, health personnel will be trained in identifying symptoms such as a cough lasting more than two weeks, night sweats, weight loss or any other signs as defined by MSPP/WHO. HIV patients will be systematically screened for TB because of the high co infection rate which is about 30%. Staff will be trained in sputum smear microscopy as well as rapid testing for HIV/AIDS patients. This training is expected to increase the volume of case detection in patients suspected of having TB and accelerate testing of sputum smears to confirm TB infection. The contractor will reinforce the current system of quality control of the laboratory network in the geographic target area by rechecking of slides, results and periodic external reviews through ICC central laboratory or the National Reference Laboratory both located in Port au Prince.

Treatment of TB cases: Ensuring TB treatment is critical both to achieve the cure of the patient and by doing so avoiding the spread of resistance. All patients treated should benefit from a 2, 3, 5 and 8 months sputum smear microscopy to make sure that they have responded correctly to the treatment. The contractor will utilize the DOTS approach and ensure that health personnel and volunteer community workers support patient compliance and adherence to treatment. Therefore, health personnel and community workers will be trained in the DOTS in order to assure patients complete the course of their treatment. The contractor will secure TB drugs from the MSPP on a quarterly basis and train staff in the management of TB commodities. The contractor will also ensure

that ICC and CDS continue to collaborate with the World Food Program in order to provide TB patients with nutritional support.

Performance Standards for Result #2 Tuberculosis: At a minimum

2.1 Establish Year 1 baseline and annual targets for indicators under this Program Element Result.
2.2 Enter into sub agreements with the two TB NGOs to continue their efforts under this Program Element Result.
2.3 Meet annual targets for TB cases detected and treated in 20 sites as designated in the above identified geographic target area.
2.4 Increase the percentage of new smear positive TB patients detected under DOTS.
2.5 Provide basic laboratory infrastructure and equipment including microscopes to 20 sites in the above identified geographic target area.
2.6 Annually or as needed, train health workers and community workers in DOTS according to MSPP/WHO protocol in the 20 sites in the above identified geographic target area.
2.7 Annually or as needed, train lab personnel to conduct HIV rapid testing in the 20 sites in the above identified geographic target area.
2.8 Increase the number of TB patients tested for HIV in the 20 sites in the above identified geographic target area.
2.9 Develop regular quality control system within the lab network of 20 sites in the above identified geographic target area.
2.10 Collaborate with the World Food Program to improve the provision of nutritional support for TB patients.

Program Element Result #3 Maternal Health: This element has three key components: 1) pre-natal and maternity services; 2) post natal services; and 3) PMTCT services.

Maternal Health Result Summary: By 2010, USAID anticipates that use of antenatal care in the above identified geographic target area will increase, and that all service providers in the geographic target area will have been adequately trained to provide a full package of pre-natal and post-partum care, reproductive health, EOC, and PMTCT services. In addition, traditional birth attendants will be more widely available to provide maternal services. Special attention will be given to increasing access to and use of maternal services in the "hot spots" of Petit Goave, Port-au-Prince, St. Marc, Gonaives, Cap Haitian, and Les Cayes and the two "watershed" areas. See list of tables and maps in the electronic document section of this Task Order which clearly indicate the geographical target area and the type of services to be delivered.

Indicators:

Percentage of women who attend at least 3 prenatal care visits in USAID target areas.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Percentage of births supervised by trained personnel in USAID target areas.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of pregnant women provided with a complete course of ARV prophylaxis for prevention to mother to child transmission (PMTCT) in selected USAID target areas.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of people trained in child health maternal health and nutrition care through USAID supported programs	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number antenatal care visits by skilled providers from USAID assisted facilities	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Performance Requirements for Result #3 Maternal Health: The contractor will improve access to and use of maternal health services in three key areas: pre-natal care and maternity services; post-natal care and PMTCT in the above identified geographic target area. The number of pregnant women receiving a comprehensive package of maternal services is expected to increase appreciably.

Pre-natal and Maternity Services: Pre-natal and maternity care aims to continue providing at least three prenatal checkups at the service delivery point where pregnant women receive medical care. Attention will be given to expanding the full range of maternity and reproductive health services to young, adolescent women between 15-24 years old. Pre-natal services include health education, nutrition during pregnancy, and the role of family planning and birth spacing on the health of the mother and her new-born. To reduce the risk of anemia, most women receive iron supplementation and monthly food supplements. The "Safe Delivery" strategy focuses on having a trained health provider present during childbirth and paying attention to the "critical delays" in accessing care. To improve birth outcomes, it will be necessary to continue to train these TBAs in safe delivery practices, on the importance of breastfeeding and personal hygiene. To handle obstetrical emergencies, an EOC Package will be supported at selected locations in Haiti. MSPP staff at locations that handle several of deliveries will continue to be provided with in-country training in the management of obstetrical emergencies. The contractor will ensure that pre-natal and maternity services include: birth planning and birth preparedness, nutrition instruction, tetanus toxoid immunizations, iron and folic acid supplementation, STI detection/treatment, breastfeeding and family planning counseling.

Post-natal Services: Postnatal care is critical to ensure the health of the baby as well as that of the mother in the post delivery period. Ideally a trained TBA should visit the woman at home within the first 24 hours of delivery. A home visit within the first week of delivery is encouraged. At a minimum the woman should be encouraged to visit the health facility six weeks after delivery and TBAs should play an important role to ensure that the visit takes place. The contractor will continue to train TBAs to ensure skills in supporting new mothers in the post natal period. The contractor will also ensure that post-natal services include: instruction on exclusive breastfeeding for the first six months; introduction of appropriate solid food between 7-9 months; newborn hygiene and cord care; immunization; maternal nutrition; birth spacing and family planning, including clinical methods; and reproductive health services.

Prevention of Mother-to-Child Transmission of HIV (PMTCT): This initiative is an important aspect of providing pre-natal services to women. Emphasis will be placed on: informing HIV-positive mothers about breastfeeding options to reduce vertical transmission to their newborn; assisting them with dietary and nutritional assessments for themselves and their young children; and educating them on optimal feeding and weaning of their newborn. In addition, infants born to HIV-positive mothers will be eligible for an array of services by connecting them to NGOs working in orphan and vulnerable children (OVC) activities so families will benefit from a package of services including access to safe water, bed nets, and food supplementation. The major thrust of this activity is to reduce mother-to-child-transmission of HIV/AIDS through testing, diagnosis and treatment of pregnant women. Administration of anti-retroviral drugs (ARVs) is used to reduce by two-thirds the number of HIV positive women who transmit the virus to their newborn infants. This effort also coordinates closely with the PL 480 Title II food program which provides food supplements and nutritional education to vulnerable pregnant women through their mothers' clubs and HIV positive people networks. Health messages that target young women through non-formal channels as well as through community radio will be a critical strategy to reach young women and men 15-24. PMTCT programs will be linked to a wider range of HIV/AIDS services, including TB, HIV counseling and testing and provision of ARV services. The contractor will maintain the level of PMTCT services as designated in the above identified geographic target area. The challenge in the public sector *Zones Cibleés* is to reach the standard of care offered by the NGO service delivery sites that USAID has been supporting during the past several years.

Performance Standards for Result #3 Maternal Health: At a minimum

3.1 Establish Year 1 baseline and annual targets for indicators under this program element.

3.2 Meet the annual targets for providing maternal health services in above identified geographic target area.

3.3 Provide quality pre-natal, post natal and maternity services which Include: birth planning and birth preparedness; nutrition instruction; tetanus toxoid immunizations; iron and folic acid supplementation, STI detection/treatment; breastfeeding; and family planning counseling.

3.4 Clinic standards for the provision of pre-natal, post and maternity services in primary health care setting are adopted and used annually

3.5 Develop/adopt a standard protocol and TOT program for EOC services in 10 Departments developed and used in for the administration of drugs, as appropriate, manual removal of the placenta, removal of retained products following miscarriage and assisted vaginal delivery.

3.6 A community plan to reduce life-threatening delays developed and used to identify high risk factors and obstetric emergencies at home or at the clinic; and ensure all TBAs and nurses recognize when and how to refer high risk pregnancy and obstetric emergency cases.

3.7 Provide training to TBAs to provide post-natal services that include hygienic newborn and cord care, introduction of exclusive breastfeeding for first six months; introduction of appropriate solid food between 7-9 months, immunization, maternal nutrition, reproductive health services, birth spacing and family planning, including referrals to post partum clinical methods.

3.8 Improve and expand youth and adolescent friendly maternal services at health facilities for young women 15-24 years old to include the full range of care - ante-natal care, post-partum care, family planning and linkages with VCT and HIV/AIDS activities.

3.9 Integrate PMTCT into maternal health services in the above identified geographic target area.

3.10 Collaborate with the PL480 Title II program to identify mutual targeting of vulnerable populations, including pregnant and lactating women to expand maternal nutrition services.

3.11 Develop referral linkages to ensure HIV-positive women and their newborn will be benefits from an array of OVC and care services including access to safe water, bed nets, and food supplementation.

Program Element Result #4 Child Health: This element has three key components: immunization; 2) nutrition; and 3) prevention/treatment of diarrhea.

Child Health Result Summary: By 2010, within the above identified geographic target area, USAID expects: increases in the percentage of fully immunized (with BCG, measles, tetanus, DTP and polio) children under the age of one year; increases in the number of children from 6 months to five years who receive Vitamin A supplementation; and a reduction in deaths due to diarrheal disease in children under the age of five year through breastfeeding promotion, health education (which includes education on clean water and sanitation) and increased use of oral rehydration solution (ORS). Special attention will be given to increasing access to and use of child health services in the "hot spots" of Petit Goave, Port-au-Prince, St. Marc, Gonaives, Cap Haitian, and Les Cayes and the two "watershed" areas. See list of tables and maps in the electronic document section of this Task Order which clearly indicate the geographical target area and the type of services to be delivered.

Indicators:

The percentage of children less than 12 months of age who received DPT 3(fully vaccinated) in a given year from USAID-supported NGO and *Zones Ciblees* service delivery sites.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of children under 5 years of age who received Vitamin A from USAID supported NGO and *Zones Ciblees* service delivery sites.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of Children reached by USG supported programs that promote good infant and young child feeding and/or growth promotion.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of Cases of Child Diarrhea treated with a) Oral Rehydration Therapy (ORT) and b) Zinc Supplements by trained Community Health Workers in USAID geographical target areas.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of people trained in child health and child nutrition in USAID geographical target areas.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Performance Requirements for Result #4 Child Health: Under this Task Order, the contractor will continue or initiate activities which strengthen and improve access to and use of child survival interventions. Improvements are expected in immunization, nutrition and prevention and treatment of diarrhea in the above identified target areas.

Immunization: Immunization services are delivered primarily through NGOs and some public sector services throughout Haiti which focus on preventing tetanus, diphtheria, whooping cough, measles, and polio and reduce the incidence of severe pediatric TB cases with BCG. In order to expand immunization coverage, innovative approaches such as mobile rally posts, campaigns, or "child health weeks" to mobilize communities to immunize children should be considered.

The USAID Health technical team has worked closely with Food Security and Humanitarian Assistance Office (FSHA) and the PL 480 Title II Cooperating Sponsors to standardize immunization indicators. Under this Task Order, the contractor will improve coordination of this Task Order's immunization assistance with USAID Title II implementing partners, Pan-American Health Organization/World Health Organization and the United Nations Children's Fund (PAHO/WHO and UNICEF) to support the MSPP in improving coverage in the Expanded Program on Immunization (EPI). Assistance under this Task Order will continue to provide logistical support and technical

assistance to the national EPI program and will continue to support MSPP to ensure PAHO/WHO and UNICEF are able to address the constraints faced in human resources; and in vaccine management and the cold chain system to improve coverage and ensure Haiti benefits from new vaccine technology. This will lead to better synergy of donor efforts, attract new donors such as Brazil, Canada, and the European Union, and improve logistics and capacity at central, departmental and health center levels to manage the national EPI program.

Nutrition: Under this Task Order and in collaboration with Title II implementing partners, nutrition assistance will continue to be delivered within the above identified geographic target area to children and pregnant women. This includes health education to women for preventing malnutrition, food supplementation, promotion of exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under 5 years and nutritional supplementation to reverse malnutrition. The contractor will support MSPP to plan and implement "Child Health Weeks" where Vitamin A supplementation will be provided to children 6 months to 59 months. The contractor will identify linkages with the World Food Program and Title II implementing partners to better leverage and target food to the most at risk and vulnerable women and children, including those children infected and affected by HIV/AIDS. The Title II program also provides food, nutrition and demonstration training to vulnerable women and children and other vulnerable groups. The complementary PEPFAR funded programs for orphans and vulnerable children (OVCs) closely coordinates with all efforts to improve nutritional status of children orphaned or made vulnerable by HIV/AIDS.

Prevention/Treatment of Diarrhea: Through the existing health delivery system, diarrhea prevention is addressed through health education, promoting exclusive breastfeeding, clean water and sanitation. The contractor will place emphasis on improving access to safe water, hygiene, hand washing and education of parents and heath workers, especially community based agents. Also, emphasis will be made to educate mothers on the early signs and treatment of diarrhea. The contractor will promote basic principles of clean water and sanitation and promote timely use of ORS. If appropriate, promotion of water purification products for treating drinking water in order to reduce death resulting from diarrhea should also be considered. The contractor will be expected to coordinate assistance with UNICEF and PAHO/WHO which promotes breastfeeding and strengthening the Integrated Management of Childhood Illness (IMCI).

Performance Standards for Result #3 Child Survival: At a minimum

4.1 Establish baseline and annual targets for indicators above for the Program Element Result Child Survival.
4.2 Meet annual targets for maintaining child survival services in the above identified geographic target area.
4.3 Increase vaccination rates in the above identified geographic target areas.
4.5 Increase outreach and community level activities to expand the availability of growth monitoring, nutrition, and health promotion services infants and children.

4.6 Promote exclusive breast feeding up to 6 months and breastfeeding and appropriate complementary feeding 6-9 month, as well as use of oral rehydration therapy as a means to reducing diarrheal disease.
4.7 Conduct training in child survival of service providers in the above identified geographic target area.
4.8 Increase Vitamin A supplementation of children 6 months to five years in the above identified geographic target areas.

Program Element Result #5: Family Planning and Reproductive Health. This element has three key components: 1) family planning services; 2) STI services; and 3) family planning commodities logistics and management.

Family Planning and Reproductive Health Result Summary: By 2010, USAID expects the contraceptive prevalence rate to increase on average by 1% annually in the above identified geographic target area. Technical assistance will focus on supporting GOH efforts to reposition family planning nationally, increase contraceptive use among individuals between 15-49 years of age (including long term and permanent methods), increase access to and use of STI services and improve national, department and service delivery point commodities management. Special attention will be given to increasing access to and use of family planning services in the "hot spots" of Petit Goave, Port-au-Prince, St. Marc, Gonaives, Cap Haitian, and Les Cayes and the two "watershed" areas. See list of tables and maps in the electronic document section of this Task Order which clearly indicate the geographical target area and the type of services to be delivered.

Indicators:

Number of people trained in FP/RH	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of individuals counseled in FP/RH	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of interventions providing services, counseling, and/or community based awareness activities intended to respond to and/or reduce gender-based violence.	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of service delivery points providing FP counseling or services	Actual 2006 130 Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Percentage of women using a modern family planning method in USAID geographic target areas	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Couple Year Protection (CYP) in USAID geographic target areas	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Number of service delivery points reporting stock outs of any contraceptive commodity offered by SDP at anytime during the reporting period	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD
Percentage of individuals treated for STIs	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Performance Requirements for Result #5 Family Planning and Reproductive Health:

Family Planning Service Delivery: This assistance will expand sustainable provision of family planning services in clinical and non-clinical programs including those in the above identified geographic target area. USAID assistance will: support activities that help improve the quality of the services and care provided, including pre- and in-service training of providers and application of evidence- based service-delivery norms and standards; and improve availability of a wide range of contraceptive options (temporary, fertility awareness methods, and clinical methods) for men and women. The assistance will improve responsiveness to client needs, including the FP/RH needs for youth, men, women and girls affected by violence in vulnerable areas. The contractor will continue to update provider skills in all family planning methods with a special focus on improving skills in long term and permanent surgical methods. Training protocols and national guidelines need to be updated, reproduced and disseminated. If needed by the MSPP, place a Family Planning Technical Advisor at the central level to provide strategic planning of a national family planning strategy and provide assistance at the departmental level to assist the MSPP in its implementation of department level family planning efforts aimed at repositioning family planning.

Reproductive Health Services. There is a high prevalence of untreated STIs in Haiti. Untreated STIs can facilitate the transmission of HIV and raise the chances of mother-to-child transmission of STIs. Technical assistance will target 15-24 year olds with youth-friendly services and messages for prevention of pregnancy and sexually transmitted

infections (STIs), including HIV/AIDS. Through USAID's in-school and out of school education assistance activities, stronger linkages will be made to provide youth with information on increasing skills in risk perception, reducing high risk behavior, early pregnancy and correct and consistent condom use. Special efforts will be made to improve linkages and synergies with USAID's HIV/AIDS prevention programs. To address this problem, the contractor will provide technical assistance to improve access to and use of prevention and treatment services for STIs, including pregnancy testing and counseling services as a part of reproductive care. Integrated family planning and HIV/AIDS prevention programs will target youth 15-24 years old, especially young women, to improve their reproductive health.

Commodities Management & Systems Strengthening. USAID continues to be the largest donor of family planning commodities in Haiti. Assistance under this Task Order will aim to strengthen organizational capacity building in human and financial resource management and leadership in the provision of FP/RH commodities. Support will ensure near- term and long term availability of high quality temporary and long lasting contraceptives including condoms for family planning and STI prevention, direct financing, procurement, delivery, quality assurance and strengthening country supply chains to manage and deliver contraceptives and condoms, particularly those to be used in the service delivery sites of the USAID geographic target areas. This assistance will provide MSPP with support in forecasting, procuring, distributing, tracking and managing inventory at the departmental depots and service delivery points and reporting on contraceptives financed by USAID. The contractor will also provide technical assistance to MSPP to encourage other key donors such as UNFPA and Kfw to increase their commodity purchases and provide logistics support in ensuring other donor financed commodities are made available.

Performance Standards for Result #5 Family Planning and Reproductive Health: At a minimum

5.1 Establish baseline and annual targets for indicators the Program Element Result Family Planning and Reproductive Health.
5.2 Meet annual targets for increasing use of family planning services in the above identified geographic target areas.
5.3 At least five modern family planning methods, including 2 clinical methods are routinely available in the above identified geographic target areas.
5.4 Clinical standards for the provision of voluntary family planning services in a primary health care setting are adopted and used annually in the above identified geographic target area.
5.5 Clinical training curricula are developed and implemented for physicians and nurses to revitalize the provision of long-term family planning methods.
5.6 Clinical standards and protocols are revised and used for the diagnosis and treatment of STIs in the above identified geographic target area.
5.7 Mobile unit initiated monthly to expand access to clinical contraceptive methods.

5.8 Place long term FP Technical Advisor to work with MSPP on strengthening commodities and logistics management systems for implementing national FP program and achieving annual targets for this Task Order.

5.9 Provide forecasting, logistics, inventory and commodities management training and technical assistance for staff within the service delivery sites in the above identified geographic target area.

5.10 Age appropriate behavior change messages (print and electronic) for 15-24 year olds to promote comprehensive approach to abstinence, being faithful and condoms (ABC) are disseminated monthly at the community level.

5.11 Youth friendly reproductive health services (including health education, FP, STIs, voluntary counseling and testing for HIV/AIDS and PMCT) are available in the above identified geographical target area.

5.12 Family planning services and counseling become an integral part of HIV/AIDS testing services and PMTCT programs.

5.13 Monthly community based approaches used to mobilize clients and provide information and services to promote family planning use.

Cross Cutting Result #6 Strengthen MSPP Public Sector Executive Function: This component is comprised of five key elements: 1) strategic planning; 2) *Zones Cibleés*; 3) performance based financing; 4) commodities and logistics management; and 5) financial management and governance.

Public Sector Executive Function Result Summary: By 2010, USAID expects that the MSPP will significantly increase its ability to carry out its executive function as a central Ministry and at the department level. This includes increased capacity in setting policy, standards, norms and guidelines for the health sector; strategic national and department level planning (which includes information management and use); commodities management from the central level to the department level to the service delivery point; donor coordination at the central and department level; and transparency and accountability for resources used. Furthermore, the MSPP vision and strategy to decentralize health care services will continue to be supported.

Indicators:

Percentage of Departments implementing approved strategic plans	Actual 2006 60% Target 2007 80% Target 2008 100% Target 2009 100% Target 2010 100%
Number of MOH sector sites providing minimum packages of services through *Zone Cibleés*	Actual 2006 30 Target 2007 30 Target 2008 30 Target 2009 30 Target 2010 30
Number of MSPP departments experimenting with "Performance Based Financing" or other similar innovations to improve results	Actual 2006 0 Target 2007 3 Target 2008 6

	Target 2009 8 Target 2010 10
Number of Department Offices with effective financial management systems in place	Actual 2006 0 Target 2007 3 Target 2008 6 Target 2009 8 Target 2010 10
Percentage of service delivery sites within USAID geographic target area fully stocked with USAID financed commodities	Actual 2006 TBD Target 2007 TBD Target 2008 TBD Target 2009 TBD Target 2010 TBD

Performance Requirements of Result #6 Strengthening MSPP:

Strategic Planning for Decentralization. A significant problem hindering the effort to provide basic health services to Haitians has been the centralization of authority and weak leadership at the central level due to continuing political instability. To address this problem, in June 2004, the MSPP formally launched its "Departmental Strategy" to promote coordination of health sector actors closer to where the services are delivered. This assistance will continue to: support the development of annual health plans in the 10 departments, including community plans; strengthen MSPP central level to oversee implementation of the plans; coordinate donor resources to more effectively achieve results; and provide technical assistance to implement and monitor the plans. Technical Advisors will continue to be placed in each department to support plan implementation. Annually, the contractor will assist the Department Directors to develop and implement integrated departmental plans which capture the inputs of all donors and Haitian organizations providing health services in that department. This assistance will support MSPP decentralization efforts and strengthen its capacity to better coordinate and direct donor resources to ensure equitable coverage of health services and reinforce public/private partnerships to expand service delivery to underserved and vulnerable populations. The contractor will also provide support in human resource planning, deployment of newly trained physicians, and training for key health providers in approximately 130 service delivery sites.

Zones Cibleés. Under this Task Order, technical assistance will assist the MSPP by strengthening its executive leadership as it rolls out its decentralization strategy by improving its implementation and management capacity. This assistance will support MSPP to provide essential health services in 30 public sector sites to underserved pockets of the population. The 30 sites will be provided with staff, technical assistance, materials and equipment to provide access to services to improve maternal/child health, family planning and infectious diseases, including HIV/AIDS, to approximately 1.5 million people. Refer to lists and maps of *Zones Cibleés* in the electronic documentation section which form a part of this Task Order.

Performance Based Financing. The model of providing incentives to NGOs for achieving agreed results—Performance Based Financing—will be experimented with the public sector under this contract. Building on USAID's success of the performance based financing with NGOs, the contractor will establish a similar mechanism to bring innovation into the public sector and stimulate performance in achieving results in the 30 MSPP *Zones Cibleés*. As a part of the annual strategic plan, each of the 10 departments will identify milestones for improving its own management and supervision systems and milestones for expanding services in targeted communities in the *Zones Cibleés*. The contractor will work with MSPP Central and *Zones Cibleés* implementers at the community level to identify incentives for milestones which will be negotiated and agreed upon in advance. A flexible, transparent and innovative mechanism for implementing the performance based financing system in the public sector will be developed by the contractor in consultation with USAID. The contractor will provide assistance in monitoring the milestones set by the departments and *Zones Cibleés* in order to confirm progress and reward those departments which plan, manage and achieve agreed results.

Commodities Management. Under this Task Order, USAID will continue to strengthen the MSPP's systems for procurement, distribution and management of essential drugs and medical supplies and improve the national-level health management information system. The contractor will develop a plan for ensuring control and accountability of USAID financed commodities. Building on investments to strengthen management of family planning commodities (Result #5), the contractor will provide technical assistance to improve forecasting, logistics and management of other USAID-finance commodities. Currently, the actual procurement of these items is financed separately through central field support mechanism in Washington. However, at the country level, at a minimum the contractor will ensure that essential drugs and supplies for family planning and child survival are available at all 130 service delivery sites. The contractor will coordinate its work with the supply chain management partner who is responsible for ensuring commodities at the PEPFAR sites.

Financial Management and Governance. Corruption and mismanagement of health resources and commodities continue to plague the sector. USAID has supported the MSPP to develop a financial management manual based on Haiti's public accounting laws and codes. The contractor will use this manual to strengthen financial management and controls in MSPP at the central and department levels and reinforce these skills within the 30 *Zones Cibleés* service delivery sites. In the short term, USAID expects improvements in tracking health resources and expenditures and increased transparency, accountability and public confidence in the health sector. In the long term the contractor will develop a financial plan for NGOs by assisting them in diversifying their funding and leverage non-USAID Haiti health funds.

Performance Standards of Result #6: At a minimum:

6.1 All 10 Departments are provided assistance to develop an annual Integrated Strategic Plans in support of to the MSPP decentralization and health sector reform efforts.

6.2 10 Long Term (LT) Technical Advisors placed in the 10 departments and additional Long Term Advisors are placed at the MSPP Central level as identified and needed by the MSPP, pending funding availability.

6.3 MSPP uses data to guide decision making across the board to improve management of facilities, rational deploy staff in the Departments, allocate resources and track financial expenditures for achieving results in the health sector.

6.4 Clinical standards for the provision of quality health services developed for and implemented in the service delivery sites in the above identified geographical target area.

6.5 Quality primary health care services are provided in the above identified geographical target area.

6.6 Performance-based financial mechanism implemented in the above identified geographical target area.

6.7 Selected overseas leadership and clinical training for MSPP national and departmental personnel conducted annually, pending funding availability.

6.8 Commodities management and logistics established and functioning to ensure adequate stocks for service delivery in the USAID geographical target area.

6.9 In-country training opportunities for senior level health personnel in clinical skills, planning, management and supervision conducted annually as needed.

6.10 In-country virtual leadership & management develop training conducted for departmental health team managers including service providers in the above identified geographic target area.

6.11 MSPP Financial Planning Manual reproduced, updated and implemented to guide public sector fiscal planning and management in the departments.

6.12 NGOs develop and implement a plan to diversify their non-USAID funding and secure funding from other donors, foundations or private sector entities. At least 10 NGOs will be less dependent on USAID funding by the end of the contract.

6.13 Administer the Grants Under Contract mechanism as a flexible instrument to expand service delivery in response to USAID and GOH requirements.

7. **Other Performance Requirements**. In addition, to the technical performance standards expected in the above results, the contractor will also be responsible for the below identified performance standards to improve start-up and success in achieving results under the health component of the Social Services SO. This will also include the design and execution of the Grants under Contract (GUC) component which will provide flexibility and innovation to support non traditional approaches in expanding services to vulnerable population.

Other Performance Standards: At a minimum

7.1 Mobilize in country within one month of contract award and initiate service delivery under new contract within 90 days of award to ensure smooth transition from current contract and no disruption of services.

7.2 Contribute up to 20% match (in cash and in-kind) of the cost of the contract as contractor's own share of implementing the contract. The 20% matching funds cannot include MSPP funding or funding from proposed sub-contract or sub-grant implementing partners who will be responsible for implementation of health care services at the department or community level.

7.3 Strengthen linkages with health and education interventions to target in-school and out of school youth with health information and services.

7.4 Provide access to and use of basic health services to approximately 50% of the population in Haiti.

7.5 Provide services in the USAID's six "hot spots" and two watersheds areas.

7.6 Ensure programming for health includes USAID's cross cutting themes such as the environment, gender, conflict and governance.

7.7 Create program linkages with USAID's Livelihoods and Governance Strategic Objectives to increase synergies and increase impact of USAID interventions to vulnerable groups and underserved populations.

7.8 Design and execute up to 3 small grants under the GUC component annually.

7.9 Increase awareness of the availability of services supported under this contract through mass media, community mobilization, outreach, and/or national campaigns.

7.10 Increase behavior change interventions to encourage constructive engagement of men, equitable gender norms and adoption of positive health behaviors by women/girls and men/boys.

7.11 Establish/and strengthen MSPP management information systems and development of tools for collecting, analyzing and disseminating information related to program results.

7.12 Promote activities, which reduce corruption; increase equity; improve efficiency; increase opportunities for maximizing resources; and leverage donor and private sector funding e.g. GDA initiatives in the health sector.

XIX. Quality Assurance Plan

During the period of the contract, the USAID Task Order Cognizant Technical Officer (TOCTO) will conduct periodic performance reviews to monitor the progress of work and the achievement of required results under this contract. These reviews will form the basis of the contractor's permanent performance record and tracked in the USAID/Washington database. A variety of mechanisms will be used to monitor the progress and success of this assistance and the contractor's performance in achieving agreed results.

1. Monthly meetings with USAID (described below)
2. Semi-annual review meetings (described below)
3. Review of contractor's scheduled reports (which include updates to the Work Plan, fiscal expenditures and accruals, progress reports, consultancy reports, etc.)

4. Feedback from GOH, MSPP, NGO counterparts and collaborating donors.
5. Site visits by USAID personnel.
6. Periodic impact assessments or performance evaluations.
7. Regular planning meetings between MSPP, USAID and the contractor to finalize annual work plans and/or identify emerging priorities requiring attention.

XX. Work Plan

The Work Plan is a comprehensive document that will serve as the primary management tool for monitoring performance of the contractor by USAID. As part of the proposal submission, the contractor will propose a draft three-year Work Plan, which will include a three-month transition plan, a draft detailed implementation plan for Year 1, and an illustrative implementation plan for Year 2 and Year 3. Information on the implementation schedule or timetable should be included in the information provided in the Work Plan. A budget plan should be included in the Work Plan indicating planned expenditures for each year, by result area and funding earmark. During contract performance, the Work Plan will be approved by the TOCTO. Contracting Officer approval of Work Plan shall be required if at anytime the work plan is changed and the proposed changes significantly impact the use of available contract funds. It is anticipated that USAID, host country officials and other appropriate persons will review the Work Plan regularly (i.e. annually or at any other time of a proposed significant change to the Work Plan) in order to provide comments, recommend changes, and provide official approval. Such comments and changes, however, if agreed to by USAID and the contractor, shall not constitute a change from the terms of this contract. At a minimum, the Work Plan will be updated annually.

As part of the proposal submission, Offerors will need to include in their annex a draft Work Plan (see section describing proposal submission for more details). The contractor may develop their own format for the Work Plan. The format may be changed at anytime to best meet the management information needs of both the contractor and USAID. There is no expectation that the information in the Work Plan will be widely disseminated to the public. No later then two weeks after contract award, the Work Plan will be presented to USAID during an in-person "contract start-up" meeting for final review. The Work Plan will be finalized within 30 days of contract award.

In summary, the Work Plan should include, at a minimum:

- 3 year activity implementation plan with budget (detailed Year 1 plan, illustrative Year 2 and Year 3 plan, and corresponding budget for each year indicating how the funds will be spent by result area and by funding earmark)
- Start up transition plan for first 90 days to be implemented immediately upon award of the contract to indicate how the contractor proposes to implement a smooth transition and start up of activities with an assurance to avoid disruption of USAID technical assistance to the Haiti.
- Monitoring and Evaluation Plan (see below for detailed description of what to include in the monitoring and evaluation plan)

- A time line for proposed implementation of activities each year.
- Geographic implementation of activities should be included in the Work Plan.
- Summary information on how activities will be implemented should additional information be needed to ensure clarity of contractor's proposed implementation approach for each activity.
- Major equipment to be procured annually.
- Details of collaboration with MSPP (central and departments) and other USAID-funded partners

XXI. Monitoring and Evaluation Plan

The contractor will be responsible for developing and executing a Monitoring and Evaluation (M&E) plan, which at a minimum includes the relevant indicators in the "Investing in People" Objective under the new Strategic Framework for U.S. Foreign Assistance and contractor proposed plans for periodic evaluations during the contract period. As of the date of this Task Order announcement, the indicators (and targets) relevant to this Task Order have been identified and included in the above results section. (For more information on the US Foreign Assistance Guidance and Standard Indicators, go to the web site indicated in the background documents section.) The M&E plan should include the contractor's proposed annual and end of contract targets, which must include at a minimum the indicators and targets listed in the results section above as well as any additional indicators and targets that the contractor proposes to use to monitor progress. In the M&E Plan, clearly mark those indicators that are listed above in the results section as the required USAID reporting indicators. As applicable, indicators should be disaggregated by gender, age cohorts, and geographical location (i.e. Haiti Departments). A brief description of additional monitoring and evaluation activities proposed during the contract period should be included in the draft M&E plan, such as baseline surveys to be conducted at the start of the contract, mid-term evaluation, a final evaluation, and any "one time" studies to fill in information gaps needed to guide implementation of technical assistance. A draft M&E plan will be included in the contractor's proposal submission as a part of the Work Plan described above. A final M&E plan will be included in the final Work Plan that will be submitted to the TOCTO within 30 days of the award of the contract, as per directed above. To the extent possible, the M&E plan will be integrated into, and enhance, existing MSPP management systems. The M&E plan will be updated and revised regularly as appropriate in collaboration with USAID (i.e. annually). A final format to be used for the M&E plan will be decided upon by USAID after award and will be based on the emerging reporting requirements and guidance from the U.S. State Department Director of Foreign Assistance. For each required indicator under the Foreign Assistance Framework, after award of the contract a detailed indicator sheet must be developed by the contractor, which will provide extensive details on that indicator, such as the exact indicator definition, whether or not the indicator is disaggregated (and if so, how), the method of data collection, etc. Format for individual indicator sheets will be provided to the contract upon award.

XXII. Contract Management and Reporting Requirements

All work under this contract shall be completed by September 30, 2010, unless otherwise extended by the USAID Contracting Officer, which may include two one-year extensions as already noted in this Task Order. During the time period of the contract, the following contract management processes and reporting will be required. All reports indicated below will be submitted to USAID in English unless noted otherwise. The following processes and reporting may be amended or changed as needed by the TOCTO and contractor upon award of the contract. Specifically, the following may be amended by the TOCTO in consultation with the contractor based on the evolving annual reporting guidance by U.S. State Department Director of Foreign Assistance as it relates to implementation of assistance under the Foreign Assistance Strategic Framework.

- *Contractor "Start Up" Meeting, Final Work Plan Presentation and Submission:* Within two weeks of award of the contract, the USAID and the contractor will meet to officially review the requirements of the awarded contract. As a component of this meeting, the contractor will be expected to present to USAID the Work Plan for discussion, review, and final comment by USAID. A final Work Plan will be submitted to the TOCTO within 30 days of award of the contract.

- *Monitoring and Evaluation plan development meeting:* During the first 30 days of the award of the contract, a monitoring and evaluation planning meeting will be held with USAID to finalize the contractor's M&E plan that will be submitted as part of the Work Plan within 30 days of award of the contract. An in-depth discussion will be held to agree upon and finalize required indictors to be reported on, targets, and methodology for data collection. The USAID Title II food program implementing partners may be a part of this discussion in order to ensure complimentary reporting and monitoring. This meeting may be held separately or as a part of the described above Work Plan presentation meeting.

- *USAID and Contractor Monthly Management Meetings:* The TOCTO and contractor will organize a monthly meeting schedule that will focus on routine administration of the contract (which includes fiscal management and procurement administration as well as identification and resolution of implementation issues during the course of the contract period). The completion of meeting minutes will be the responsibility of the contractor and will include a summary of key decisions made between USAID and the contractor and follow up actions required. The meeting minutes will be submitted to the TOCTO within two working days at the conclusion of each monthly meeting. Meeting minute format is to be decided upon between the TOCTO and the contractor. These meeting minutes will be part of the official USAID management files for the contract. Pending the issues or subjects to be discussed at any of the monthly meetings, meeting participants may vary (i.e. MSSP representatives may be asked to participate to address a specific issue related to public sector support). The location of the meeting will be

determined by the contractor and TOCTO and may vary throughout the life of the contract.

- *Financial Reporting*: A quarterly estimated accruals & expenditures summary and a detailed quarterly financial report will be submitted to the TOCTO. The quarterly estimated accruals and expenditures summary will be submitted to USAID 15 days prior to the end of each quarter and will include actual expenditures and estimated accruals. This is a very simple report that will be provided via e-mail to the TOCTO and a format will be provided. Timing of the financial reports may be amended by the TOCTO in consultation with the contractor based on the evolving annual reporting guidance by U.S. State Department Director of Foreign Assistance as it relates to implementation of assistance under the Foreign Assistance Strategic Framework. The detailed quarterly financial report will be submitted to USAID 30 days at the conclusion of each quarter and will include at a minimum:
  1) Total funds sub-obligated into the contract to date by USAID by funding earmark and by result area.
  2) Total funds expended by the contractor during the quarter and total funds expended by the contractor since the award of the contract, which includes updated information on the previous quarter's monthly burn rate based on actual expenditures.
  3) Pipe-line of remaining funds available to date.
  4) A monthly funds flow for proposed planned expenditures for the remainder of the funds sub-obligated to date in the contract.

- *Semi-Annual Performance Meetings:* The contractor will be required to hold two performance meetings per year. Participants at each meeting will include the contractor's core management team, USAID representatives, MSPP representatives, and the contractor's major department-level NGO and public sector sub-partners (this sub-group of meeting participants does not need to include all sub-partners, just major sub-partners who are implementing significant portions of the contractor Work Plan). Specifically, who will participate in the meetings will be decided upon by the contractor and the TOCTO. One of the two meetings will be held 30 days prior to the end of annual performance period and will focus on presenting and discussing the contractor's anticipated annual performance (including whether or not the contractor anticipates meeting annual targets) and updating the Work Plan to detail and amend the following year proposed implementation of activities. The other required performance meeting will be held six months after the start of each annual performance period. The focus of the second meeting will be to review progress to date and implementation issues. Frequency, timing and purpose of the performance meetings may be changed or adapted to meet the needs of the TOCTO and contractor to ensure optimal overall monitoring of contractor performance. Specifically, timing of the meetings may be amended by the TOCTO in consultation with the contractor based on the evolving annual reporting guidance by U.S. State Department Director of Foreign

Assistance as it relates to implementation of assistance under the Foreign Assistance Strategic Framework.

- *Semi- Annual Performance Reporting:* Two written performance reports will be required each year of the contractor. One report will be submitted 30 days after the end of each annual performance period and will summarize the annual performance of the contractor for the recently completed annual performance period using the indicators and targets in the M&E plan. (This will be submitted at the same time as the annual update to the Work Plan, see next bullet below). The second performance report will be submitted 30 days after the completion of the first six month period of each annual performance period and will include a summary of progress to date towards meeting annual targets, implementation issues identified and resolution of those issues, and a summary of the discussion at the six-month performance meeting described in the above bullet. For each report, annual results achieved (or progress towards achieving results to be achieved) will be described in narrative form by result area. The specific format and exact content of each report will be decided upon by the TOCTO and the contractor. Both the format and timing of the reports may be amended by the TOCTO in consultation with the contractor based on the evolving annual reporting guidance by U.S. State Department Director of Foreign Assistance as it relates to implementation of assistance under the Foreign Assistance Strategic Framework.

- *Annual Work Plan Update:* As indicated already, at a minimum, the Work Plan will be updated annually to detail plans for implementation of activities and assistance during the following annual reporting year, as well as update the M&E plan annual targets for the remainder of the contract based on actual achievements from the previous annual performance period. An updated Work Plan will be submitted no later than 30 days after the completion of the most recent annual performance period. Timing of the reports may be amended by the TOCTO in consultation with the contractor based on the evolving annual reporting guidance by U.S. State Department Director of Foreign Assistance as it relates to implementation of assistance under the Foreign Assistance Strategic Framework.

- *Monthly Success Stories*: Once a month the contractor will be required to submit at least one success story concerning the people level impact of the USAID assistance to the health sector. A one-page format will be provided by the TOCTO. Each success story will be accompanied by photographs.

- *Other Public Relations Requirements:* The contractor will be required on an as needed basis to prepare site visits and related supporting documents for site visits by high-ranking USG delegations (i.e. US Ambassador, Congressional Delegations, USAID senior management). Formats for supporting documentation and timelines for submission to USAID will be provided to the contractor in advance. Supporting documentation may be required in both

English and French. USAID's Public Relations representative will work in collaboration with the contractor's designated public relations representative. The contractor will be required to develop and maintain an official electronic library of all public relations material, photos, and other related documents (i.e. major media news releases in the Haitian periodicals) for use by both the contractor and USAID. Upon completion of the contract, the complete electronic library will be "turned over" to USAID for official filing and archiving.

A summary of all reporting requirements (detailed above) and proposed due dates are listed in the table below. As a reminder, the format, content and timing of any of these reporting requirements may be amended by the TOCTO in consultation with the contractor based on the evolving reporting guidance by U.S. State Department Director of Foreign Assistance as it relates to implementation of assistance under the Foreign Assistance Strategic Framework.

. **Type of Report**	**Date Due**	**Distribution**
Work Plan (which includes a Monitoring and Evaluation plan)	Final Work Plan submitted 30 days after contract award. Updates to the Work Plan submitted 30 days after the TOCTO and contractor review of proposed updates and changes. At a minimum, the Work Plan will be updated annually.	1 electronic copy and 1 hard copy sent to: - Task Order CTO (TOCTO; based in Haiti) - Task Order Contracts Officer (TOCO; based in Haiti) - IQC CTO (based in USAID Washington)
Financial Quarterly Reports and estimated accruals	Estimated expenditures and accruals summary report due 2 weeks prior to the end of each quarter. The TOCTO will provide format. SF 296 30 due 30 days prior to the end of each quarter.	1 electronic copy and 1 hard copy sent to: - Task Order CTO (TOCTO; based in Haiti) - Task Order Contracts Officer (TOCO; based in Haiti) - IQC CTO (based in USAID Washington) - USAID Financial Management Officer (based in Haiti)

Monthly Meeting minutes	two days following the monthly meeting	1 electronic copy and 1 hard copy sent to: Task Order CTO (TOCTO; based in Haiti)
Performance Monitoring Reports.	Semi-annual submission 30 days after the end of each annual performance period 30 days after the end of the first six-months of each annual performance period	1 electronic copy and 1 hard copy sent to: - Task Order CTO (TOCTO; based in Haiti) - Task Order Contracts Officer (TOCO; based in Haiti) - IQC CTO (based in USAID Washington)
Foreign Tax Reporting	TBD by USAID Financial Management Officer pending US Government federal reporting requirements	TBD
Final Financial Report and Final Voucher	90 days after completion of contract	1 electronic copy and 1 hard copy sent to: - USAID Financial Management Officer (based in Haiti) - Task Order CTO (TOCTO; based in Haiti) - Task Order Contracts Officer (TOCO; based in Haiti) - IQC CTO (based in USAID Washington)
Final Performance Report	First draft due 30 days after completion of contract. Final report due 90 days after completion of the contract.	1 electronic copy and 1 hard copy sent to: - Task Order CTO (TOCTO; based in Haiti)

		- Task Order Contracts Officer (TOCO; based in Haiti) - IQC CTO (based in USAID Washington)
Success Stories	Submitted during first week of each month of contract	1 electronic copy and 1 hard copy sent to: - Task Order CTO (TOCTO; based in Haiti) - USAID Public Relations Representative (based in Haiti) - IQC CTO (based in USAID Washington)
Briefing documents for site visits	TBD as needed	TBD

XXIII. ACCRONYMS

AAD	Activity Approval Document
ARI	Acute Respiratory Infection
AIDS	Acquired Immuno-Deficiency Syndrome
CBOs	Community-Based Organizations
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CS	Child Survival
CSH	Child Survival Health
CTO	Cognizant Technical Officer
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment System
EOC	Emergency Obstetrical Care
FBO	Faith-Based Organization
FP	Family Planning
GDA	Global Development Alliance
GOH	Government of Haiti
GUC	Grants Under Contract
HIV	Human Immuno-Deficiency Virus
HS 2007	*Haiti Santé* 2007, health sector program for USAID/Haiti
ID	Infectious Disease
IDB	Inter-American Development Bank
IMCI	Integrated Management of Childhood Illness
IQC	Indefinite Quantities Contract
Kfw	German Development Agency
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MSPP	Ministry of Public Health and Population
NGO	Non-Governmental Organization
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children
PAHO	Pan-American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PHN	Population Health and Nutrition
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
SO	Strategic Objective
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TO	Task Order
UNICEF	United Nations Children's Fund
WHO	World Health Organization

SECTION B – INSTRUCTIONS PREPARATION OF THE PROPOSAL SUBMISSION

B.1. PREPARATION & SUBMISSION OF THE PROPOSAL

1. USAID will entertain proposals only from the entities under the TASC III IQC mechanism that possesses the breadth, depth, and technical and country-specific knowledge required to successfully achieve results under this contract. Offerors are encouraged to be creative in their technical approach to implement technical assistance under this Task Order and use unique and different development approaches such as performance-based financing, "outsourcing" to the private sector, health sector revenue generation (fee for service) and partnerships with commercial sector partners, for example.

2. The total estimated value of this procurement over three years (2007-2010) is $43 million split between $15.6 million in maternal and child health funding; $14 million in family planning funding; $1.5 million in tuberculosis funding; and $11.5 million in PEPFAR funding. Total funding for Year 1 is $13.550 million. The Offeror is expected to provide a minimum of a 20% match in private sector funding (which can include in-kind and non-profit funding) annually. The 20% matching funds cannot include MSPP matching funds or matching funds from proposed sub-contract or sub-grant implementing partners who will be responsible for implementation of health care services at the department or community level. It is envisioned that this Task Order will overlap with the close out of current USAID health sector assistance, prior to its completion on or before September 30, 2007. Under this Task Order, it is recommended that approximately 70% of the funding is to be allocated to costs associated with service delivery and 10% to the executive function assistance with the MSPP.

3. USAID requests that proposals be kept as concise as possible. Detailed information should be presented only when required by specific RFTOP instructions. Technical Proposals are limited to 30 pages and directly responsive to the scope of work, terms, conditions, specifications, requirements and clauses of this RFTOP. Technical Proposals should be single-spaced, have a font size of Times New Roman 12 pt and have once inch margins. This page limit does not include the cover page, executive summary, and authorized attachments (list provided below). Proposal submissions that can be submitted in less than 30 pages are encouraged. USAID requests that proposals provide all information required by following the general format described below.

4. One original plus five (5) copies of the Technical Proposal and one original, plus five (5) copies of the Cost/Business Proposal must be submitted. All materials must be submitted in English. In addition to hard copies, Offerors must supply a copy of their proposal electronically via e-mail, formatted in a PDF file. Any graphics/tables must be drafted in or converted to MS Word 2000 or Excel 2000 and saved as PDF file. Technical Proposals must not make reference to *specific* or *detailed* pricing or cost data in order that the technical evaluation may be made strictly on the basis of technical merit.

5. All copies of the Technical Proposal and Cost/Business Proposal must be separately placed in sealed envelopes clearly marked on the outside with the following words "RFP No. 521-07-004 Technical or Cost/Business (as appropriate) Proposal". These individual envelopes must then be bundled together to be received as one complete package.

6. Any proposal with data not to be disclosed should be marked with the following legend:

"[This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed in whole or in part for any purpose other than to evaluate this application. If, however, a cooperative agreement is awarded to this applicant as a result of or in connection with the submission of this data, the US Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting cooperative agreement. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in sheets [insert numbers or other identification of sheets]"

Mark each sheet of data it wishes to restrict with the following legend: "Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this proposal."

7. Hard copy proposal submissions should be submitted with the name and address of the Offeror on the envelope. Proposals are due to Annette E. Tuebner at the address below no later than 3:00PM (Eastern Time) January 31, 2007.

Proposals should be addressed as follows:

Hard copy submission sent by courier to:

Annette E.Tuebner
Contracts Officer
USAID/Haiti
17 Blvd. Harry Truman
Port-Au-Prince, Haïti
Tel: 509-229-3070

Electronic submission sent to:

Annette E.Tuebner – atuebner@usaid.gov
Stephane C. Bright - sbright@usaid.gov

Offerors should retain for their records one copy of the proposal and all enclosures that accompany their application. The person signing the proposal must initial erasures or other changes.

Proposals submitted later than the January 31, 2007 3:00PM (Eastern Time) deadline will be treated according to FAR clause 52.215-1(3). Proposals that are incomplete or are non-responsive may not be considered.

B.2 INSTRUCTIONS FOR THE PREPARATION OF THE TECHNICAL PROPOSAL

The Technical Proposal represents the technical portion of the entire proposal submission. The required format and content of each section of the Technical Proposal are detailed below. As indicated above, the following should be formatted as single-spaced, font size Times Roman 12 pt, with one-inch margins. As a reminder, there is a 30-page limit on the core technical and management sections of the proposal submission (sections III, IV, and V.). This page limit does not include the cover page, executive summary of authorized attachments (listed below). Offerors are required to adhere to the page limit.

Technical Proposal Submission Outline

I. Cover Page (one page) - include name and number of Task Order IQC mechanism, Title of proposal, name of organization(s) submitting proposal, primary contact person, telephone and fax numbers, e-mail, and mailing address.

II. Executive Summary (up to 3 pages maximum) – summarize overall objective and what will be achieved at the end of the contract; summarize technical and management approach to be used to achieve results under each of the program element result areas; provide any additional information that may help reviewers of the proposal submission to clearly understand the proposal submission.

III. Technical Approach (suggest 15 to 18 pages of the 30 page maximum limit) – describe in detail the technical approach to be used to achieve annual and end of contract targets and the performance standards of each Program Element Result Area and "Other Performance Requirements" described in detail in Task Order Section XVIII.

   a. Result 1 HIV/AIDS
   b. Result 2 Tuberculosis
   c. Result 3 Maternal Health
   d. Result 4 Child Health
   e. Result 5 Family Planning
   f. Result 6 Cross Cutting - Strengthening MSPP

IV. Management Plan (suggest-5 to 7 pages of the 30 page maximum limit) – Given the breadth of the technical requirements of this RFTOP, Offerors may propose partnerships of organizations or groups, each bringing a particular set of experiences and expertise, that would contribute to achieving results under this RFTOP. Any formal sub-agreement partnerships need to be clearly articulated in the proposal as part of the management plan. Offerors should describe how they will be organized and how they will manage the implementation of assistance to minimize non-productive costs to the U.S. Government and ensure success in achieving results. The management plan should include a description of the

management and administrative approach for overall implementation of the contract including organizational structure, functions and responsibilities of key personnel, personnel management, logistical support, and procurement arrangements for goods and services. Describe how the Offeror will manage a complex set of activities in politically changing and unstable environment, ensuring flexibility and rapid re-organization as needed based on the current development context. Demonstrate a willingness to ensure flexibility in order to respond to shifts in USG Foreign Assistance and Policy objectives and ability to form non-traditional and innovative partnerships to achieve results. Indicate how the Offeror will work with host country nationals, local subcontractors, local partners, other USAID assistance activities, and other implementing organizations to achieve results. Realistic strategies or approaches for knowledge management, cost-containment and coordinating with non-USAID supported organizations, foreign governments, and their development partners.

V. Personnel (suggest 2 pages of the 30 page maximum limit) – Offerors should provide a full staffing plan including support staff, and an organizational chart demonstrating lines of authority and staff responsibility accompanied by position descriptions for each key position proposed. Resumes for all proposed staff filling key personnel positions should be included in the annex (as noted below). See next section for a detailed description of required Key Personnel. Note that USAID expects that in the case of consortium proposals, staff of all consortium partners involved in the award will be co-located. Additionally it is expected that the contractor will have minimum core staff but will be able to add additional technical staff in response to evolving needs. The staffing pattern proposed for non-key staff should explain how additional expertise and skill mix might be obtained while attending to the necessity of cost-containment and avoiding unnecessary staffing.

VI. Organizational Capability (suggest 2 of the 30 page maximum limit) - Offerors should demonstrate a proven track record of developing and implementing effective solutions that achieve results in health service capacity building in the public and NGO sector, preferably Haiti and the Caribbean Region. Propose creative and/or non-traditional partners whose particular capabilities or approaches that might strengthen the overall capacity of the host government, PVOs, local NGOs, faith-based organizations, universities, professional organizations, south-south partnerships, and private sector partnerships in improving primary health care service delivery. Offerors should demonstrate their technical capabilities and experience to undertake the results described in this Task Order. The Offerors are asked to provide specific examples of how the Offeror and any of its primary sub-partners has successfully implemented worldwide and/or national projects in strengthening host government capacity to expand access to primary health care services.

VII. Past Performance. (suggest 2 of the 30 page maximum limit)

Offerors should provide a summary of their past performance, with specific emphasis on past performance managing and implementing similar technical health sector assistance activities to this Task Order. USAID will consult with its contractor's performance database, as well as any other information it deems necessary, to assess past performance on the following factors of quality of services; timeliness of performance; business practices and customer satisfaction; and cost control. Offerors are recommended to highlight these past performance factors in their summary.

VIII. Authorized Attachments - specified below; shall not be counted towards the page limits described above; however, any attachments other than those specified shall be counted within the combined maximum 30-page limit for above Sections III, IV, V, VI and VII).

a. Draft Work Plan, which includes a 90-day transition plan, a detailed Year 1 implementation plan (which includes an equipment / vehicle purchasing plan for the first year), illustrative Year 2 and Year 3 implementation plan, and Monitoring and Evaluation plan (details provided in Task Order Section A- XXI).
b. Staffing Plan with proposed organizational chart and position descriptions for key personnel
c. Corporate capability statements and statements of work for potential sub-Offerors
d. Resumes or curriculum vitae of Key Personnel proposed
e. Offeror Performance Reports from the last three most recently completed contracts, cooperative agreements or grants funded by USAID that have a similar technical scope as this Task Order.

Description of Key Personnel

To be included as a part of the Technical Proposal Section V described above, the key staff positions (and qualifications) required to be included in the Offeror's proposal submission include the following.

Chief of Party (COP)

The proposed Chief of Party is expected be responsible for the overall planning, implementation and management of the performance of the contract and to establish the administrative and technical oversight framework to monitor and assure progress toward the achievement of the goals and objectives. The Chief of Party is expected to:

- Have a minimum of a Masters Degree in Public Health or related area (exceptional relevant experience, which includes a minimum of 15 years managing the implementation of development assistance programs may be considered in lieu of an advanced degree).
- Provide vision and strategic leadership.

- Minimum of 15 years experience working in developing countries in the health sector and successfully managing a high-pace multi-disciplinary team to achieve development results.
- Minimum of 5 years experience in managing donor-funded projects from design to implementation to completion in the Caribbean with some of the experience in Haiti.
- Ability to perform at a senior policy level, demonstrated by previous experience in leading the development and implementation of international health sector development programs.
- As demonstrated by experience, ability to liaise with senior GOH and MSPP officials, USAID officials, university professors and dignitaries, executives of NGOs, FBOs, CBOs, the for-profit business community, and senior members of the Haitian donor community.
- Ability to lead and guide team in the timely completion of all required reporting and performance deliverables under a multi-million U.S. dollar contract.
- Required to have strong interpersonal, oral and written communication, and presentations skills in French (tested FSI R3/S3) and English; working knowledge of Creole is highly desired.
- Be familiar with USAID or other USG administrative, management and reporting procedures and systems as required when managing a USAID-funded contract.

Technical Director/Deputy Chief of Party

The proposed Technical Director/Deputy Chief of Party is expected to be responsible for the overall technical direction and to have at a minimum:

- A medical degree or Doctorate in Public Health.
- 10 years experience in the field of primary health care with in-depth technical knowledge of implementing maternal and child health, family planning, HIV/AIDS and other infectious disease programs.
- At least 5 years experience in managing donor funded projects and in the design and implementation of overseas health projects; preferably in the Caribbean.
- The ability to perform at a senior policy level, demonstrated by previous experience in leading the development and implementation of primary health care programs.
- The ability to liaise with senior MSPP officials, University Professors and dignitaries, executives of NGOs, FBOs, CBOs, the for-profit business community, and senior members of the Haitian donor community.
- Strong oral and written communication and presentations kills in French (tested FSI R3/S3) and English; working knowledge of Creole is preferred.
- Strong Computer skills (word processing, graphic programs and excel spread sheets).
- Familiarity with USAID or other USG administrative, management and reporting procedures and systems.
- The ability to foster team work and to work as a team member.

- Perform as acting COP in the absence of the COP.

Communication & Public Relations Specialist

The proposed Communication & Public Relations Specialist will be responsible for the development of all public outreach and public relations materials (print and electronic) used under the contract to inform the public of USAID assistance to the health sector under this contract. S/he will also be responsible for developing materials to document the successes and the lessons learned to USAID, the Embassy, and the US Congress, the GOH, the MSPP and the Haitian public. This also includes establishing an electronic photo library. The incumbent will also be the primary point person responsible for development of site visits for VIP delegation visits and all related background material to support those site visits (briefing documents, talking points, speeches, press releases, etc). The incumbent must be full cognizant of USAID branding requirements. The incumbent will work closely with the USAID and U.S. Government public relations representative. The incumbent is expected to have:

- A Masters Degree in Communication, Journalism or related field. Extensive experience in leading communication initiatives in developing countries may be substituted in lieu of a Masters Degree.
- Fluency in oral and written communication and presentations skills in French, English, and Creole is required.
- Five years of progressively responsible work experience in communications activities associated with international primary health care programs, preferably in the Caribbean.
- The ability to develop information and education program materials (print and electronic media) for primary health care programs.
- Demonstrated ability to work as a team member, as well as provide leadership skills in his/her areas of competency.
- The ability to work independently, possess sound judgment and the ability to represent the program to country counterparts, partners, US dignitaries and beneficiaries.
- The ability to develop public relations material about the program for presentation to the Haitian public health community, the Haitian public and private sectors, the US Congress, USAID and the Embassy.
- The capacity to be analytical and present information creatively and accurately.

Acquisition and Assistance & Financial Management Specialist

The proposed Acquisition and Assistance & Financial Management Specialist has a combined role of managing all sub-agreements under the contract as well as managing all financial aspects of the contract. The incumbent will serve as the principal point of contact to USAID in these areas. The successful candidate for the position is expected to have:

- At a minimum a Bachelors Degree in Business Administration, Finance Commerce or related field. Extensive experience in managing grants or contracts for NGOs or private and voluntary organizations (PVOs) may be substituted in lieu of a degree in business, administration or commerce.
- Experience and knowledge in fiscally managing all aspects of a large multi-million US dollar contract agreement funded by USAID.
- Strong oral and written communication and presentations kills in French (tested FSI R3/S3) and English; working knowledge of Creole is preferred.
- Seven years of progressively responsible work experience in managing small grants with international health NGOS and/or PVOs, preferably in the Caribbean.
- Knowledge of USAID or other USG assistance instruments, policies and procedures and requirements.
- Skill in organizing, tracking and monitoring resources and establishing priorities.
- Ability to gather data, compile information and prepare reports.
- Strong Computer skills (word processing, graphic programs and excel spread sheets)

B3. INSTRUCTIONS FOR PREPARATION OF THE COST/BUSINESS PROPOSAL

The cost/business proposal must be completely separate from the Offeror's technical application. The Cost/Business Proposal should be for the basic period of May 2007 – September 2010 with two additional option years. In addition to five (5) hard copies, technical and cost/business applications must be submitted on separate CDs in Microsoft Word 2000. Any graphics/tables must be formatted in MS Word 2000 or Excel 2000. The Offeror should propose a minimum cost share (20% of the total value of the contract). This cost share may be considered with the "cost effectiveness" evaluation. If the cost share is less, then the proposal shall not be reviewed and will be deemed non-responsive.
The Cost/Business Proposal shall include the following:

1. A proposed time schedule for completion of the work (to be included as an attachment).

2. For each individual who will perform directly under the Task Order, submit their names, position, level of effort, and salary.

3. The breakdown of all costs associated with the program elements.

4. The breakdown of all costs according to each partner organization involved in the program.

5. The costs associated with external, expatriate technical assistance and those associated with local in-country technical assistance.

6. The breakdown of cost share (any financial and in-kind contributions) of all organizations involved in implementing this contract.

7. Potential contributions of non-USAID or private commercial donors to this agreement.

8. Indirect Costs in accordance with your approved NICRA but not to exceed any indirect cost ceilings set forth in the IQC.

9. Proposed fee, if any, not to exceed the ceiling set forth in the IQC.

10. Procurement plan for equipment.

11. Procurement plan for commodities (if applicable).

The cost/business proposal should contain the following budget categories:

a. Salary and Wages: Direct salaries and wages should be proposed in accordance with the applicant's personnel policies;

b. Fringe Benefits: If the Offeror has a fringe benefit rate that has been approved by an agency of the U.S. Government, such rate should be used and evidence of its approval should be provided. If a fringe benefit rate has not been so approved, the cost proposal should propose a rate and explain how the rate was determined. If the latter is used, the narrative should include a detailed breakdown comprised of all items of fringe benefits (e.g., unemployment insurance, workers compensation, health and life insurance, retirement, FICA, etc.) and the costs of each, expressed in dollars and as a percentage of salaries;

c. Travel and Transportation: The proposal should indicate the number of trips, domestic and international, and the estimated costs. Specify the origin and destination for each proposed trip, duration of travel, and number of individuals traveling. Per Diem should be based on the applicant's normal travel policies;

d. Equipment: Estimated types of equipment (i.e., model #, cost per unit, quantity);

e. Supplies: Office supplies and other related supply items related to this activity;

f. Contractual: Any goods and services being procured through a contract mechanism;

g. Other Direct Costs: This includes communications, report preparation costs, passports, visas, medical exams and inoculations, insurance (other than insurance included in the applicant's fringe benefits), equipment, office rent abroad, etc. The narrative should provide a breakdown and support for all other direct costs;

h. Indirect Costs: The Offeror should support the proposed indirect cost rate with a letter from a cognizant U.S. Government audit agency, a Negotiated Indirect Cost Agreement (NICRA), or with sufficient information for USAID to determine the reasonableness of the rates. Indirect Costs in accordance with your approved NICRA but not to exceed any indirect cost ceilings set forth in the IQC.

i. Proposed fee, if any, not to exceed the ceiling set forth in the IQC.

To support the proposed costs, please provide detailed budget notes/narrative for all costs that explain how the costs were derived.

B5. UNECESSARILTY ELABORATE PROPOSALS

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective proposal in response to this RFTOP are not desired and may be construed as an indication of the applicant's lack of cost consciousness. Elaborate

artwork, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

B6. CONTRACT AWARD

The Government may, without discussions or negotiations, award a task order resulting from this RFTOP to the responsible Offeror whose proposal conforms to this RFTOP and offers the best value. Therefore, the initial proposals should contain the Offeror's best terms from a cost and technical standpoint. However, the Government may reject any or all proposals, accept other than the lowest cost proposal, and waive informalities and minor irregularities in proposals received, should it be in the best interest in Government.

Although technical evaluation factors are significantly more important than cost factors, the closer the technical evaluations of the various proposals are to one another, the more important cost considerations become. The Contracts Officer may determine what a highly ranked proposal based on the technical evaluation factors would mean in terms of performance and what it would cost the Government to take advantage of it in determining the best overall value to the Government.

B7 AUTHORITY TO OBLIGATE THE GOVERNMENT

The Task Order Contracting Officer. (TOCO) is the only individual who may legally commit the U.S. Government to the expenditure of public funds. No costs chargeable to the Task Order proposal may be incurred before receipt of either a Contract signed by the TOCO or a specific, written authorization from the TOCO.

SECTION C – EVALUATION CRITERIA

1. Overview

The criteria listed below are presented by major category with the point system for evaluation clearly indicated so that Offerors will know which areas require emphasis in proposals. Offerors should note that these criteria serve as the standard against which all technical information will be evaluated.

These technical evaluation criteria have been tailored to the requirements of this RFTOP to allow USAID to choose the highest quality proposal. These criteria serve as the standard against which the Technical Evaluation Committee (TEC) shall evaluate all acceptable proposals. USAID will award to the Offeror whose proposals best meet(s) the Scope of Work description and Performance Standards and represent(s) the best value to the U.S. Government, all things considered.

2. Technical Proposal Evaluation Criteria: (based on 100 point scale)

A. Technical Approach: (35 points)

- Proposed overall development objective to be achieved by the end of the contract is ambitious, feasible and specific. Offeror conveys clearly how the proposed program will increase access to use of a basic package of health care services in a clearly defined geographic target area. (15 points)
- Proposed technical approach is feasible, complete, state-of-the-art, creative and innovative, evidence-based and appropriate to achieve objective and results under the contract. Proposal presents comprehensive understanding of implementing strategies in Haiti, realistic approach for planning, implementing and tracking work effectively and that all assistance activities will achieve all program element results and performance requirements for Result Areas 1 through 5 detailed in Section XVII and XVIII of the Task Order. (10 points)
- Offerors proposed technical approach demonstrates clear understanding of and ability to effectively implement performance standards for Result 6: Strengthening public sector capacity detailed in Section XVIII of the Task Order. 5 points)
- Offeror demonstrates clear understanding of and ability to effectively carry out tasks to fully implement "Other Considerations" Performance Standards to achieve desired results detailed under Section XVIII of the Task Order. (5 points)

B. Management (35 points)

- Management plan proposed is logical, organized and appropriately staffed to effectively manage the contract towards achievement of annual and end of contract results specified in Sections XVII and XVIII of the Task Order. (10 points)

- Management plan will meet all required reporting requirements and contract management processes as specified in the Task Order in Section XX, XXI, and XXII. (5 points)
- Management plan proposed is cost-effective, maximizing use of local Haitian organizations, and minimizing high overhead costs and or excessive use of external short-term consultancies. (5 points)
- Management plan responds to a need to ensure flexibility of implementation of technical assistance to respond to USAID direction and Haiti's development context. (5 points)
- Monitoring and Evaluation plan, as a component of the draft Work Plan, is comprehensive, includes proposed indicators detailed in Section XVIII of the Task Order, and proposes a routine and systematic approach to monitoring and reporting annual and end of contract achievements, filling in information gaps as needed, and assessing periodic performance of the entire contract. (5 points)
- The proposed Transition plan, as a component of the draft Work Plan, is logical, timely and will ensure minimum disruption of USAID technical assistance to the health sector during the transition of contractors. (5 points)

C. Personnel (10 points)

- Proposed technical key personal meet or exceed requirements to carry out key functions of each position. Proposed key personnel are placed appropriately in the organizational chart, and have the defined duties that will enable the Offeror to effectively execute the contract. Proposed key personnel demonstrate experience in working in similar countries as Haiti, as a "rebuilding country" in the context of the new USG Foreign Assistance Strategic Framework. (5 points)
- The staffing pattern proposed is an adequate skill mix meeting the needs for technical implementation and management of the Task Order; demonstrates a strong effort towards cost containment and efficient use of short-term technical expertise as needed. (5 points)

D. Organizational Capability (10 points)

- Offeror demonstrates ability to provide the breadth of technical, regional and language skills needed to effectively execute the contract, either by describing its existing technical capabilities or by demonstrating its ability to quickly and effectively mobilize such expertise, which includes long-term and short-term sub-partnerships proposed. (5 points)
- Demonstrated successful experience and a proven track record of developing and implementing effective solutions that achieve results in health service delivery, capacity building in the public sector, preferably in Haiti and the Caribbean Region. (5 points)

E. Past Performance (10 points)

- Demonstrated capacity in providing quality services, track record of timeliness of performance; good business practices and customer satisfaction; and attention to cost control. (10 points)

USAID reserves the right to obtain past performance information from other sources including those not named in this application. Any other past performance information obtained may be used by the TEC as part of the review and evaluation of the past performance of the Offer and proposed sub-partnerships.

3. Cost / Business Proposal

Cost is of significantly less importance than the technical evaluation criteria. However, where proposals are considered essentially equal, cost may be the determining factor. The overall standard for judging cost will be whether the cost proposal presents the best value for the cost. The cost proposal will be judged on: (i) whether it is realistic and consistent with the technical proposal; (ii) overall cost control (avoidance of excessive salaries, excessive home office visits, and other costs in excess of reasonable requirements); and (iii) amount of proposed fee.