POPULATION, HEALTH AND NUTRITION TEHNICAL ASSISTANCE AND SUPPORT CONTRACT 3 – GLOBAL HEALTH (TASC 3 – GLOBAL HEALTH) INDEFINITE QUANTITY CONTRACT SECTION A –REQUEST FOR TASK ORDER PROPOSAL (RFTOP)		
"Improving National Capacity to Implement High Impact Health Services and Promote Healthy Behaviors in Mali"		
1	RFTOP Number	688-P-08-005-00
2	Date RFTOP Issued	May 06, 2008
3	Issuing Office	USAID/Mali
4	Contracting Officer	*(Neil Price RCO in Ghana)* Phone: +233-21-741-434 Fax: E-mail: nprice@usaid.gov
5	Proposals to be Submitted to	*(Mama Traoré Negotiator)* Phone:223-270-23-00 Ext. 2781 Fax: 223-222-39-33 Email: mamtraore@usaid.gov
6	Proposals Due	June 16 before 11.30 am (Mali time)
7	Payment Office	See Section G.4 Invoices
8	Name of Firm	All IQC Holders under TASC3 – Global Health
9	IQC Task Order Number	TBD
10	DUNS number	TBD
11	Tax Identification Number	TBD
12	Address of Firm	TBD
13	RFTOP Point of Contact	Name: Phone: Fax: Email:
14	Person Authorized to Sign RFTOP	
15	Signature	
16	Date	

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SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

The United States Agency for International Development (USAID), Health Population and Nutrition Office requires support aimed at improving National Capacity to implement High Impact health Services and promote healthy behaviors in Mali, as detailed in Section C.

B.2 CONTRACT TYPE

This is a Cost Plus Fixed Fee completion task order. For the consideration set forth in the contract, the Contractor shall provide the deliverables or outputs described in Section C and comply with all contract requirements.

B.3 BUDGET

a) The Total Estimated Cost of this acquisition is *$ TBD*. The Fixed Fee is *$ TBD*. The Total Estimated Cost Plus Fixed Fee is *$ TBD*.

b) Within the estimate cost plus fixed fee specified in paragraph (a) above, the amount currently obligated and available for reimbursement of allowable costs incurred by the Contractor (and payment of fee, if any) for performance hereunder is $*TBD.* The Contractor shall not exceed the aforesaid obligated amount.

c) Funds obligated hereunder are anticipated to be sufficient through *TBD*.

B.4 PAYMENT

The paying office is provided in section G.

END OF SECTION B

SECTION C – DESCRIPTION / SPECIFICATIONS/STATEMENT OF WORK

C.1 ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
AWARE	Action for West Africa Region
AWARE-HIV	Action for West Africa Region-HIV/AIDS
AWARE-RH	Action for West Africa for Reproductive Health
CBCHB	Cameroon Baptist Convention Health Board
CCM	Country Coordination Mechanism
CAFS	Center for African Family Studies
CEFOREP	Centre Régional de Formation et de Recherché en Santé de la Reproduction
CESAG	Centre Africain d'Etudes Supérieure en Gestion
CICDoc	Centre d'Information de Conseil et de Documentation
CTO	Cognizant Technical Officer
DFID	United Kingdom Department for International Development
ECOWAS	Economic Community of West African States
FAAPPD	Forum of African and Arab Parliamentarians on Population and Development
FP/RH	Family Planning and Reproductive Health
FY	Fiscal Year
GH	Global Health
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IQC	Indefinite Quantity Contract
IRSP	Institut Régional de Santé Publique
ISED	Institut de la Santé et Développement
KATH	Komfo Anokye Teaching Hospital
M&E	Monitoring and Evaluation
MCC	Millennium Challenge Corporation
MCH	Maternal and Child Health
NAP+	Network of African People Living with HIV/AIDS
NICRA	Negotiated Indirect Cost Agreement
OYB	Operating Year Budget
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMI	President's Initiative for Malaria
PMTCT	Prevention of Mother to Child Transmission
RCO	Regional Contracting Officer
RFTOP	Request for Task Order Proposal
SAGO	Société Africaine de Gynécologie et Obstétrique
SMIT-CRF	Service des Maladies Infectieuses et Tropicales – Centre Régional de Formation
SWAA	Society for Women and AIDS in Africa
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNAIDS	United Nations for AIDS
USAID	United States Agency for International Development
USAID/MALI	United States Agency for International Development/West Africa
USG	United States Government
WAAF	West Africa Ambassador's Fund for A|IDS
WAHO	West Africa Health Organization

WANASO	West African Network of AIDS Organizations
WHO	World Health Organization

C.2 INTRODUCTION, OBJECTIVES AND EXPECTED RESULTS

USAID/Mali's Health strategic objective was developed as one of five inter-related strategic/special objectives under the USAID/Mali ten-year (2003-2012) Country Strategic Plan (CSP); and as changes have come to USAID/Mali and the agency as a whole, Operational Plans (OP) have been added to increase accountability and facilitate financial and performance tracking. After careful review and the development of the OP, it has been determined that the framework of the CSP strategy remains the appropriate avenue to help Mali expand its economy and reduce poverty. The Health OP has multiple instruments focusing on the implementation of high impact health services and behavior change including two cooperative agreements (Pathways to Health [PSI, prime] and the Keneya Ciwara Project [Care, prime]) and one contract (Assistance Technique Nationale [Abt Associates, prime]) that are scheduled to end on September 30, 2008. This Request for Proposals seeks to identify an instrument that will provide technical assistance, training and limited commodity support to the Government of the Republic of Mali in order to achieve the results envisioned under the USAID/Mali Health program area. The contactor's primary clients shall be the Malian Ministry of Health and USAID. The successful offeror shall actively collaborate with other USAID-funded organizations working in the Health program area as well as USAID implementers working in other areas.

C.2.1 The objectives of the proposed task order are to:

- Increase the capacity of the Ministry of Health to develop and roll out appropriate and technically sound policies and guidance and improve the capacity of the Ministry of Health, civil society and the private sector to implement them;

- Expand and strengthen the range of services and quality of care offered through the health system in the areas of maternal health and child survival in Mali, from the central level through to the local level (CSCOM);

- Expand and improve access by underserved communities and key populations to high quality health services related to maternal health and child survival;

- Develop and manage broad-based communications interventions that enhance the knowledge of Malians about core issues related to maternal health and child survival, including persuasive information to encourage and sustain healthy behaviors; and

- Expand partnerships and increase the capacity of the public and private sectors to create an improved environment for the rational delivery of quality health services.

In addition, certain national level results are expected to be achieved during the project period to which the current procurement is expected to contribute significantly by strengthening the ability of the Government of Mali to attain national level impact on key maternal and child health-related indicators.

C.2.2. Expected results include:

Indicator	DHSM 4: 2006	DHSM 5: 2011
Percentage of women who have completed a pregnancy in the last two years that have received two or more	4%	85%

doses of IPTp during that pregnancy		
Percentage of children (6-59 months old) receiving Vitamin A supplementation	80%	85%
Percentage of pregnant women sleeping under an insecticide-treated	29%	85%
Percentage of women with at least 1 FANC visit	70%	85%
Percentage of children (12-23 months old) fully vaccinated prior to first birthday	48%	60%
Percentage of children (12 months old) who have received DPT3	68%	80%
Percentage of children 6-59 months with diarrhea receiving ORT	24%	55%
Percentage of children under five with fever in previous 2 weeks treated with appropriate antimalarial drug within 24 hours of onset of symptoms	15%	85%
Contraceptive prevalence rate for modern methods, women of reproductive age	6.4%	10%

C.3 BACKGROUND

Mali is a unique example of democracy in West Africa. Despite a rating of 174 out of 177 on the 2005 UN Human Development Index, Mali has demonstrated its commitment to democracy and determination—in spite of enormous economic challenges—to improve the standard of living of its citizens. Many positive trends are evident: democracy and decentralization are taking root; greater public investment is being put towards health and education; and agricultural technologies to reduce production risks are being promoted and adopted. Mali can boast an open press and the largest number of private radio stations in any African country. In addition, the Government of the Republic of Mali (GRM) signed a Millennium Challenge Account (MCA) compact in November, 2006 for US$462 million. At the same time, Mali, a "Heavily-Indebted Poor Country" (HIPC), has the highest percentage of people living on less than a dollar a day in the world[1]. Mali's agriculture-based economy remains under-diversified and vulnerable to external shocks such as periodic drops in cotton and gold prices, and increases in oil prices. Health conditions have improved notably since 2001 with a significant decrease in child, infant and maternal mortality between 2001 and 2006 (DHS, 2006). These key indicators however remain unacceptably high; if progress in these areas continues at the current rate, Mali will not attain the Millennium Development Goals by the target date of 2015. In addition, the poor educational system in Mali acts as an impediment to progress in health: despite recent progress in raising enrollment rates, only half of all school-aged children are enrolled in primary school, and 76% of youth and 81% of adults (mostly women) remain illiterate.

C.3.1 Health in Mali

Mali has high rates of infant and under-five mortality, 96/1000 and 191/1000 live births respectively according to the 2006 DHS (down from 113/1000 and 229/1000 live births,

[1] Human Development Report, 2005.

respectively in 2001). The total fertility rate of 6.6 children per reproductive lifetime is one of the highest in the world and has shown basically no improvement over the last 15 years.

Under-five mortality: The high under-5 mortality in Mali results from a combination of malaria, vaccine preventable diseases, diarrhea, acute respiratory infection and malnutrition. Data sources indicate that malaria is a major cause of child deaths due to inadequate prevention and treatment. Because of improving but still low vaccination rates (68% DPT3; 2006 DHS) measles and neonatal tetanus are still important causes of under-five mortality. Repeated episodes of diarrhea (13.3% of children had diarrhea during the two weeks prior to the 2006 DHS) increase the vulnerability of Malian children to other diseases and result in deaths due to dehydration; the 2006 DHS reported use of oral rehydration therapy in only 24.3% of diarrheal cases. Acute respiratory infection accounts for morbidity among young children; 5.6% of children under five had experienced IRA in the two weeks preceding the DHS and only 38% received treatment in a health center. Fever is also a major problem among this population, with 18% having experienced fever prior to the DHS of which only 33% were brought to a health center for care.

Maternal health: Lack of family planning use and poor access to health services contribute to decreasing but still high maternal mortality (the maternal mortality ratio went from 582/100,000 live births in 2001 to 464/100,000 live births in 2006; DHS). Other contributing factors include harmful traditional practices, early child bearing, closely spaced births, unsafe abortion, and inadequate obstetrical care. In 2006 only 54% of pregnant women had received two or more doses of tetanus toxoid vaccine, only 70% had received at least one antenatal care visit and only 49% were assisted by a trained provider during birth. In terms of family planning, according to DHS modern contraceptive prevalence increased only from 5.7% to 6.9% between 2001 and 2006, and in 2006 almost 63% of birth intervals were less than 36 months. Based on an annual population growth rate of 2.7%, Mali's current national population figure of 12 million is projected to increase to 23.2 million by 2020.

HIV/AIDS: While the general HIV prevalence in Mali is low, high rates in certain bridging populations underscore the necessity of maintaining a strong focus on STI and HIV prevention, especially among most-at-risk groups. Adult HIV prevalence in Mali was 1.3% in 2006 (DHS), with infection rates continuing to be higher among women (1.5%) than among men (1.0%). However, the rates of sexually transmitted infections (STIs) and HIV among certain high-risk groups are much higher. For example, the 2006 Integrated STI/HIV and Behavioral Survey (ISBS) found 35.3% HIV prevalence among sex workers, 5.9% amongst female market girls and 2.5% among truckers.

Government Response: In 1990, the Government of Mali adopted a health policy initiative known as the “Politique Sectorielle de Sante” (PDSS), followed by a ten-year plan (1998-2007) for health and social development “PRODESS”. The first five-year phase of the plan, PRODESS I ended in 2004; PRODESS II began in 2005 and will continue through 2009. The Government's health policy is based on the principles of Primary Health Care and the “Bamako Initiative”, focused on increasing the coverage and the quality of the health system nationwide. The policy encourages communities to participate in managing and financing health care through the creation of community health committees (ASACOs), which serve as boards of directors for community health centers (CSCOMs). The government health system is built around the principal of cost recovery as a means to ensuring the sustainability of health structures, salary payment, commodities and logistics.

Despite these worthwhile efforts, adequately staffed, equipped, and supplied community health facilities are still insufficient in number. Shortages and retention of health staff (primarily nurses

and midwives) remain major problems. More than 65% of nurses, midwives and physicians work in Bamako and regional capitals, leaving large segments of the rural populations with limited or no access to qualified health professionals. While there are currently more than 780 registered CSCOMs, a large number of these are not functional due to lack of personnel. Pre-service training is weak on managerial skills and some important technical areas (family planning, nutrition). While in-service training courses are plentiful, they divert the already scarce staff from service delivery without necessarily addressing performance needs. Supervision and its role in ensuring quality services also need to be strengthened. Despite community financing of health centers and essential drugs in many localities, there are still shortages of key commodities including contraceptives in some places.

Other constraints: Due to the limited health infrastructure, staffing, poverty, and cultural/behavioral reluctance to demand health services, access to health facilities is low, with approximately 25% of the population living more than 15 kilometers from a local health center, making the delivery of health services in communities difficult. Women's lack of empowerment in health care decision-making is compounded by financial dependency, and results in limited access of women and their children to the health system.

C.3.2 USAID in Mali

USAID has been assisting with Mali's development since 1961. The various programs were administered either regionally or through direct bilateral programs with USAID staff in residence. Through 1978, efforts were made to stave off massive starvation and to establish Sahel regional institutions to mitigate the horrific effects of drought throughout the region. From 1978-1987, USAID's Mali mission focused its efforts on attempting to reduce state control, create food security, restructure cereals marketing and reduce state control, establish basic maternal/child health services, create rural infrastructure and promote literacy, and do agriculture research. For the period 1987-1994, USAID concentrated on privatization and completion of projects with state-owned enterprises. Democracy and basic education became parts of the program, much of which continued to focus on basic health, agriculture and livestock. In 1995, USAID designed a new strategic approach, focusing on four key sectors (health, basic education, economic growth, and democratic governance) and two special sub-sectors (information and communications and development in the northern regions). Full implementation of the new Country Strategic Plan did not start until 1998, when USAID and the GRM signed Strategic Objective Agreements (entitled "Youth", "Sustainable Economic Growth" and "Democratic Governance") and Special Agreements (entitled "Information and Communications" and "Development in the North") covering the period through FY 2002 when the Mission strategy was reviewed and revised. Beginning in 2003 a new Mission strategy was launched that included four revised strategic objectives: Health, Education, Accelerated Economic Growth and Democracy and Governance as well as one Special Objective, Communications for Development. In 2006 the Mission's strategy was again slightly revised to ensure its alignment with the new USAID strategy for Africa; the SOs and the SpO, now referred to as "program areas" under the new foreign assistance framework retain their fundamental orientation.

The current USAID/Mali High Impact Health Services strategy, based on the strategy originally adopted in 2003 and then approved in early 2006 as part of the USAID Mali Mission Strategy Statement, aims at "motivating and empowering individuals and communities to take greater control of their health" through the attainment of four (4) intermediate results: IR1 - Policy environment for HIHS is established; IR2 - Demand for HIHS is increased; IR3 - Access to HIHS is increased; IR4 - Quality of HIHS is improved. The HIHS include: vaccination; family planning/maternal health; malaria; vitamin A; nutrition; diarrheal disease; and HIV/AIDS.

USAID/Mali currently has a variety of implementing partners including three bilaterals, one PASA and several field support and other centrally managed mechanisms; USAID/Mali also provides direct funding to the Ministry of Health. A key defining principle of the HIHS approach is that all instruments work within the same results framework toward the same goals; this approach has helped to reduce duplication of effort and increase coordination and collaboration.

C.4 PROGRAMMATIC ORIENTATION

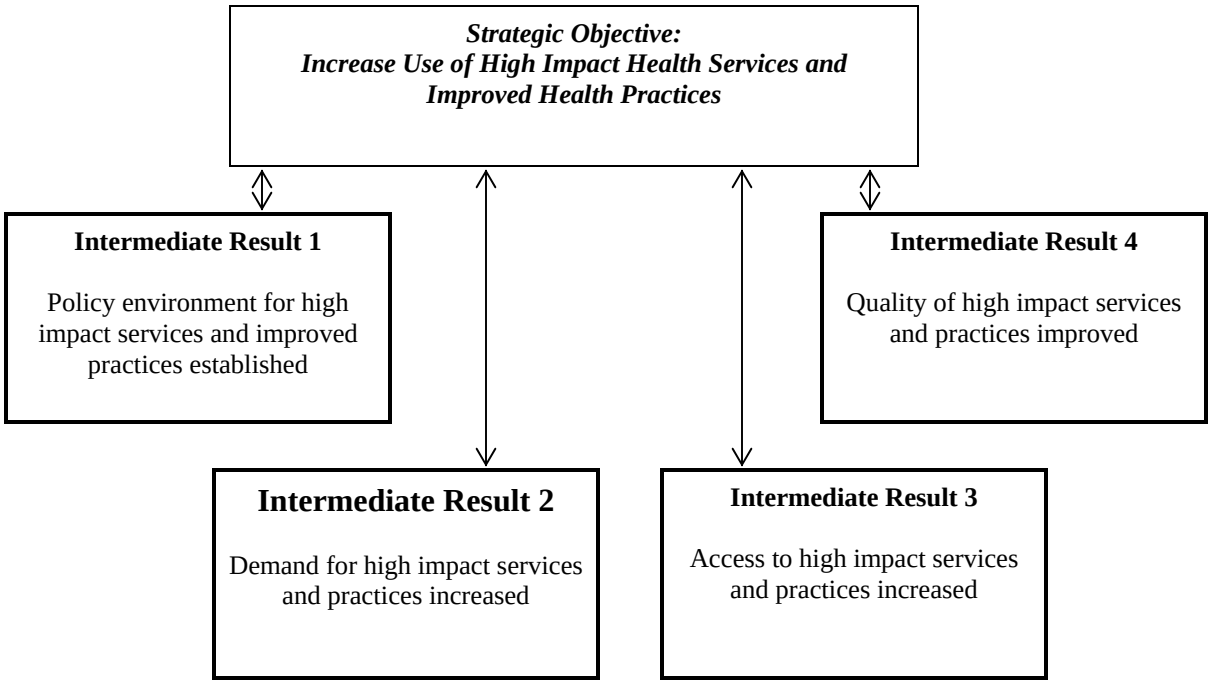
C.4.1 Technical Domains

USAID/Mali's current health strategy focuses on high impact health services and behavior change (HIHS). Originally adopted in 2003 and then approved in early 2006 as part of the USAID Mali Mission Strategy Statement, it aims at "motivating and empowering individuals and communities to take greater control of their health" by focusing on the policy environment, demand for services, access to services and improved service quality; the complete strategy can be found on the USAID/Mali website. Since 2003 the HIHS technical areas have included vaccination; family planning/maternal health; malaria; nutrition including micronutrient supplementation; diarrheal disease; and HIV/AIDS; however additional areas might be considered for inclusion if a convincing argument can be made as to their pertinence.

The strategy concentrates on the implementation of high impact, proven maternal and child health-related services that will have an effect on Mali's continued under-five and maternal mortality rates and high fertility. These services include but are not limited to:

- Vaccination
- Micronutrient supplementation
- Nutrition promotion
- Malaria prevention and treatment
- Improved maternal health services, including family planning
- Essential newborn care
- Diarrheal disease control
- Cross cutting themes as appropriate (such as behavior change communication, health human resources, health financing, etc)

The USAID/Mali Health Program Area operates within the context of a results framework implemented since 2003:



C.4.2 Levels of Focus

Level of focus refers to the operational level at which activities are carried out: through its high impact health strategy, activities funded by USAID are primarily carried out on three levels: 1) national 2) regional and district (including CSCOM) and 3) community and household. The level and extent at which activities are carried out depend in large part on the existence of complementary activities already underway by USAID or other donors/partners and not all activities are carried out at the same level in the same geographic area (level of focus does not equal geographic coverage).

The current procurement will focus exclusively on the national and regional/district levels; a follow-on to the Keneya Ciwara Project (PKC) cooperative agreement will focus on mobilization at the community and household levels. The proposed task order will be expected to work closely and in absolute harmony with the PKC follow-on to achieve a holistic vision of technical assistance and intervention at the national, regional, district, local and community/household levels.

Building on past efforts, the successful offeror will be expected to collaborate closely with the Ministry of Health to support the increased use of health services through:

- The identification of gaps and weaknesses in MOH policies and guidelines;
- The provision of assistance to the MOH in the development and updating of key policies and guidelines;

- The provision of assistance to the MOH in developing and rolling out strategic plans for the application of key policies and guidelines at the operational level;
- The training and orientation of health service providers in high impact health technical areas and innovations;
- The strengthening of the capacity of regional and district health teams to supervise health providers at the local CSCOM level and the capacity of local CSCOM teams to provide quality health services;
- Orientation in MOH guidelines and application of training modules private sector providers.

While this task order will focus on the provision of technical assistance to the Ministry of Health at the central, regional and district levels as well as local health service providers, the PKC follow-on will support the mobilization of civil society (communities, households) around health issues and service delivery. The PKC follow-on will conduct a range of activities including the following:

- Capacity building of ASACOs in management and team building;
- Relationship building between ASACOs and local commune administration including commune-wide health-related budgeting and programming;
- Relais training in conjunction with capacity building of ASACOs in relais supervision and support;
- Household and community level social mobilization (behaviour change communication) around key interventions, health messages and behaviors;
- Selected malaria-specific community mobilization efforts including ITN use verification, community mobilization for the prompt and appropriate treatment of malaria, advocacy around malaria-related issues with traditional healer, local religious leaders and other key stakeholders;
- Small grants to local NGOs to work with most-at-risk populations on HIV/AIDS prevention and mobilization.

It is anticipated that the relationship between the ASACO and the CSCOM health team will provide the natural junction for collaboration between the Task Order and the PKC follow-on in order to ensure a continuum of support from the central MOH to the most decentralized household level.

C.4.3 USAID/Mali/Health's Customers and Partners:

Customers: at the population level, USAID/Mali/Health's primary customers are women of reproductive age and specifically pregnant women, men as partners; infants and children up to age 5 and their mothers and fathers; other family members as appropriate. USAID/Mali/Health's primary institutional customer is the Ministry of Health that is responsible for the overall coordination and oversight of the implementation of health related activities in Mali. Customers also include public or private health professionals, local community and grassroots organizations, NGOs, and opinion leaders and decision makers in the areas of government, religion, civil society and private business. It is anticipated that other groups such as school children and traditional healers may become customers through synergistic activities.

Partners: in addition to being its primary customer, the Ministry of Health is USAID's main implementation partner. Other important partners include donors, international and local non-governmental organizations, local civil society entities such as ASACOs and private sector

providers and associations. USAID's partnership with the GRM is outlined in the Strategic Objective Agreement (SOAG) signed in September 2002 following extended consultations with the Ministry of Health. All donors work together within the context of the Ministry of Health's ten-year action plan for health, the PRODESS.

C.4.4 Existing bilaterals and Transition Activities:

USAID/Mali's three major health bilaterals will conclude in 2008. All three bilaterals have been successful in reaching their targets under the health element, however, USAID/Mali envisions under this task order to broaden the breadth and depth of services including the expansion of proven high impact health interventions to improve key health indicators. Therefore the bidders should demonstrate their understanding of the current bilateral structure and the vision of the USAID/Mali health team in this request for proposals. Short summaries of the three bilaterals follow:

Assistance Technique Nationale (ATN) Contract: The current central level technical assistance bilateral, ATN, has provided technical assistance to central divisions of Ministry of Health (MOH) to create a favorable policy environment and increase service capacity for quality high impact health services in the technical areas noted above. ATN assists the MOH in multiple areas including designing and updating training content and supervision tools; drafting policies and directives in order to reinforce service delivery capacity and introduce innovation; and providing guidance on best practices in behavior change communication.

Projet Keneya Ciwara (PKC) Cooperative Agreement: The current district level bilateral works with district and local level medical teams and civil society to strengthen the health system and increase service provider and community capacity to effectively respond to the population's health priorities and needs. Activities target the general population, with a particular focus on women of reproductive age and men as partners, emphasizing the engagement of men in decision-making and management of reproductive health and family planning as well as children under 5 and their caretakers. Activities include strengthening district-level supervision capacity, training of service providers, training and supervision of community-based health volunteers and women's associations in the community-based distribution of certain commodities, counseling, referral and behavior change communication activities. PKC activities cover approximately 30% of the Malian population.

Pathways to Health (PTH) Cooperative agreement: this social marketing/private sector bilateral supports the expansion of the capacity of the private sector to provide essential health related goods and services through the identification of distribution networks; training of field agents in management, oversight and monitoring; and health messages disseminated through the television, print and radio media. The primary technical areas of focus of these activities are family planning, malaria, diarrheal disease control and HIV/AIDS.

C.4.5 Complimentary programming

The successful offeror will be supported by and will work in collaboration with at least two other main instruments: 1) the Keneya Ciwara which will focus on community mobilization around high impact health services and behaviors; and 2) a monitoring and evaluation project providing support to the mission and its bilaterals in project monitoring, reporting and evaluation. In addition, the successful offeror will be expected to work in a collaborative and supportive manner with the Mission's other implementing mechanisms.

C.4.6 Direct funding to the Ministry of Health: USAID/Mali provides direct financing to the Ministry of Health to support a variety of activities. The funding flows from USAID/Mali to the MOH Directorate of Finance and Administration (DAF) through Letters of Implementation under the Strategic Objective Agreement (SOAG). USAID/Mali and the MOH develop an annual action plan and budget which includes the central division and the Regional directorates. Each Regional Directorate is responsible for planning at the regional level (including district planning). Examples of activities financed with direct funding include: training, procurement of supplies, and supervision. The amount provided through direct funding may mildly fluctuate based on articulated needs and the capacity of the national and regional levels to adequately manage and utilize funds. There is no current plan to discontinue the provision of direct funding for the Ministry of Health.

C.4.7 Synergies with other USAID/Mali Programs:

The successful offeror will work in close harmony with other USAID implementing partners and teams where appropriate, especially in areas including economic growth, education, and communications and governance. As this is an evolving activity, bidders are instructed to set aside $100,000 in each annual budget in order to permit synergistic cross sectoral activities to be planned and carried out. Illustrative examples include development of health messages for use in adult literacy classes and the training and sensitization of communal councils regarding health service priorities and management.

C.4.8 President's Malaria Initiative (PMI):

In late June 2005, the United States Government (USG) announced a new five-year, $1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions in high-burden countries in sub-Saharan Africa. The goal of this Initiative is to reduce malaria-related mortality by 50% after three years of full implementation in each country. This will be achieved by reaching 85% coverage of the most vulnerable groups---children under five years of age, pregnant women, and people living with HIV/AIDS---with proven preventive and therapeutic interventions, including artemisinin-based combination therapies (ACTs), insecticide-treated bed nets (ITNs), intermittent preventive treatment of pregnant women (IPTp), and indoor residual spraying (IRS). In implementing PMI, the U.S. Government is committed to working closely with host governments and within existing national malaria control programs. Efforts will be coordinated with other local, national and international partners such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and Roll Back Malaria (RBM).

Mali was named to the PMI beginning with the FY08 budget after which multi-partner needs assessment and planning visits took place in February and April 2007. Following these visits a Malaria Operational Plan (MOP) for Mali was approved in late 2007. The successful offeror will be responsible for carrying out designated PMI activities in coordination and collaboration with other PMI implementing partners. Bidders should ensure that all activities are consistent with the national response to malaria led by the National Malaria Control Program (PNLP) as well as PMI goals and objectives. Bidders are expected to demonstrate a good understanding of PMI priority interventions and how they plan to support the PNLP to achieve and sustain PMI objectives. The successful offeror shall demonstrate strong relationships with local organizations, partners, networks and/or communities in-country active in malaria control. The fact that funds from the President's Malaria Initiative (PMI) will be used to fund aspects of this task order necessitates a clear and well articulated malaria approach within the task order as well as the built-in capacity to monitor and report malaria-related results. Bidders will be

required to specifically define their proposed PMI malaria approach throughout the proposal as well as detail how malaria-related data will be collected, managed and reported.

Bidders are invited to consult the Mali FY08 Malaria Operational Plan available at www.fightingmalaria.gov.

C.4.9 PEPFAR: The USG mission in Mali supports the national strategic plan for HIV/AIDS in line with the "three ones" principle and in accordance with PEPFAR guidelines. USAID/Mali related HIV/AIDS activities strengthen the GRM and focuses on targeted HIV prevention, including the general population (IEC, BCC, VCT, condom use) and high risk groups such female professional sex workers, truckers and youth as a vulnerable group. USAID/Mali also recognizes the importance of MSM as a bridge population. Specific activities include:

- BCC/IEC for HIV/AIDS prevention
- HIV epidemiological surveillance and monitoring
- Advocacy
- Capacity building and institutional reinforcement
- Policy, Norms and Procedures for VCT

C.4.10 Gender: USAID/Mali is committed to the importance of gender considerations in all of its programming. The current procurement will take into account gender roles and differences as they relate to the quality of, demand for, access to and use of high impact services and related behaviors. Activities will be designed and delivered with gender needs and differences in mind and disaggregation of data by sex will be required, including clients/beneficiaries, providers, training beneficiaries and organization membership and staff. To the extent possible, men's roles in supporting MH/FP and child survival will be promoted through policy, mass media and service provision. The effective participation of women in policy dialogue and development and activities designed to foster leadership among women will be welcomed. As required in USAID's Automated Directive System (ADS), attention to gender issues will be included in the evaluation criteria of the RFP.

C.4.11 Program Coordination: Collaboration between USAID/Mali health implementing partners will be fostered through several processes including but not limited to:

- Participation of all USAID/Mali/Health implementing partners in regular coordination meetings that will provide a venue to share and discuss progress and problems, issues of common concern, and identify areas for joint action;
- Active participation of all relevant health implementing partners in local level integrated planning, implementation, and monitoring processes with local entities in focus areas;
- In collaboration with the M&E instrument, active participation of all health implementing partners in monitoring and evaluating the progress (or lack thereof) of their programs, in terms of their own mechanisms and in relation to the Health Team's Performance Monitoring Plan (PMP).
- Semi-annual meetings with the Ministry of Health to examine results and evaluate progress.

C.4.12 Geographic coverage

From 2003 – 2007 USAID/Mali/Health's bilaterals have provided differing levels of geographic coverage depending on the type of intervention. PKC has provided technical assistance in 13

districts across 8 regions and the District of Bamako covering approximately 30% of Mali's population; ATN's technical assistance occurs at the central level but has contributed to the execution of activities throughout the country; Pathways to Health interventions have also had nationwide coverage through the national and local media and support to national social marketing networks. Geographic focus under this task order will change somewhat in order to respond to priorities outlined in the MOH's National Child Survival Strategy and to ensure complementary planning with other donors and partners, in particular UNICEF[2]. Specifically, desired geographic coverage of the task order is as follows:

- **Maternal health/family planning**: Nationwide coverage of technical assistance to regional and district medical teams including CSCOMs.

- **Child survival:** Bamako, Timbuktu and Kidal (in addition to MH/FP TA). Technical assistance to be provided to regional, district medical teams and CSCOMs. Please note: Bidders should adapt the approach to realities of working in the North, including strengthening CSCOM outreach approaches to satisfactorily link with *relai*s in nomadic areas and pastoralist communities.

- **Private sector**: Technical assistance to private sector providers (including pharmacies where appropriate) for a reduced package of interventions (suggested focus: GATPA, Family Planning, malaria, CDD, others possible); build upon and expand Profam accreditation system. Geographic focus as permitted by budgetary and programming considerations in order of priority: 1) Bamako, 2) other regional capitals, 3) other urban areas.

- Any proposed technical advisors should be based at the regional level (and at the District level in Bamako) and oversee technical assistance throughout each region as appropriate.

C.5 STATEMENT WORK

A. Title of Task Order

"Improving National Capacity to Implement High Impact Health Services and Promote Healthy Behaviors in Mali"

B. Duration of Task Order

It is estimated that the period of performance will be five years.

[2] **Please note:** UNICEF has stated its intention to focus on six (6) of Mali's nine (9) regions in its next five (5) year program of Child Survival (beginning in 2008): Kayes, Sikasso, Segou, Mopti, Koulikoro and Gao. The UNICEF package will include regional, district and local support to implement a comprehensive child survival package, provide key commodities as well as *relais* training and equipment. USAID will work in close collaboration with UNICEF under the tutelage of the DNS to provide a complementary package of services to areas where UNICEF is active and to provide a similar child survival package in the areas where UNICEF is not present (Timbuktu, Kidal, and Bamako).

C.5.1 Purpose of Task Order

The purpose of this task order is to provide technical support to the Ministry of Health in its implementation of high impact health services. As noted above, the objectives of the proposed task order are to:

- Increase the capacity of the Ministry of Health to develop and roll out appropriate and technically sound policies and guidance and improve the capacity of the Ministry of Health, civil society and the private sector to implement them;

- Expand and strengthen the range of services and quality of care offered through the health system in the areas of maternal health and child survival in Mali;

- Expand and improve access by underserved communities and key populations to high quality health services related to maternal health and child survival;

- Implement and manage broad-based communications interventions that enhance the knowledge of Malians about core issues related to maternal health and child survival, including persuasive information to encourage and sustain healthy behaviors; and

- Expand partnerships and increase the capacity of the public and private sectors to create an improved environment for the rational delivery of quality health services.

The task order will conduct activities at the central and regional and district levels in Mali where its main partners and clients will be the Ministry of Health and to a lesser extent the Ministry of Social Development. Accordingly the successful offeror will be expected to provide support to the formal clinical health system (including both its public and private components) rather than civil society. In general, and in particular at the operational level, the successful offeror shall work along the following principles:

1. Collaboration with the MOH: the MOH is responsible for setting standards and assuring appropriate provision of health services throughout the country. The successful offeror shall seek to coordinate and collaborate closely with the MOH, particularly at the regional and district levels The successful offeror shall build the capacity of the MOH to coordinate and supervise comprehensive maternal and child health activities to the greatest extent possible.

2. Expansion of coverage, scaling up: Much has already been learned about strategies that work for providing high impact services at the district level. USAID/Mali is interested in how the bidders propose to apply these effective measures to larger coverage areas through the provision of technical assistance to organizations already on the ground rather than establishing parallel systems to deliver services.

3. Promote the Malian Government's decentralization policy: Although Mali has made great strides in decentralization of health structures the GRM is still challenged in effective resource mobilization and management, including human resources. The successful offeror shall work with MOH authorities so as to support decision-making and resource allocation at national, regional and district levels.

4. Encourage civil society organization implication, community dialogue and problem solving: USAID Mali believes that strong civil society organizations, open debate and self-sufficient individuals and communities lead to effective community responses to health issues. Accordingly, the successful offeror will work with the formal health system to strengthen appropriate collaboration with their civil society (ASACO) counterparts as well as community relais.

5. Partner Coordination: Given the proposed collaboration between USAID and UNICEF, bidders should particularly investigate the UNICEF/MOH planned expansion and demonstrate programmatic complementarities in the proposal.

C.5.2 Guiding Principles for Performance

In preparing the proposal the offeror will incorporate the following ***guiding principles*****.** These principles will also be used to assess the offeror's performance during program implementation.

- **Alignment with the USG Foreign Assistance Framework:** The program must be compatible with the USG Foreign Assistance Framework and must contribute to the overall goal of "helping to build and sustain democratic, well-governed states that will respond to the needs of their people and conduct themselves responsively in the international system." To do this, the offeror will meet one of the five priority objectives, ***Investing In People*** **(IIP)**. The offeror will contribute to the achievement of this objective in the health Program Area thereby helping "nations achieve sustainable improvement in the well-being and productivity of their populations through effective and accountable investments in education, health and other social services." The offeror will work mainly in the Family Planning and Reproductive Health, Maternal and Child Health and Malaria Program Elements; however, the offeror may be expected to work in other Program Elements under the Health Program Area if funding becomes available.

- **Building on past experience:** The offeror will not "reinvent the wheel," but rather build on previous experiences and use lessons learned to continue with replication and scale-up of effective and efficient programs. While the emphasis is on building on past experiences, the offeror is not limited to doing this, therefore, innovation and identifying new approaches is expected.

C.5.3 SPECIFICATION OF DELIVERABLES/STATEMENT OF WORK/EXPECTED RESULTS

Each result specified below is a deliverable under the terms of this Task Order. The illustrative sub-results provide examples of ***what*** the offeror shall achieve during the duration of the Task Order and shall be considered as examples of the ***standard of performance*** expected under this Task Order. In its proposal, the offeror shall define its proposed technical content and show ***how*** it intends to achieve the expected results.

Proposed intervention areas

Significant policy work in the various focus areas under HIHS has been accomplished under USAID/Mali's current bilateral projects, but the translation and roll out of policy into practical strategic approaches by the MOH continue to require significant reinforcement for practical, viable and sustainable implementation throughout the health system. As new or updated interventions are introduced, there is a tendency within the MOH to roll them out without first

developing a rational roll out strategy that takes into consideration the intervention's limitations while ensuring long term commitment for commodities and program support. At the central level the successful offeror will provide technical assistance to build the MOH's capacity to adopt and implement rational and effective policy decisions and new strategies.

At the operational level, health services in Mali are grossly underused, with only 0.25 new visits per resident per year (Joint WHO/UNICEF annual report, 2006). Although the MOH has had some success expanding the first level service delivery infrastructure, still 25-30% of the population lives beyond 15 kilometers of a health service delivery site (considered by WHO to be the maximum distance for access to a facility). The combination of difficult terrain, insufficient health infrastructure, long distances to reach service delivery points, frequent unavailability of a particular product or service and insufficient and under-qualified staff severely limit utilization. To address these issues, the successful offeror will provide technical and material support to the decentralized levels of Mali's health system, with a focus on regional level systems strengthening.

Primary areas of intervention shall include but are not restricted to the following:

- Improved maternal health service delivery including active management of the third stage of labor (AMTSL), prevention of post-partum hemorrhage (PPH), prevention and repair of fistula, post-natal and postpartum care;
- Childhood vaccinations and tetanus toxoid vaccination for women of reproductive age;
- Micronutrient supplementation including twice yearly vitamin A supplementation of children 6-59 months and iron-folate supplementation for pregnant women ;
- Best practices in nutrition including growth monitoring, nutrition promotion and child feeding (e.g., exclusive breastfeeding and weaning foods);
- Promotion of the use of insecticide treated bednets/materials and prompt and effective treatment with appropriate anti-malarials, including intermittent preventive treatment of pregnant women during antenatal care (ANC) services;
- Essential newborn care, e.g. immediate warming and drying, clean cord care, immediate/exclusive breastfeeding;
- Diarrheal disease control including zinc and oral rehydration therapy for diarrhea including oral rehydration solution (ORS), increased feeding, sanitation and hygiene;
- Modern family planning available at all levels including: communication, supervision, behavior change and contraceptive technology training, capacity building for quality service delivery and management support and capacity building of private service delivery personnel and sites;
- Cross cutting health systems strengthening including support to decentralized planning, quality assurance, supportive supervision, public private collaboration;
- Support to the Ministry of Health in its liaison with the community level via the decentralized health system including assistance to the district CSCOM levels in supervising, implementing and expanding community based health services (such as community level use of ACTs, community administration of Depo-Provera etc) as they are adopted.

C.5.3.1 MATERNAL HEALTH

Adequate maternal health care is a key to ensuring maternal and child survival. The 2001 DHS estimate of maternal mortality in Mali was one of the highest in the world at 582 deaths per 100,000 births and while the 2006 figure of 464 deaths per 100,000 births showed considerable

improvement, maternal mortality remains unacceptably high. In order to offset this alarming level of mortality, USAID works with the MOH, the MDSSPA and other partners to implement a maternal health package including, but not limited to family planning to prevent unintended, closely spaced and/or high risk pregnancies; intermittent preventive treatment of malaria for pregnant women, iron-folate distribution, improved and expanded antenatal care (CPN+), post partum hemorrhage prevention, reduction of harmful traditional practices (FGC) and detection and referral for fistula repair.

Expected results

Policy level (national): maternal health related policies will be implemented and clarified in order to allow full access to antenatal care and pre and post delivery services by women and their families.

Illustrative sub-results may include:

- Active management of third stage of labor (AMTSL) will be introduced throughout the country; the results of the ongoing *matrone* AMSTL pilot study will be incorporated into national policies, norms and procedures and a strategy for expansion developed.
- Barriers to use such as confusion around antenatal care commodity costs will be addressed and removed.
- Participative supervision will be strengthened and improved supervision tools introduced.
- Constraints identified as obstacles to the correct implementation of the free cesarean policy will be addressed.

Operational level (regional medical team, district medical team and local CSCOMs): Maternal health care services in Mali will be strengthened and use of ante- and post-natal care, birth planning and assisted delivery will improve.

Illustrative sub-results may include:

- Use of antenatal care services will continue to increase, ensuring enough timely ANC visits for pregnant women to receive two doses of SP for the intermittent preventive treatment of malaria.
- The proportion of women delivering with a skilled provider will increase.
- Family planning will be fully incorporated into the postpartum care package.
- All qualified providers will be trained in AMTSL and job aids and supervision introduced to ensure its use.
- Participative supervision will be strengthened and improved supervision introduced.

C.5.3.2 FAMILY PLANNING

Current research has revealed that birth intervals of at least three years are associated with lower infant/child/maternal mortality, and improved infant/child/maternal nutritional status. By reducing the number of births and spacing births at least three years apart, family planning can thus potentially prevent a quarter of infant deaths. Very short birth intervals are also associated with increased risk of complications during pregnancy. It is estimated that by allowing women to delay motherhood and avoid unintended pregnancies and unsafe abortions, family planning can prevent one in four maternal deaths. High fertility also negatively impacts health and economic development. Based on an annual population growth rate of 2.7%, Mali's current national population figure of 12.3 million is projected to increase to 23.2 million by 2020. In Mali, modern

contraceptive prevalence has not significantly increased since 2001, now at 6.9% (DHS 2006), and is one of the lowest of any USAID-supported country.

Through various local and international partners, USAID/Mali is working with the GRM to increase the availability of family planning services and contraceptive prevalence in order to reduce maternal and infant morbidity and mortality. The national family planning strategy focuses on a number of approaches including increasing community awareness of the benefits and availability of family planning through national campaigns, community associations and volunteers; expanding method choice; improving quality and accessibility of family planning services through training and improved supervision; and establishing and disseminating national Policies, Norms and Procedures in RH/FP and ensuring contraceptive commodity security.

Expected results

Policy level (national): family planning related policies will be implemented and new approaches identified and developed in order to increase family planning use by women, couples and families.

Illustrative sub-results may include:

- State-of-the-art FP approaches such as the use of depo provera at the community level will be introduced to increase contraceptive prevalence.
- Provider confidence is increased through regular participative FP supervision.
- Additional resources for FP leveraged due to improved donor coordination.
- The average time interval between pregnancies is increased.
- Greater coordination with the private sector in achieved including improved private sector reporting of data.
- The contraceptive method mix is expanded to include more methods at more levels of the health system.
- Policies developed to expand the cadres of workers who can be trained to safely provide various contraceptive methods.

Operational level (regional medical team, district medical team and local CSCOMs): Modern family planning use will increase.

Illustrative sub-results may include:

- Service provision quality is improved through increased provider knowledge.
- Fewer stockouts of contraceptive commodities are registered at the regional, district and CSCOM levels.
- Contraceptive availability at the community level is assured due to improved communication and coordination between CSCOM and community relais.
- Medium and long term method adoption increases due to greater availability of medium and long term methods and better understanding of when they should be used.
- Greater harmonization of prices and service provision quality is achieved across the private sector.

C.5.3.3 ESSENTIAL NEWBORN CARE

Almost 50% of infant mortality in Mali occurs during the neonatal period although still high it has decreased significantly since 2001. Mali currently has in place many of the guidelines and policies recommended in a comprehensive response to neonatal morbidity and mortality

however these essential policy elements are not yet rolled out or implemented to the extent necessary to make a difference in this aspect of Mali's mortality.

Policy level (national): The national plan for essential newborn care (part of the maternal mortality roadmap and included I the national child survival strategy) is applied and new approaches identified and implemented in order to decrease neonatal mortality.

Illustrative sub-results may include:

- Policy and guidelines developed for the implementation of essential newborn care at the household level;
- Innovative approaches rolled out in order to ensure the timely delivery of ENC and post-natal maternal care at the community level (e.g. adaptation of outreach approaches).
- An essential package of postnatal/postpartum care for household and facility levels is disseminated and widely implemented.

Operational level (regional medical team, district medical team and local CSCOMs): Neonatal death decreases with systematic use of essential newborn care best practices at the operational level.

Illustrative sub-results may include:

- ENC becomes routine at the household level due to the training and equipping of traditional birth attendants and designated community relais.
- Premature infant survival increases due to the introduction of the kangaroo care approach.
- Colostrum intake by newborns increases thanks to TBA and health service provider orientation on the importance of exclusive and immediate breastfeeding.

C.5.3.4 IMMUNIZATION

Child immunization is one of the most cost-effective public health interventions for reducing child morbidity and mortality. The goal of immunization programs is to reduce the incidence of vaccine-preventable diseases in children by means of high vaccine coverage at the appropriate age. While the latest Mali DHS 2006 showed a significant increase in vaccination coverage from 29% to 48% of children 12-23 months fully immunized at the time of the survey, there remains a strong need to focus on immunization in order to address rural-urban disparity and the ongoing challenge of introducing new vaccines.

USAID/Mali is an active player of the Interagency Coordination Committee (ICC) for EPI, which is focused on GAVI support. The ICC approves all vaccination campaigns, the annual vaccination work plan, and planning and reporting on GAVI investments. Recently, a nationwide, Comprehensive Multi-year plan for Mali for 2007-2011 was adopted for routine vaccinations (includes maternal/newborn Tetanus vaccination) and Mali introduced the new pentavalent vaccine, which includes Diphtheria, Tetanus, Pertussis, HepB and Hib. As part of the meningitis belt of Africa, Mali is also participating in trials under the Meningitis Vaccine Project (MVP), a partnership between the World Health Organization (WHO) and the Program for Appropriate Technology in Health (PATH), created in 2001 with core funding from the Bill & Melinda Gates Foundation. Mali is also part of the global effort towards polio eradication.

Expected results

Policy level (national): Sound immunization policy will be developed and implemented and new vaccines introduced in a rational and effective manner.

Illustrative sub-results may include:

- Meningitis related morbidity and mortality will decrease due to improved epidemiological surveillance and strengthened capacity to respond to outbreaks and epidemics.
- Vaccination coverage of children in remote areas will improve through the expanded implementation of the "reach every district" approach.
- Injection safety will improve through the introduction of improved medical waste management policies.

Operational level (regional medical team, district medical team and local CSCOMs): Immunization rates will increase.

Illustrative sub-results may include:

- Outreach service provision will occur as planned resulting in higher numbers of children immunized.
- EPI micro planning will occur on a regular basis throughout intervention zones;
- Vaccine wastage will be reduced through the improved use of coverage and population data at the regional and local levels for planning.
- The Reach Every District (RED) approach coverage is expanded throughout Mali.

C.5.3.5 DIARRHEAL DISEASE

Over two million children die each year in developing countries from three main types of diarrheal disease: acute watery diarrhea, dysentery (bloody diarrhea), and persistent diarrhea (diarrhea lasting 14 days or more). There is a strong association between childhood diarrhea and reduced nutritional status; children with diarrhea are more likely to become malnourished; and children who are malnourished are predisposed to getting diarrhea and dying from the disease. In Mali, where 13% of children had diarrhea during the two weeks prior to the 2006 DHS, repeated episodes of diarrhea increase the vulnerability of children to other diseases and result in deaths due to dehydration. Even though preliminary results from the 2006 DHS show a slight increase in ORS use, there is still a limited demand for it and it is not routinely available at the health center level. While the newly formulated low-osmolarity ORS and zinc as an adjunct treatment have been introduced in Mali at the national level, neither have been used at scale.

Expected results

Policy level (national): National level treatment policy and commodity management are improved to ensure the availability and use of appropriate diarrheal disease control approaches.

Illustrative sub-results may include:

- The correct use of low-osmolarity ORS and zinc is adopted due to policy clarification and dissemination from the national level.
- Low osmolarity ORS and zinc are widely available throughout the health pyramid and are routinely prescribed in response to child diarrhea.

Operational level (regional medical team, district medical team and local CSCOMs): The number of children being appropriately administered with ORT and zinc increases.

Illustrative sub-results may include:

- Provider understanding of the benefits of zinc and its correct application increases.
- Low osmolarity ORS and zinc are routinely available throughout the health pyramid.

C.5.3.6 NUTRITION INCLUDING MICRONUTRIENT SUPPLEMENTATION

Malnutrition contributes to about half of the deaths of children under five in developing countries, and even in its milder forms malnutrition increases the risk of death. The goal of nutrition interventions is to decrease malnutrition-associated under-five mortality by improving the nutritional status of infants, children, and/or pregnant and lactating women. Women and children in Mali suffer from both micronutrient and energy protein malnutrition. According to the 2006 DHS, 34 % of children under five are stunted, and rates of stunting are higher in rural areas: 24% urban, 38% rural. Thirteen percent of children under five years old suffer from acute malnutrition (weight-for-height), showing no improvement from the last survey. Low rates of micronutrient supplementation, still low but improving exclusive breastfeeding rates (37.8%, 2006 DHS), and poor nutritional practices all contribute to malnutrition.

Vitamin A supplementation is one of the most cost effective interventions for reducing infant and under-five mortality. In Mali, among children 6 to 59 months old, 68% have diets that are Vitamin A deficient (DHS 2001). Since 2005, the MOH has institutionalized the semi-annual National Nutrition Weeks (NNW) that include vitamin A supplementation as a key activity and have helped to achieve a successful transition from the administration of vitamin A during National Immunization Days.

Expected results

Policy level (national): Increased visibility of political engagement to nutrition-related issues demonstrated through increased budget support to nutrition weeks and the adoption of sound nutrition related policy.

Illustrative sub-results may include:

- More than 80% of Malian children age 6-59 months receiving vitamin A supplementation twice yearly.
- Unfortified flour and oil no longer permitted for sale in Mali.
- More than 50% of Malian infants are exclusively breastfed through age 6 months.
- Growth monitoring guidance and directives are adopted and disseminated on a large scale.

Operational level (regional medical team, district medical team and local CSCOMs): Number of children 6-59 months receiving Vitamin A twice yearly increases.

Illustrative sub-results may include:

- Increased regional commitment to National Nutrition Week activities demonstrated through increased regional level NNW programming and budgeting.
- Zero stockouts of iron and folic acid at the CSCOM level;
- Zero stockouts of vitamin A capsules for routine administration at the CSCOM level.
- Growth monitoring is successfully incorporated as a key element of outreach service strategy.

C.5.3.7 MALARIA, INCLUDING SPECIFIC ACTIVITIES RELATED TO PMI

Mali was named a President's Malaria Initiative (PMI) country beginning in FY08. As a result malaria-related activities are high priority and close monitoring and reporting are required. Malaria is one of the major causes of morbidity and mortality in Mali and is the primary cause of all outpatient visits for children <5 years of age (39%) with one-third of all health facility reported deaths due to malaria, of which 76% occur in children < 5 years of age. It also is a major cause of anemia in pregnant women and low birth weight in their infants. Most malaria deaths occur in the home and without having sought or received appropriate care. Artemisinin-based Combined Therapy (ACTs) was introduced in Mali in June 2007, but confusion persists about its correct use at both the clinical and community levels.

Expected results

Policy level (national): (1) Objectives for the number of children receiving prompt and appropriate treatment for fever are met according to PNLP targets

Illustrative sub-results may include:

- Policy and strategic plans developed and rolled out for the home based management of fever, including referral and treatment of severe malaria, and the effective recognition of severe illness (including pneumonia).
- Providers are trained in the correct management of fever and severe illness according to PNLP guidelines.
- Policy guidelines are available and implemented for the treatment of fever at the village and household levels.
- A national malaria monitoring and evaluation plan is available and implemented.

Operational level (regional medical team, district medical team and local CSCOMs): Objectives for the number of children receiving prompt and appropriate treatment for fever are met according to PNLP targets

Illustrative sub-results may include:

- CSCOM providers appropriately refer complicated cases of fever to the district level.
- Clinicians at the CSCOM level appropriately implement diagnostic and treatment protocols for fever.
- ACT stock levels are reported on a regular basis by CSCOMs through the integrated-surveillance reporting system.

C.5.3.8 HEALTH SYSTEMS STRENGTHENING AND QUALITY ASSURANCE

Many aspects essential to the success of technical programs are in fact cross cutting and involve the overall strengthening of the health system. While systems strengthening is a vast and complex subject, certain elements of systems strengthening are particularly pertinent to achieving high impact health strategy goals. The Government of Mali is well advanced in the area of systems decentralization however the capacity for decentralized planning and budgeting is still weak. The implementation of quality assurance schemes at the decentralized level has

also made considerable progress in the last five years thanks to the Keneya Ciwara project's Ciwara d'Or quality accreditation program, now adopted as a national strategy by the MOH. Finally the extension of health services beyond the CSCOM to the community and household level continues to be a high but underdeveloped priority.

Expected results

Policy level (national): Health service use increases due to improved quality and availability of services.

Illustrative sub-results may include:

- The national planning process takes place smoothly due to improved capacity of the MOH/CPS permanent secretariat.
- National level capacity to implement the Ciwara d'Or quality accreditation approach demonstrated through the approach's continued implementation.
- Sound policy developed and strategic plan rolled out for the extension of the community *relais* network, including detailed guidelines on the administration of ACTs and other life saving drugs by *relais*.
- Model approaches to introduce a minimum package of community-based services are piloted and results are used to develop a national strategy for the appropriate implementation and expansion of national community-based health approach.

Operational level (regional medical team, district medical team and local CSCOMs):

Illustrative sub-results may include:

- Increased mobilization and justification of USAID direct funding at the regional level.
- Ciwara d'Or quality assurance programs are operational in each of Mali's regions.
- Increased CSCOM capacity to interact and correctly utilize community relais for outreach and educational activities.

C.5.4 PROJECT MONITORING AND REPORTING

Monitoring and reporting are critical components of the task order; this is particularly true with regard to PMI targets. The successful offeror will need to be able to measure progress against project goals and targets, identify problems in program implementation and allow modifications to be made, and confirm the success of modifications. The successful offeror will not be asked to undertake baseline, mid-term or final population-based evaluation; this will be contracted separately by USAID/Mali.

USAID/Mali reports its progress against standard indicators developed by Washington; the selection of pertinent indicators takes place at the mission level and is in included in the annual Operational Plan. The following indicators are included in the FY08 Operational Plan and the successful offeror should expect to collect data on relevant indicators to provide to the mission for reporting purposes.

LIST OF OPERATIONAL PLAN INDICATORS—USAID/ MALI/HEALTH
MCH
Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities
Number of children less than 12 months of age who received DPT3 from USG-supported

programs
Number of children reached by USG-supported nutrition programs
Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs
Number of medical and para-medical practitioners trained in evidence-based clinical guidelines
Number of newborns receiving essential newborn care through USG-supported programs
Number of people trained in child health and nutrition through USG-supported health area programs
Number of people trained in maternal/newborn health through USG-supported programs
Number of women receiving Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs
Number of children under 5 years of age who received Vitamin A from USG-supported programs (CUSTOM)
Non-polio acute flaccid paralysis rate in children under 15 yrs of age 2 per 100,000 (Y/N) (CUSTOM)
FP/RH
Couple years of protection (CYP) in USG-supported programs
Number of medical and para-medical practitioners trained in evidence-based clinical guidelines
Number of new approaches successfully introduced through USG-supported programs
Number of people trained in FP/RH with USG funds
Number of policies or guidelines developed or changed with USG assistance to improve access to and use of FP/RH services
Number of service delivery points reporting stock-outs of any contraceptive commodity offered by the SDP (do not use)
Number of USG-assisted service delivery points providing FP counseling or services
MALARIA
Number of ITNs distributed that were purchased or subsidized with USG support
Number of people trained in malaria treatment or prevention with USG funds
Number of people trained in monitoring and evaluation
Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs
HIV/AIDS
Number of individuals reached through community outreach that promotes HIV/AIDS

prevention through other behavior change beyond abstinence and/or being faithful
Number of individuals trained in counseling and testing according to national and international standards
Number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)
Number of individuals trained in the provision of laboratory-related activities
Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful
Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
Number of individuals who received counseling and testing for HIV and received their test results
Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests
Number of local organizations provided with technical assistance for HIV-related institutional capacity building
Number of local organizations provided with technical assistance for HIV-related policy development
Number of targeted condom service outlets
Number of service outlets providing counseling and testing according to national and international standards
WATER & SANITATION
Number of people in target areas with access to improved drinking water supply as a result of USG assistance

C.5.5 MANAGING FOR MAXIMUM RESULTS

A. Management for Results

The Offeror will design a technically sound program with both a management plan and an organizational structure focused on accomplishing the expected results cited in the above section. The proposed chief of party and senior staff shall have extensive experience in planning, directing, managing, and evaluating large and complex projects in the health sector. The core staff and consultants must possess demonstrated expertise, skills, experience and knowledge of the West African and preferably the Malian context to implement the full range of technical, field and administrative tasks required under this Task Order Proposal. Offerors are strongly encouraged to seek West African technical and management staff for the range of positions proposed.

The successful offeror's primary office must be located in Bamako, Mali. In-country

management staff must have the authority and management control to interface directly with USAID/Mali in management decision-making, thereby reducing management costs.

B. Program Accountability

All of the expected results are within the manageable interest of the successful offeror and it's performance will be measured on the achievement of the expected results, not inputs or level of effort. The Contractor will organize and manage this Task Order to acquire the best return on the USG investment, using the best available technology and seeking synergistic, integrated approaches to have a multiplier effect, to avoid duplication, and to yield the greatest impact of resources allocated. The Contractor will be held accountable for program results, good technical management, and sound financial management and full accountability of funds, thus the Contractor will be transparent and forthcoming in reporting its progress and problems in these areas.

USAID/Mali requires the Contractor to provide adequate oversight and management for all project resources and management of sub-contract and grant funds. In an effort for cost reduction, USAID/MALI demands a significant proportion (greater than 80 percent, excluding fee and NICRA) of funds to be spent on field programs instead of home office expenses. The field officer must have technical and managerial competencies and be empowered to do the job on the ground.

C. Measuring and Monitoring Results

The Offeror will develop a draft Performance Milestone Plan (hereafter called Milestone Plan) which will present ***performance measures*** and ***milestones*** towards the achievement of each Expected Result over the life of the Task Order. This plan will serve as a Monitoring and Evaluation tool for both the Contractor and USAID. The Annual Workplan, which will be updated as needed, will detail the activities taken to achieve the milestones.

The Milestone Plan sets forth the major results and activities with target dates and shows a clear link between achieving the milestones and their contribution to achieving overall program results. In the proposal, for each milestone, the Offeror will address how the milestone accurately predicts progress towards achievement of the Expected Results described in the Statement of Work. The Milestone Plan may be amended as necessary at the request of USAID/Mali during the life of project in response to the evolving health situation. The plan will measure the direct accomplishments of the project and show the indirect results and impact of project activities on health in Mali.

The offeror will also propose a Program Monitoring Plan which will detail the plan for collecting, analyzing and validating the data used to measure the achievement of the proposed milestones. At an overall project level, the successful offeror must develop a monitoring plan addressing at least three major areas including:

- **Tracking data within the country**. Country-level indicators and results must be monitored.
- **Collaborating in the development and use of performance monitoring mechanisms**. The successful offeror will collaborate with partners and stakeholders on the development of indicators and share responsibility in performance monitoring.
- **Providing adequate and appropriate PMI specific data and results** per the Mali Malaria Operational Plan;

Both the Milestone Plan and the Monitoring Plan will cover the entire five year contract performance period, including detailed explanations of planned activities for each Expected Result. The Monitoring and Evaluation Plan will be updated throughout the contract period as required and the dates for completion of milestones in the Milestone Plan will be updated as necessary.

C.5.6 QUALITY ASSURANCE PLAN

A variety of mechanisms will be used to monitor the progress/success of the activity and the contractor's performance:

- Weekly progress meetings/phone calls during contract mobilization;
- Feedback from other donor and country counterparts;
- Formal and informal site visits by USAID/Mali Health Team advisors and other personnel;
- Meetings to review quarterly quantitative updates and semester narrative reports;
- Other coordination meetings as deemed appropriate by USAID/Mali.

Periodic performance reviews

The USAID CTO will conduct periodic performance reviews to monitor the progress of work and the achievement of results under this contract, based on the contract terms and conditions. USAID will assess the contractor's progress in project implementation and success in meeting benchmarks, as defined in the Milestone Plan. The information provided and exchanged through these progress reviews (of quarterly quantitative updates, semester narrative reports, performance milestone plan and the other mechanisms mentioned above) will form the basis for assessing and reporting on contractor performance.

The successful offeror shall submit, for technical review, all information and appropriate documentation necessary to demonstrate and support the achievement of milestones to the Cognizant Technical Officer (CTO), with a copy to the Contracting Officer. The contractor shall also provide an explanation and/or justification if any milestones have not been achieved according to the schedule. The CTO will lead a review of the documentation to determine if the milestones have been met. The CTO and Contracting Officer (CO) will discuss the CTO's recommendations, and the CO will approve or disapprove the payment of fee.

In addition to the technical performance requirements stated in Section C., above, the contractor will be held fully accountable for responsible management of its contract. Of particular concern shall be the following:

- Satisfactory performance record, which includes effective independent cost control;
- Amounts of cost overruns and under runs, and reasons for them;

- Compliance with terms and conditions of contract, particularly areas where the Contracting Officer approval or consent is needed prior to execution of action, purchase of equipment, consent to subcontract, formalization of constructive change, timeliness of reports and other deliverables;

- Task completion as against completion date as stated in the contract Work Plan/Performance Milestone Plan, with explanation for completion delays; and,

- Terminations for default or convenience.

END OF SECTION C

SECTION D – PACKAGING AND MARKING

D.1 AIDAR 752.7009 MARKING (JAN 1993)

(a) It is USAID policy that USAID-financed commodities and shipping containers, and project construction sites and other project locations be suitably marked with the USAID emblem. Shipping containers are also to be marked with the last five digits of the USAID financing document number. As a general rule, marking is not required for raw materials shipped in bulk (such as coal, grain, etc.), or for semifinished products which are not packaged.

(b) Specific guidance on marking requirements shall be obtained prior to procurement of commodities to be shipped, and as early as possible for project construction sites and other project locations. This guidance will be provided through the cognizant technical office indicated on the cover page of this contract, or by the Mission Director in the Cooperating Country to which commodities are being shipped, or in which the project site is located.

(c) Authority to waive marking requirements is vested with the Regional Assistant Administrators, and with Mission Directors.

(d) A copy of any specific marking instructions or waivers from marking requirements is to be sent to the Contracting Officer; the original shall be retained by the Contractor.

D.2 BRANDING

Refer to ADS 320 (http://www.usaid.gov/policy/ads/300/), specifically ADS 320.3.2.2 and 320.3.2.3, for more information. The Contractor shall comply with the requirements of the USAID "Graphic Standards Manual" available at www.usaid.gov/branding, or any successor branding policy.

END OF SECTION D

SECTION E - INSPECTION AND ACCEPTANCE

E.1 TASK ORDER PERFORMANCE EVALUATION

Task order performance evaluation shall be performed in accordance with Population, Health, and Nutrition Technical Assistance and Support Contract (TASC 3 – Global Health) IQC, Section E.2

END OF SECTION E

SECTION F – DELIVERIES OR PERFORMANCE

F.1 PERIOD OF PERFORMANCE

The estimated period of performance for this task order is from o/a September 1, 2008 through o/a August 31, 2013. (5 years). *[Final date will be provided at the time of award.]*

F.2. DELIVERABLES

See Section C for full information and definitive listing. All of the evaluation findings, conclusions, and recommendations shall be documented in the Final Report. All written deliverables shall also be submitted electronically to the CTO. Bound/color printed deliverables may also be required, as directed by the CTO.

F.3 TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS

(Neil Price RCO in Ghana)
Phone: +233-21-741-434
Fax: 233-21-741-365
E-mail: nprice@usaid.gov

The Cognizant Technical Officer (CTO) will be designated separately.

The CTO address is:
Health Team, USAID/Mali
ACI 2000, RUE 243 Porte 297
B.P. 34
Bamako, Mali

F.4 PLACE OF PERFORMANCE

The place of performance under this Task Order is Mali, as specified in the Statement of Work.

F.5 AUTHORIZED WORK DAY / WEEK

The contractor employees and consultant are authorized up to 5-day workweek with no overtime or premium pay is authorized under this Task Order.

F.6 DELIVERABLES AND REPORTING REQUIREMENTS

In addition to the requirements set forth for submission of reports in Sections I and J, and in accordance with AIDAR clause 752.242-70, Periodic Progress Reports, the Contractor shall submit reports, deliverables or outputs as further described below to the CTO (referenced in Sections F.3 and G). All reports and other deliverables shall be in the provided in both English and French, unless otherwise specified by the CTO.

Reporting Requirements

The Contractor will adhere to requirements listed below. Reports will be submitted by the due date for approval by the USAID/MALI CTO. Reports requiring review and clearances, when necessary, are listed under each requirement. The Contractor will consult with the CTO on the format and expected content of report prior to submission. In particular, the Contractor will work

closely with USAID/MALI in the update of the Annual Work Plans and Monitoring Plans. Three types of reports (further described below) will be required:

- Quarterly quantitative updates
- Semester narrative reports (in addition to the corresponding quarterly quantitative update)
- Annual quantitative and narrative report reviewing progress throughout the year

F.6.1 Financial Reporting

The Contractor will submit to USAID/MALI through the CTO a quarterly financial report 15 days before the end of each USAID fiscal year quarter through the life of the Task Order. The financial reports shall show detailed line item budgets, expenditures and accruals and show a pipeline analysis as well as a table with expenditures, accruals and other financial information requested. Funding may vary each year and the Contractor must adapt to expanding or decreasing funding levels. To conform to financial reporting needs of the US Foreign Assistance Framework ("F Framework"), the Contractor will also work with USAID/MALI staff to attribute overall annual budgets to F Framework Program Elements and Sub-Elements. The Contractor will also provide estimates of quarterly expenditures according to these initial budget attributions. This may be estimated on a percentage basis from overall accruals to minimize financial management burden.

F.6.2 Annual Work Plan/Performance Milestone Plan and Monitoring Plans

As part of the Task Order Proposal, the Contractor must produce a draft detailed Annual Work Plan, Performance Milestone Plan, and Performance Monitoring Plan for consideration and approval by USAID/MALI. Within 60 days after the signing of the Task Order Contract, the Contractor will finalize the Milestone and Monitoring Plans together with, and in a format to be provided by USAID/MALI. The Contractor will then submit the finalized plans for final approval.

The Annual Work, Milestone, and Monitoring Plans must describe the time frame and sequence of all activities targets and anticipated results with a detailed budget for each activity. Milestone performance indicators will be defined and will measure the Contractor's performance. The Contractor and USAID/MALI staff will complete a joint quarterly monitoring exercise of Performance Milestone Plan execution and achievement of deliverables and benchmarks. This will be based on the plan itself; narrative reports will be required only at the end of each semester. Each subsequent Annual Work Plan/Performance Milestone Plan and Monitoring Plan shall be the result of a joint planning exercise with relevant advisory groups, partners and stakeholders and USAID/MALI.

F.6.3 Annual Performance Reports

The Contractor will submit an annual report on its performance, based on the Performance Milestone Plan in relation to expected results, including both successes and areas for improvement. The annual performance report shall be prepared in accordance with specific guidance issued by USAID/MALI. The report will elaborate several types of information including: performance indicator data; Operational Plan indicator data; progress towards objectives and expectations regarding future results achievements. The report must specify the following:

- Evidence that activity outputs are adequately contributing to the expected results and ultimately to the achievement of the Task Order Objectives;

- Status and timeline of input mobilization efforts;

- Status of critical assumptions and causal relationships defined in the results framework, as well as related implications for performance toward expected results;

- Status of related partner efforts contributing to the achievement results;

- Status of the operating unit's management agreement and any changes needed to the approved strategic plan;

- Contractor team effectiveness and adequacy of staffing;

- Vulnerability issues and related corrective efforts; and

- Highlights of success stories to be used in public relations and other results reporting.

Following the submission of the annual performance report, USAID/MALI will conduct a formal performance review with the Contractor. USAID/MALI will request from the Contractor a quantitative status report quarterly on performance monitoring indicators and a semester report that includes narrative to support quantitative findings. USAID/MALI and Contractor will make mid-course corrections and adjustments if needed in the work plan and monitoring plan.

F.6.4 Baseline and Special Reports

The Contractor will need to provide special and/or baseline reports for USAID/Mali's portfolio review or as an activity within the Milestone Plan. In addition, the Contractor will document best practices and success stories on achievements suitable for dissemination to potential program users or for public relations purposes.

F.6.5 Final Task Order Report

Major successes achieved during the entire Task Order Period with references to meeting established objectives, results, and indicators will be highlighted in the final report as well as any deficiencies or constraints encountered. The final report will also serve to present the lessons learned and the significance of the Task Order's approach and impact on health in Mali. The Contractor will submit to the CTO the detailed Final Task Order Report within 60 days of completion.

The report will include:

i. A summary of accomplishments in relation to the work plans, providing final tangible results, summary of deliverables/benchmarks, addressing lessons learned during implementation and suggesting ways to resolve constraints identified; and any recommendations for future programming.

ii. A financial report detailing how funds were expended by line item.

F.6.6 Distribution of Reports

Reports described in this section must be submitted in original form with two copies to the Task Order CTO. Substantive technical reports and intellectual property and products produced under the Task Order must also be submitted in electronic format and hard copy to the USAID Development Experience Clearinghouse: Email (the preferred means of submission) is: docsubmit@dec.cdie.org. The mailing address via US Postal Service: Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, Maryland, MD 20910.

F.6.7 Research, Studies, and Survey Documents

In the event that research, studies and or surveys are conducted under this Task order upon the request of the CTO, the Contractor shall submit an original and two copies in English of the terms of reference and of the reports for all research, studies and survey documents to the Cognizant Technical Officer (CTO). An original and two copies in French of the same documentation should be submitted when determined necessary by the CTO. After receiving written acceptance from the CTO, the Contractor shall also submit one electronic copy of the reports in English to the USAID Development Experience Clearinghouse. This should be done within 30 calendar days of receiving written acceptance from the CTO. The Contractor is also required to send the CTO proof of **receipt** by CDIE of the submitted document within 10 calendar days of submission. The Contractor shall follow-up with CDIE and confirm that CDIE has received the document.

F.6.8 Participant Training Reports

The Contractor shall collect information on all participant training financed under this contract. This includes training data for any in-country training program or sub-program of more than 3 consecutive class days in duration, or more than 15 contact hours scheduled intermittently. This training data must be recorded using the web-based “TraiNet” reporting system. The training data must be consolidated according to training program or sub-program and must identify the following:

(1) subject area of training;

(2) total trainees per participant group, *with gender breakdown*;

(3) total cost of training for each program; and

(4) direct training costs (program costs, not overhead/fees).

The Contractor shall enter and submit the participant training information on a semi-annual basis as part of the Semi-annual Performance Report, specified above in “Semi-annual Performance Report.” Simultaneously, the Contractor shall also submit one copy of the participant training information on a diskette or CD directly to the Mission Program Officer. Contact the Mission Program Officer for further information about site registration and use of TrainNet.

F.7 AIDAR 752.7005 SUBMISSION REQUIREMENTS FOR DEVELOPMENT EXPERIENCE DOCUMENTS (JAN 2004) (AAPD 04-06)

(a) Contract Reports and Information/Intellectual Products.

(1) The Contractor shall submit to USAID's Development Experience Clearinghouse (DEC) copies of reports and information products which describe, communicate or organize program/project development assistance activities, methods, technologies, management, research, results and experience as outlined in the Agency's ADS Chapter 540. Information may be obtained from the Cognizant Technical Officer (CTO). These reports include: assessments, evaluations, studies, development experience documents, technical reports and annual reports. The Contractor shall also submit to copies of information products including training materials, publications, databases, computer software programs, videos and other intellectual deliverable materials required under the Contract Schedule. Time-sensitive materials such as newsletters, brochures, bulletins or periodic reports covering periods of less than a year are not to be submitted.

(2) Upon contract completion, the Contractor shall submit to DEC an index of all reports and information/intellectual products referenced in paragraph (a)(1) of this clause.

(b) Submission requirements.

(1) Distribution.

(i) At the same time submission is made to the CTO, the Contractor shall submit, one copy each, of contract reports and information/intellectual products (referenced in paragraph (a)(1) of this clause) in either electronic(preferred) or paper form to one of the following:

(A) Via E-mail: docsubmit@dec.cdie.org;

(B) Via U.S. Postal Service: Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910, USA;

(C) Via Fax: (301) 588-7787; or

(D) Online: http://www.dec.org/index.cfm?fuseaction=docSubmit.home

(ii) The Contractor shall submit the reports index referenced in paragraph (a)(2) of this clause and any reports referenced in paragraph (a)(1) of this clause that have not been previously submitted to DEC, within 30 days after completion of the contract to one of the address cited in paragraph (b)(1)(i)of this clause.

(2) Format.

(i) Descriptive information is required for all Contractor products submitted. The title page of all reports and information products shall include the contract number(s), Contractor name(s), name of the USAID cognizant technical office, the publication or issuance date of the document, document title, author name(s), and strategic objective or activity title and associated number. In addition, all materials submitted in accordance with this clause shall have attached on a separate coversheet the name, organization, address, telephone number, fax number, and Internet address of the submitting party.

(ii) The report in paper form shall be prepared using non-glossy paper (preferably recycled and white or off-white using black ink. Elaborate art work, multicolor printing and expensive bindings are not to be used. Whenever possible, pages shall be printed on both sides.

(iii) The electronic document submitted shall consist of only one electronic file which comprises the complete and final equivalent of the paper copy.

(iv) Acceptable software formats for electronic documents include WordPerfect, Microsoft Word, and Portable Document Format (PDF). Submission in PDF is encouraged.

(v) The electronic document submission shall include the following descriptive information:

(A) Name and version of the application software used to create the file, e.g., MSWord6.0 or Acrobat Version 5.0.

(B) The format for any graphic and/or image file submitted, e.g., TIFF-compatible.

(C) Any other necessary information, e.g. special backup or data compression routines, software used for storing/retrieving submitted data or program installation instructions.

END OF SECTION F

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1 CONTRACTING OFFICER'S AUTHORITY

The Contracting Officer is the only person authorized to make or approve any changes in the requirements of this task order and notwithstanding any provisions contained elsewhere in this task order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other than the Contracting Officer, the change shall be considered to have been made without authority and no adjustment shall be made in the contract terms and conditions, including price.

G.2 TECHNICAL DIRECTION

The USAID Mali Health Office shall provide technical oversight to the Contractor through the designated CTO. The Contracting Officer shall issue a letter appointing the CTO for the task order and provide a copy of the designation letter to the contractor.

G.3 ACCEPTANCE AND APPROVAL

In order to receive payment, all deliverables must be accepted and approved by the CTO.

G.4 INVOICES

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to the Controller Office, USAID/Mali's Office of Financial Management and a copy to the CTO.
Claims for reimbursement or payment under this Purchase Order/Contract must be submitted to the Controller's Office. The Contractor must submit the SF-1034 Public Voucher for Purchases and Services Other Than Personal and SF-1034A continuation, if necessary, attached. Each voucher shall be identified by:

(a) Name of the vendor/contractor;
(b) Date and invoice number;
(c) USAID Purchase Order/Contract number;
(d) Description, price, quantity, period of goods and services rendered;
(e) Contact name, telephone and fax number;
(f) Other substantiating documentation or information required by the Purchase Order/Contract. Original invoice is required.

Invoice with required supporting documents may be submitted either through paper or electronic in a Portable Document File (PDF) format through an electronic mailbox.. Electronic submission (PDF format) are encouraged and do not require subsequent transmittal of original paper invoice. The SF-1034 must be signed, and it must be submitted along with the invoice and any other documentation in Adobe. If submitting invoices electronically, please request a confirmation of receipt from the CTO and the Office of Financial Management.

Paper Invoices shall be sent to the following address:

USAID/Mali
Office of Financial Management (OFM)
2050 Bamako Place
Washington DC 20521-2050

Attention: Financial Controller

END OF SECTION G

SECTION H – SPECIAL TASK ORDER REQUIREMENTS

H.1 Reference: Section H of TASC3 – Global Health IQC.

H.2 KEY PERSONNEL

The contractor shall provide the following key personnel for the performance of this task order:

1. Chief of Party, TBD
2. Maternal Health Specialist
3. Child Health Specialist
4. Malaria Specialist
5. Behavior Change Communication Specialist

USAID reserves the right to adjust the level of key personnel during the performance of this task order.

H.3 LANGUAGE REQUIREMENTS

All deliverables shall be produced in English and French unless otherwise directed by the CTO. Ability to hire French and local language expertise are required when necessary for the completion of field support tasks.

H.4 GOVERNMENT FURNISHED FACILITIES OR PROPERTY

The Contractor and any employee or consultant of the Contractor is prohibited from using U.S. Government facilities (such as office space or equipment) or U.S. Government clerical or technical personnel in the performance of the services specified in the Task Order unless the use of Government facilities or personnel is specifically authorized in the Task Order or is authorized in advance, in writing, by the CTO.

H.5 CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY

In accordance with the relevant FAR clauses of the Basic IQC.

H.6 CONTRACTOR'S STAFF SUPPORT, AND ADMINISTRATIVE AND LOGISTICS ARRANGEMENTS

The Contractor shall be responsible for all administrative support and logistics required to fulfill the requirements of this task order. These shall include all travel arrangements, appointment scheduling, secretarial services, report preparations services, printing, and duplicating.

H.7 ANTI-TRAFFICKING ACTIVITIES--LIMITATION ON USE OF FUNDS; RESTRICTION ON ORGANIZATIONS PROMOTING, SUPPORTING, OR ADVOCATING PROSTITUTION

http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd07_03.pdf

"PROHIBITION ON THE USE OF FEDERAL FUNDS TO PROMOTE,
SUPPORT, OR ADVOCATE THE LEGALIZATION OR PRACTICE OF PROSTITUTION – TIP ACQUISITION (MAY 2007)

(a) The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. None of the funds made available under this contract may be used to promote, support, or advocate the legalization or practice of prostitution.
Nothing in the immediately preceding sentence shall be construed to preclude assistance designed to ameliorate the suffering of, or health risks to, victims while they are being trafficked or after they are out of the situation that resulted from such victims being trafficked.
(b) The contractor shall insert this clause, in its entirety, in all sub-awards under this award.
(c) This provision includes express terms and conditions of the contract and any violation of it shall be grounds for unilateral termination of the contract, in whole or in part, by USAID prior to the end of the term.
(End of Provision)"

H.8 IMPLEMENTATION OF THE UNITED STATES LEADERSHIP AGAINST HIV/AIDS, TUBERCULOSIS AND MALARIA ACT OF 2003 – ELIGIBILITY LIMITATION ON THE USE OF FUNDS AND OPPOSITION TO PROSTITUTION AND SEX TRAFFICKING

http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd05_04_amendment1.pdf

"PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING (ACQUISITION) (OCTOBER 2007)
(a) This contract is authorized under the United States Leadership Against HIV/AIDS, Tuberculosis and Malaria Act of 2003 (P.L. 108-25). This Act enunciates that the U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. The contractor shall not use any of the funds made available under this contract to promote or advocate the legalization or practice of prostitution or sex trafficking. Nothing in the preceding sentence shall be construed to preclude the provision to individuals of palliative care, treatment, or post-exposure pharmaceutical prophylaxis, and necessary pharmaceuticals and commodities, including test kits, condoms, and, when proven effective, microbicides.
(b)(1) Except as provided in (b)(2) and (b)(3), as a condition of being awarded USAID funds for HIV/AIDS activities under this contract or subcontract, a non-governmental organization or public international organization contractor/subcontractor must have a policy explicitly opposing prostitution and sex trafficking.
(b)(2) The following organizations are exempt from (b)(1): the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Health Organization; the International AIDS Vaccine Initiative; and any United Nations agency.
(b)(3) Contractors and subcontractors are exempt from (b)(1) if the contract or subcontract is for commercial items and services as defined in FAR 2.101, such as pharmaceuticals, medical supplies, logistics support, data management, and freight forwarding.
(b)(4)Notwithstanding section (b)(3), not exempt from (b)(1) are contractors and subcontractors that implement HIV/AIDS programs under this contract or subcontract by:
(i) providing supplies or services directly to the final populations receiving such supplies or services in host countries;
(ii) providing technical assistance and training directly to host country individuals or entities on the provision of supplies or services to the final populations receiving such supplies and services; or
(iii) providing the types of services listed in FAR 37.203(b)(1)-(6) that involve giving advice about substantive policies of a recipient, giving advice regarding the activities referenced in (i) and (ii), or making decisions or functioning in a recipient's chain of command (e.g., providing

managerial or supervisory services approving financial transactions, personnel actions).
(c) The following definition applies for purposes of this provision:
“Sex trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. 22 U.S.C. 7102(9).
(d) The contractor shall insert this clause in all subcontracts.

(e) Any violation of this clause will result in the immediate termination of this contract by USAID.
(f) This clause does not affect the applicability of FAR 52.222-50 to this contract.”

END OF SECTION H

SECTION I – CONTRACT CLAUSES

Reference *TASC3 – Global Health* **IQC.**

END OF SECTION I

SECTION J – LIST OF DOCUMENTS EXHIBITS AND OTHER ATTACHEMENTS SECTION J

Reference/ Attachment Number	Title
J.1	Available Electronically on the TASC3 Website at http//ghiqc.usaid.gov/tasc3
J.2	U.S. Foreign Assistance Framework www.state.gov/documents/organization/79748.pdf
J.3	U.S. Foreign Assistance Standardized Program Structure and Definitions www.state.gov/f/releases/factsheets2006/79645.htm
J.4	U.S. Foreign Assistance Reform: Achieving Results and Sustainability in Support of Transformational Diplomacy www.state.gov/f/releases/factsheets2006/68202.htm
J.5	USAID Global Development Alliance (GDA) Webpage www.usaid.gov/gda
J.6	USAID/Mali Malaria Operational Plan www.fightingmalaria.gov
J.7	ADS 204, Environnemental Procedures www.usaid.gov/policy/ads/200/204
J.8	ADS 320, Acquisition and Assistance www.usaid.gov/policy/ads/300/
J.9	USAID FORM 1420-17 Contractor Biographical Data Sheet www.usaid.gov/forms/
J.10	AAPD 07-01 - Procurement of Anti-Retrovirals for HIV/AIDS Programs http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd07_01.pdf
J.11	AAPD 07 – 05 - USAID List of Approved HIV/AIDS Test Kits http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd07_05.pdf

SECTION K – REPRESENTATIONS, CERTIFICATIONS, AND OTHER STATEMENTS

Not required.

SECTION L - INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS

L.1 GENERAL

The Government anticipates the award of one (1) Cost Plus Fixed fee Completion Type Task Order as a result of this RFTOP; however, it reserves the right to make multiple awards or no award.

L.2 ACQUISITION SCHEDULE

The schedule for this acquisition is anticipated to be as follows:

	Date
RFTOP issued	May 06, 2008
Questions due	May 16, 2008
Answers to questions disseminated	May 16, 2008
Proposals due	June 16, 2008
Technical evaluation	June - July, 2008
Award of Task Order	August 1, 2008
Estimated Performance begins	Sept 1, 2008

All Questions relating to this RFTOP must be submitted to Mama Traoré at *(mamtraore@usaid.gov* no later than May 16, 2008 at 3:00 p.m. local Mali time. Unless otherwise notified by an amendment to the RFTOP, no questions will be accepted after this date. Offerors must not submit questions to any other USAID staff, including the technical office for either the Task Order or the basic IQC.

L.3 PROPOSAL INSTRUCTIONS

The proposals will be evaluated using Tier 3 per section F.5.2.2.3 of the basic IQC.

L.3.1 GENERAL INSTRUCTIONS TO OFFERORS

Offerors shall submit task order proposals electronically - internet email with up to 3 attachments (6 MB limit) per email compatible with MS WORD, Excel, PDF, in a MS Windows environment. There has been a problem with the receipt of *.zip files due to the anti-virus software. Therefore, Offerors are discouraged from sending files in this format as we can not guarantee receipt by the internet server.

Please submit your task order proposal to the following e-mail address: mamtraore@usaid.gov no later than June 20, 2008 at 3:00 p.m. local Mali time. The subject line of the email shall state the RFTOP number (688-P-08-005) and the name of your firm. You will receive an email confirming receipt of the task order proposal.

Offerors are reminded that e-mail transmission is not instantaneous. In some cases, delays of several hours occur from transmission to receipt. For this RFTOP, the initial point of entry to the government infrastructure is USAID's Washington mail server.

Offerors are also requested to submit one original and six paper copies (and duplicate CDs) of the technical proposal and one original and two paper copies (and duplicate CDs) of the cost

proposal postmarked no later than the closing date stipulated above. All mail is subject to US Embassy electronic imagery scanning methods, physical inspection, and is not date and time stamped prior to receipt by USAID and the Contracting Officer. Please be advised that since the issuing office receives regular international mail only once weekly, submission via commercial courier is advised:

Regular Mail: Hand Delivery/Commercial Courier:

Regular Mail:	**Hand Delivery/Commercial Courier:**
American Embassy Bamako ACI 2000, Rue 243, Porte 297 B.P. 34, Bamako, Mali	Mama Traoré C/O American Embassy Bamako ACI 2000, Rue 243, Porte 297 BP.34 Bamako, Mali

Regardless of the method used the Technical Proposal and Cost Proposal must be kept separate from each other. Technical Proposals must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit. The US Government is not obligated to make an award or to pay for any costs incurred by the Offeror in preparation of a proposal in response hereto.

Unnecessarily Elaborate Proposals: 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 Contractor's lack of cost savings. Elaborate artwork, expensive paper and binding, expensive visual and other presentation aids are neither necessary nor wanted.

L.3.2 INSTRUCTIONS FOR PREPARATION OF THE TECHNICAL PROPOSAL

The technical proposal in response to this solicitation shall be specific, clear, and complete, and shall respond to the instructions set forth in this Section. The technical proposal shall be written in English and will be no more than 40 pages in length; an executive summary of no more than 5 pages shall be provided in French, but will **not** be included as part of the 40 page limit and will not be considered in the evaluation of the technical proposal. The proposal should be organized according to the technical evaluation criteria listed in below and should address the key principles described above and the specific points specified below.

Proposal Format: The technical proposal must not be more than ***40 pages***. Proposals will be on pages of 8-1/2 inch by 11-inch paper (210 mm by 297-mm paper), single-spaced, 11-point or larger type in a single column, with one-inch margins on all sides and tabs to distinguish each section. Proposals may contain matrices, tables and figures if they synthesize needed information. Proposals may contain text boxes, and text may be in 10-point font, as long as the boxes are formatted so as to not unduly interfere with readability. Cover pages, dividers, table of contents, and attachments (i.e., key personnel resumes, and letters of commitment, supporting documentations) do not count within the 40-page limitation.

The technical proposal at a minimum shall include the following:

Cover Page: The RFTOP title, name of organization(s) submitting the proposal, contact person, telephone and fax numbers, address and email, plus identification of all formal partner

organization must all be included.

Executive Summary (not to exceed 3 pages): Briefly summarize the technical and managerial approach to reach the proposal goals, objectives, and expected results. Briefly describe technical and managerial qualifications of the Contractor.

Proposal Body (not to exceed 40 pages): The technical proposal shall describe ***how*** the Contractor intends to carry out the work statement, and give details of what performance indicators will be used to measure success. It shall also demonstrate a clear understanding of the work to be undertaken and delineate the responsibilities of all parties involved.

The Offeror shall address the following areas:

L.3.2.1 Technical and Management Approach

Describe your overall technical and managerial approach to carrying out the statement of work and how the expected results will be achieved. The illustrative tasks and performance measures, listed in the Expected Results section, provide examples of ***what*** the Offeror shall achieve during the duration of the Task Order and shall be considered as examples of the ***standard of performance*** expected under this Task Order. The Offeror must specify ***how*** it will achieve these expected results. The Offeror will present a detailed Milestone plan and Monitoring and Evaluation Plan for the life of the Task Order (see Section IV, C). The Offeror will be responsible for proposing measurable performance indicators and milestones, baselines, targets, and measurable outputs and outcomes. These performance measure and milestones will be used in monitoring the Task Order performance and impact.

Significant technical considerations include:

How the Offeror proposes to set up its consortia to include local partners in the various aspects of the program planning and implementation.

How the Offeror proposes to build local capacity, transfer skills, and ***use*** African personnel (staff or consultants) and institutions in the design and implementation of program activities.

How the Offeror will maintain momentum by building on and further developing best practices, adopted approaches and lessons learned that have been built under previous USAID/MALI effort.

How the Offeror will coordinate and collaborate with other donors and partner providing technical support within Mali such as the Global Fund, bi- and multi-lateral technical assistance mechanisms, local and international NGOs and other U.S. Government bilateral initiative teams (PMI, PEPFAR).

L.3.2.2 Organization Capacity and Management

The Offeror shall describe the organizational and management structure proposed to successfully undertake this Task Order including how they will utilize the capabilities of proposed subcontractors effectively and efficiently. The Offeror shall provide an organizational chart, illustrating the responsibility and relationships between prime and subcontractor, lines of authority and accountability, and patterns for utilizing and sharing resources.

L.3.2.3 Key Personnel

A key factor in the success of current USAID/Mali implementing mechanisms is their highly experienced professional technical staff and ability to influence senior-level donor and government counterparts to adopt new policies and service delivery approaches. The Offeror shall have demonstrated ability to manage USAID funding and to influence priority budget and program decisions of other large donors in the region (i.e. Global Fund).

Key personnel will include the Chief of Party and technical advisors as specified above. The Offeror has maximum flexibility in putting together a team that demonstrates the following strengths:

Candidates for the Chief of Party must have a minimum of fifteen (15) years of experience managing large-multi-donor-funded health grants at national and international levels. At least ten (10) years of this experience shall be in West Africa;

Candidates for key technical advisors must demonstrate senior-level expertise in the following areas as appropriate: Family Planning, Reproductive Health, Child Survival, Malaria, Nutrition, Health policy/advocacy, Health Sector Reform; as well as at least 7 years demonstrated experience in West Africa.

All candidates must demonstrate proven ability to negotiate and influence policy and program decisions with senior government and donor officials;

Candidates must have an advanced degree in public health or another relevant technical area; and

All candidates shall be fluent (FSI rating S/R 3+/3+) in French and English.

The Offeror shall provide;

A complete staffing plan with underlying rationale (including support staff), an organizational chart demonstrating lines of authority and staff responsibility, and brief position descriptions for each technical staff position proposed for the life of the task order.

A matrix of all proposed personnel and the relevant skills that they bring to the performance of this activity. Resumes for all proposed staff should be included as an annex.

If the Offeror proposes the use of subcontractor personnel in any key personnel position, the proposal shall explain how potential conflicts between on-the-job relationships and employer-employee relationships will be resolved.

As an annex to the technical proposal, the Offeror shall submit resumes or curriculum vitae of key personnel planned for performance of the work (Bio-data sheets with salary information should be attached to the cost proposal, not the technical proposal). Resumes/curriculum vitae may not exceed two pages in length per individual and shall be in chronological order starting with the most recent experience. Each resume/ curriculum vitae shall be accompanied by a

SIGNED letter of commitment from each candidate indicating his/her: (a) availability to serve in the stated position, in terms of number of days after award and (b) intention to serve for a specified duration.

A wealth of technical expertise already exists in Africa in the areas of FP/RH, MCH, malaria, nutrition, health policy/advocacy, health systems reform. The Offeror shall propose an appropriate mix of talent and expertise to implement the project and utilize non-African expertise only when skills or experience in specific project areas are lacking from African countries. It is particularly important to tap the talents and resources of the African private sector in promoting economic development.

L.3.2.4 Past Performance

Past performance sub-factors include quality, cost control, timeliness, and business relations. In evaluating past performance, the Offeror's past performance in using small business concerns under previous contracts will be taken into consideration. The Offeror shall identify five past (within the last three years) or current contracts for efforts similar to the requirement and include contact information as well as information pertaining to problems encountered on the identified contracts and the Offeror's corrective action. "Similar" in this context means in relation to size, scope, and complexity, as well as to a specific subject matter.

In evaluating past performance, USAID shall consider the information provided by the Offeror, as well as information obtained from other sources. Furthermore, USAID shall determine the relevance of similar past performance information.

The past performance references required by this section shall be provided as an attachment to the Technical Proposal.

L.3.3 Instructions For Preparation Of The Cost/Business Proposal.

This will be a five-year task order with an estimated dollar range of $18 to $22 million over the life of the Task Order. This range is provided to give offerors the relative order of magnitude of the anticipated project and should not be used as a target. Each offer will be evaluated for cost reasonableness and realism. The contractor will not be paid any sum in excess of the Task Order ceiling price. The offeror is expected to propose a realistic budget to support the expected results described in Section II of this RFTOP. Offerors are reminded that the resulting Task Order will be partially funded through the Presidential Malaria Initiative (PMI). FY Funding levels by PMI will be determined through Task Order modifications

Cost Elements Total

001. DIRECT LABOR	$_____
002. TRAVEL, TRANSPORTATION & PER DIEM	$_____
003. ALLOWANCES	$_____
004. EQUIPMENT	$_____
005. SUBCONTRACTS	$_____
006. OTHER DIRECT COSTS	$_____
007. INDIRECT COSTS	$_____
008. FIXED FEE	$_____
TOTAL ESTIMATED COST PLUS FIXED FEE	$_____

Note: Individual subcontractors shall include the same cost element breakdowns in their budgets as applicable.

The offeror's budget shall include the following information:
A detailed level of effort estimate. Please provide a separate line item for each proposed individual and identify each by name and labor category as set forth in the contract.

Biographical Data Sheets (AID Form 1420-17) supporting unburdened daily rates for proposed candidates.

The offeror shall provide the computations that were utilized in developing the proposed locally-hired national personnel and other non-U.S. expatriate salary.

The offeror shall show the unburdened rate and any other costs applied to develop the proposed salary.

A detailed estimate for other direct costs (for example, travel, allowances, etc.). Please explain the basis and budget narrative for the estimate for each category of cost; and if subcontracting is contemplated, other than the approved subcontractors identified in Section H.21 of the basic award, the offeror shall indicate the types of work to be subcontracted, stating: The percentage of each type of work subcontracted, the extent to which competition was or will be solicited prior to selection, subcontractor(s) selected and reasons therefore, and the method of analyzing prospective subcontractor proposals. USAID will provide government-furnished equipment, so any equipment costs shall minimal.

In the cost proposal, for each milestone, the Offeror shall include the milestone plan and percentage of fixed-fee based on the accomplishment of the milestones in the Milestone Plan. The offeror shall include the dollar breakdown for payment of fee as part of the business/cost proposal. The Offeror's proposed the fee structure that will be paid upon the completion of each milestone.

SECTION M – EVALUATION FACTORS FOR AWARD

M.1. GENERAL INFORMATION

The evaluation criteria have been tailored to the requirements of this TO, to allow USAID to choose the highest quality proposal. These criteria: a) identify the significant areas that the Offerors shall address in their proposals and b) serve as the standard against which all proposals will be evaluated.

The Government intends to evaluate task order proposals in accordance with technical evaluation factor provided below and award to the responsible contractor whose task order proposal represents the best value to the U.S. Government. "Best value" is defined as the offer that results in the most advantageous solution for the Government, in consideration of technical, cost, and other factors.

The submitted technical information will be scored by a technical evaluation panel using the technical criteria shown below. The evaluation committee may include industry experts who are not employees of the Federal Government. When evaluating the competing offerors, the Government will consider the written qualifications and capability information provided by the offerors, and any other information obtained by the Government through its own research.

Price has not been assigned a numerical weight. Offerors are reminded that the U.S. Government is not obligated to award a negotiated contract on the basis of the lowest proposed cost (see FAR 15.101-1) or to the offeror with the highest technical evaluation score. For this procurement technical proposal and cost or price are of equal weight to each other.

M.2. TECHNICAL PROPOSAL EVALUATION CRITERIA

The specific evaluation criteria are as follows:

Each proposal will be scored by the technical evaluation committee using the criteria shown in this section.

I. TECHNICAL PROPOSAL (100 PTS)

A. Proposed technical approach: Methodology and content (50 pts)

- Proposed technical approach is comprehensive, prioritized, technically sound and reflects an understanding of the Malian context and USG Foreign Assistance priorities; (20 pts)

- Proposed interventions lead to program harmonization, integration, and collaboration with partners, stakeholders and donors; (5 pts)

- The Annual Work Plan is logical and shows clear linkages between proposed program activities and the achievement of the Expected Results within the time frame of the Task Order; (10 pts)

- The Performance Monitoring Plan presents realistic and robust performance measures that will reflect the Task Order's impact. (5 pts)

- The Milestone Plan demonstrates a realistic timeline; Milestones are clearly linked to performance results, requirements and standards, per the stated indicators. (10 pts)

B. Organization Capacity and Management (30 pts)

- The proposal presents a clear and efficient management plan and organizational structure for accomplishing all aspects of Task Order implementation; (15 pts)

- Proposed sub-contractors and local partners possess complimentary skills and that it is demonstrated that those skills will be fully utilized in every aspect of Task Order implementation, not just presented at proposal submission; (10 pts)

- The proposed management approach promotes the progressive transfer of skills and responsibilities to West African individuals and entities throughout program implementation. (5 pts)

C. Key Personnel (20 pts)

- Task Order Chief of Party and other key personnel demonstrate expertise in influencing health policy and program decisions among senior-level donor and government counterparts; (10 pts)

- Key personnel and other project personnel demonstrate solid expertise in health sector planning, directing, managing, and evaluating large complex programs; proposed core staff and consultants demonstrated requisite expertise, skills and experience, and knowledge of the African context to implement the Task Order; (5 pts)

- African professionals are proposed in senior and core capacities and their skills, capabilities and expertise are used in a substantive way in the management and implementation of the program. (5 pts)

D. Past Performance (Adjectival)

Quality: Demonstrated successful experience in managing and implementing programs of similar scope and size, preferably on the African continent.

Cost Control: A demonstrated ability to budget and manage cash flow while maintaining strict cost control measures. Demonstrated use of local expertise where available instead of more costly expatriate labor.

Timeliness: Timeliness of performance, including adherence to contracting schedules and other time-sensitive project conditions, and effectiveness of home office field management to make prompt decisions and ensure efficient operation of tasks

Business Relations: Customer satisfaction, including satisfactory business relationship with clients, coordination among partners, and prompt and satisfactory correction of problems if and when they arose.

Use of Small Businesses: Demonstrated use of small business subcontractors under previous contracts of similar scope and complexity

M.3 COST PROPOSAL EVALUATION

The contractor should demonstrate a structure that will allow it to provide the best value, greatest results at the lowest cost. Each offeror's cost proposal of the contract period shall be evaluated in terms of reasonableness and realism to determine the appropriate cost for the work, the offeror's understanding of the work, and the offeror's ability to perform the work. Price has not been assigned a numerical weight. Offerors are reminded that the U.S. Government is not obligated to award a negotiated contract on the basis of the lowest proposed cost (see FAR 15.101-1) or to the offerors with the highest technical evaluation score. After the final evaluation of the proposals, the Contracting Officer will make the award to the offeror whose proposal offers the best value to the Government, considering both technical and cost factors. It should be noted that estimate cost is an important factor and its importance as an evaluation factor will increase as the degree of equality of technical competence between proposals increases.

END OF SECTION M