ATTACHMENT

STATEMENT OF WORK

Community Based Family Planning (FP) and Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) Services in Malawi

A. TITLE

The title of the program in this task order is Community Based Family Planning (FP) and HIV/AIDS Services

B. PURPOSE

The purpose of this task order is to support the Government of Malawi (GOM) Ministry of Health (MOH) goal of promoting through informed choice, safer reproductive health (RH) practices by men, women and young people including increased use of high quality, accessible reproductive health services. The offeror awarded this task order shall be responsible for implementing integrated innovative approaches to community-based programs that promote access and utilization of family planning, reproductive health and HIV/AIDS services. The bulk of funding for this integrated program will be allocated for the Family Planning /Reproductive Health related programming (85%), with the remaining funds earmarked for HIV/AIDS activities 15%. It is possible that in out years, additional monies will be added in from HIV/AIDS depending on funding levels as PEPFAR is reauthorized. The proposed program will have three integrated components – Behavior Change Communication (BCC); outreach and health provider capacity building. BCC will adequately portray family planning and HIV testing as a mainstream health intervention, and influence the hearts and minds of individuals to make them more open to practice family planning, HIV prevention and treatment and positive leaving and endorse these to their fellow community members. Outreach and community based services will help influence the creation of a social atmosphere where family planning and HIV/AIDS are open and relevant topics among influential individuals, groups and communities. BCC interventions/messages and community-based services should address the unique needs of women and men in accessing FP/RH and HIV services, and engage men as supportive partners in FP decisions and to adopt HIV preventive behaviors. The program shall target rural and underserved areas and high risk populations defined by high unmet demand for services or marginalized groups.

The task order supports activities designed to reduce fertility and population growth, which is essential for attaining broad based economic growth and lowering the risk of HIV/AIDS to mitigate the enormous impact on human resources and productivity. These inter-related elements contribute directly to the Health, Population and Nutrition program goal of Healthier Malawian Families and the overall Mission program goal of Poverty Reduction and Increased Food Security through Broad-Based, Market-led Economic Growth.

By the end of the task order, it is expected that the following outcomes shall have been achieved:

- Fully functional community based FP services initiated in the eight target districts.
- Community knowledge and interest in FP and HIV/AIDS services increased.
- Quality of FP service delivery by health providers at the facility, community and local level improved.

- Access and utilization of FP services in communities increased.
- Integrated FP and HIV/AIDS services increased.
- Linkages between point of service and the community and household levels improved.
- Enabling social and policy environment for FP/RH and HIV/AIDS services and behaviors strengthened.

Duration of the Task Order

The task order will be for a period of three years, beginning o/a August, 2007, plus one option year, subject to availability of funds.

C. BACKGROUND

The health situation in Malawi reflects the Nation's poverty. Malawi with a population of 13 million people is ranked one of the ten poorest nations on earth, and its poverty is starkly represented in its demographic and health indicators - an average life expectancy of 40 years, a literacy rate of 63 %, and 55 % of the population living on $1 per day or less. Food insecurity is widespread and chronic. 25% of the population is chronically food insecure and 45% of children are stunted by malnutrition. HIV/AIDS prevalence rates are high, estimated at 14% among the 15 to 49 years age group (2005 Sentinel Surveillance Survey). The 2004 Malawi Demographic and Health Survey (MDHS) revealed that HIV prevalence was 12% among persons aged 15 to 49 years in 2004 Prevalence is significantly higher in urban areas (17%) than in rural areas (11%). However, there is evidence that while infection rates are slowing in urban areas, HIV prevalence continues to increase in rural areas where 85% of the population live. High birth rates (6.0) are offset by high infant, child and maternal mortality rates (76/1000, 133/1000, and 984/100,000, respectively) (MDHS 2004). An estimated 60% of the government's health worker positions are vacant and only 96 government doctors address the health needs of 12 million people. Malawi's MOH identifies four key health problems requiring priority attention: high child mortality and morbidity; high maternal mortality and morbidity; high morbidity and mortality in the general population due to infectious diseases and high HIV sero-prevalence and deaths due to HIV/AIDS related illnesses. The government is also actively engaged in antiretroviral therapy (ART) scale up and is now prioritizing prevention of mother to child transmission (PMTCT) scale up and to a lesser degree prevention of new infections.

Cutting across these major health issues is the high fertility rate, which undermines the poverty reduction effort, contributes to high maternal and infant mortality levels and exacerbates the AIDS-related orphan problem. Considerable progress has been made over the last decade in reducing total fertility from 6.7 in 1992 to 6.0 in 2004. At the same time, the contraceptive prevalence rate (CPR) for modern methods has been raised from 7% in 1992 to 28% in 2004. At current rates of CPR growth, the target fertility rate of 4.9 in 2012 looks achievable. However, desired fertility is declining at less than 2% per annum – from 5.7 in 1992 to 4.1 in 2004 – though this may not continue to be concurrently reflected in a growth of the CPR unless the availability and quality of reproductive health services, and clients' attitudes toward them, can be further improved over the next decade.

The state of the health service delivery platform continues to be a barrier that limits opportunities for rural communities to access the Essential Health Package (EHP) especially for the most vulnerable groups - mothers and children. The other important cross-cutting

issue is the staffing crisis in the health sector. Frontline health workers continue to leave the public health sector and thus exacerbating the human resources crisis. According to the 2006 Sector Wide Approach (SWAp) annual review report, on average the vacancy rate for nurses stood at 61% in the public health sector and 77% at Christian Health Association of Malawi (CHAM) facilities. The average vacancy rate for medical doctors stood at 62%, at both Ministry of Health (MOH) and CHAM institutions. There are many causes for this human resource crisis including the impact of the HIV/AIDS epidemic; unattractive compensation, benefits and incentives; shortages of qualified secondary school graduates; past shortages of appropriately qualified tutors; and inadequate funding for health training schools. Many improvement initiatives are in hand or planned, but lead times will be long and it is unlikely that staff shortages will be resolved shortly.

Malawi Ministry of Health devolved the delivery of health services to the district level. Districts assemblies, in conjunction with the district health management team, now have authority over their capital cost and recurrent cost budget and are able to set their own priorities within the EHP. The MOH now works in more of a policy development and supervisory role. The MOH has established five zonal offices each of which will supervise and assist several districts.

1. FP/RH and HIV/AIDS Services

Malawi has built an excellent foundation for family planning services because of good work done in the 1990s. About 99% of adults know at least one modern method of contraception, there is little opposition to practicing family planning, and the rate of modern contraceptive use has been increasing although there is still a wide gap between knowledge and practice. Policy changes in 1992 removed multiple barriers to contraceptive use. Women can now use injectables before they are 35 and before they have four children; use contraceptives before marriage; and use contraceptive methods without their husbands' consent. Although the contraceptive prevalence rate has steadily increased since 1992 from 7.4% to 28% in 2004, the increase in the past five years was very insignificant; fertility has remained high at 6.0 national level; 4.2 in the urban areas and 6.4 in rural areas. According to the 2004 DHS, four in five women want to delay or stop child bearing; 40% of the pregnancies are unplanned and unwanted and the desired family size is 4.1 compared to the (actual family size of 6.0) national average of 6.0. This gap between actual fertility versus desired fertility signals a significant unmet need for family planning services. Although services are free, only 54% of the health facilities provide family planning services according to the SWAp mid year review report 2006.

While the use of modern contraception has greatly increased in Malawi in a short period, the gains have been tempered by weakening efforts in commitment to comprehensive FP programs in recent years. Attention to family planning has declined and donor and government funding has stagnated, while the number of couples needing family planning continues to rise. There is still substantial unmet need in Malawi and specifically in the rural areas where fertility is still 6.4. Meeting the unmet need for family planning has myriad positive impacts on women, their families, and their communities, and at a higher level, can help Malawi achieve the Millennium Development Goals (MDGs).

There remain numerous barriers to accessing family planning that continue to thwart progress. Obstacles to meeting unmet need range from social factors such as lack of decision making power among women; limited access to family planning through the public sector;

inadequate healthcare personnel trained and authorized to provide comprehensive FP services. The human resource shortage of healthcare workers in Malawi and particularly the shortage of nursing staff—the primary source of family planning information and services for women in the health facilities, seriously compromises women's ability to access family planning. Most rural women in Malawi have long work days in which they have to do housework, farming, marketing, and care for their families. It is very difficult for these women to travel a minimum of eight kilometers to a clinic for family planning services. In addition, men tend to be the major decision-makers in the area of family planning, so that after a woman has struggled to find the time to get to a clinic and be counseled on various contraceptive methods, she may not be able to take a method because she needs to discuss first with her husband.

While a majority of Malawians perceive family planning as important to attaining a better quality of life, many couples and service providers are misinformed about the safety and effectiveness of modern contraception, including the scientific natural family planning methods. As a result, those who desire to plan their family size are reluctant to adopt these proven effective methods, and there is need to improve health practitioners' skills in counseling and clinical services. Although the FP program has made some tremendous achievements in expanding access and use of contraceptive methods, informed choice is limited by a narrow range of temporary methods that are available, especially for adolescents. Providing a wide range of contraceptive choices is key to increasing contraceptive prevalence. Injectables are currently the most popular means of contraception followed by pills, Norplant and condoms. The intrauterine contraceptive device (IUCD), a popular long term method in some places, is now available but there are few current staff members who are trained and skilled in IUCD insertion. Tubal-ligations and vasectomies are available at the district hospitals but a patient must come at a specified day and time when those procedures are done. Clients have to travel to district hospital for Norplant insertion because it is not available at health centre level. If Malawi is to reduce poverty and improve the nutritional status of its population, the contraceptive prevalence rate must continue to increase.

Despite 15 years of a national response, the impact of HIV and AIDS in Malawi remains devastating, given the pace of its spread and the poverty of this small nation. Nearly 1 million people in a population of 12 million are HIV-infected. Women are more likely to be infected than men, and prevalence is higher in urban areas (21.6% of adults) than in rural areas (12.1%). However, there is evidence that while infection rates are slowing in urban areas, HIV prevalence continues to increase in rural areas.

Widespread poverty, low access to local health services and low literacy rates contribute to high prevalence rates. Compounding these factors are gender inequalities and cultural practices which exist in Malawian society. Typically, men in Malawi dominate the decision making, including decisions regarding sex, and women feel powerless to refuse sex or negotiate safe sex. Cross-generational sex is prevalent and the food crisis and general poverty are believed to force younger women into sex with older, more affluent men.

It is against this backdrop that GOM embarked on its bold National Action Framework (NAF) to provide HIV and AIDS prevention, treatment and care services through 2009. This is coordinated by the National AIDS Commission (NAC); one agreed upon National M&E Plan is used to monitor progress and results of the response. The national strategy calls for a decentralized response, strong involvement of medical institutions, Non-Governmental

Organizations (NGOs), Community-based Organizations (CBOs) Faith-Based Organizations (FBOs), and civil society, and systems to ensure quality of services. Malawi has made tremendous progress in scaling up HIV and AIDS services, especially in its ART program, exceeding targets for enrolling patients in ART. Continued expansion, sustainability, and quality of services are imperative for Malawi and partners for the continued response to HIV.

The Government of Malawi is currently implementing a second National HIV/AIDS Action Framework (NAF) 2005 -2009 under the leadership of the Office of the President and Cabinet with a National AIDS Commission providing overall coordination and secretariat.

From 2001 to 2006, there has been a steady increase in the number of sites offering HIV counseling and testing services. Almost 40% of the approximately 620 health facilities in Malawi were providing HIV testing and counseling services as of June 2005, only 70 (48%) were located in rural areas. The 2004 MDHS estimated that 14% Malawians had ever tested for HIV (13% women, 15% men). However, the number of persons going for testing is increasing every year. The total number of people tested for HIV is therefore 424,212 assuring access to treatment, care and support and preventing new infections. Note: although the number tested has increased, there is need to ensure that men and women are able/supported to disclose their status by addressing issues such as stigma and fear of violence or abandonment.

The Government of Malawi (GoM) response to the epidemic for treatment, in collaboration with the Global Fund, USG and other international partners, has been impressive. In 2003, only 2.3% of eligible HIV+ patients were on ART. At the end of September 2005, a cumulative total of 30,055 patients had been started on ART, and by June 2006, 57,533 patients had ever been prescribed ARVs, surpassing the set national target of 35,000. According the Ministry of Health, by June 2006, there were 129 facilities in Malawi (101 public and 28 private) delivering anti-retroviral therapy (ART) to eligible people living with HIV.

2. USAID/Malawi's Work in FP/RH and HIV/AIDS

USAID/Malawi has played a substantial role in supporting the Government of Malawi's family planning program since child spacing became legal in the 1980's. The Agency supported the Ministry of Health in the development of FP policy and guidelines and subsequent reforms, development and subsequent review of RH strategy, improvement of facilities for FP service provision including establishing facilities for mini laparoscopy procedures, and supply of contraceptive commodities.

USAID/Malawi also provided support for the development of a national program for community-based distribution of family planning methods, including development of the curriculum and training materials and training of trainers in the early 90s. Non-Governmental Organizations (NGOs) were funded to train and supervise the activities of Community-Based Distribution Agents (CBDAs). Community-based distribution agents have been a key contributor to the success of family planning in the country. In a country where the majority of the population lives in rural areas, often far from health facilities, Community Based Distribution (CBD) has been essential to make services more convenient. In 2000 the MOH started the Population and Family Planning Project (PFPP) to test the feasibility of implementing a comprehensive, district wide community based distribution approach to family planning services. Since the PFPP was being funded by a World Bank loan, the

Support to AIDS and Family Health (STAFH) Project stopped supporting the Government of Malawi's (GOM) Community Based Distribution (CBD) program.

In order to improve availability of contraceptives at service delivery points, USAID provided technical assistance in contraceptive logistics management system and Remarkable improvements have been made in the contraceptive management system and the supply of contraceptives has been relatively stable.

Following the International Conference on Population and Development (ICPD) in 1994, USAID supported the Ministry of Health to integrate family planning with other RH programs. USAID provided funding for training health workers to provide post abortion care (PAC), emergency contraception (EC) and cervical cancer screening at selected district hospitals. Staff in targeted health facilities has been trained to administer the diagnostic test for cervical cancer using visual inspection under acetic acid and the treatment for women who need it using cryotherapy and referral for surgical intervention where necessary.

All United States Government (USG) assistance directed to combat the AIDS epidemic in Malawi is now incorporated within the President's Emergency Plan for AIDS Relief, with 15 countries targeted as focus countries. Within the focus countries, the Emergency Plan specifies targets in prevention, treatment, care, and support to be achieved over the next five years: treat two million HIV-infected people with antiretrovirals (ARVs) (approximately 50 percent of eligible adults and children); prevent seven million new infections (60 percent of projected new infections) and provide care and support for 10 million HIV-infected individuals and AIDS orphans. Although Malawi is not one of the fifteen focus countries, the Emergency Plan has shown the resolve of the USG to combat the HIV/AIDS epidemic and to contribute significant USG resources to the process.

The overall vision for the USG mission in Malawi is to partner with the Government of Malawi (GOM), other bilateral and multilateral institutions, and civil society to prevent HIV infection, improve access to treatment, care for eligible people living with HIV and AIDS, and mitigate the impacts of HIV and AIDS on individuals, families, communities and the nation. The USG mission is committed to working within the National HIV and AIDS Action Framework (NAF) 2005-2009.

USG support for HIV and AIDS interventions in Malawi has been, and will continue to be, in the areas of prevention, care, treatment, and cross-cutting issues. For each of the major interventions, USG will support both national-level initiatives and pilot point-of-service interventions that, in partnership with other development partners, can be successfully scaled up across Malawi.

USG assistance for PMTCT to date has been predominantly direct support for PMTCT services at 13 sites and indirect support for 8 districts. In FY 2007, USG has strategically increased the support it provides for the national rapid scale-up of PMTCT.. Currently, USAID is working to expand the reach of service delivery emphasizing the referral systems linking communities, families and mothers and infants to PMTCT services. The USG also provides technical assistance to MoH and implementing partners to strengthen the quality of service delivery and address infant feeding and nutrition issues.

USAID has provided modest support for injection safety activities in two key areas: rolling out national standards and guidelines, and increasing knowledge and skills of health care workers to prevent occupational exposure of HIV and other communicable diseases.

USAID also provides support for the National Behavior Change Intervention Strategy, designed to change the way Malawians think, speak and behave in regards to HIV and AIDS. USAID supports a comprehensive approach to prevention that includes targeted prevention strategies including abstinence, faithfulness, and correct and consistent condom use.

More broadly, the program takes into account traditional gender roles and cultural issues (i.e. sexual initiation or cleansings practices, cross generational sex, men as decision makers, etc.) and is strengthening linkages with other care interventions, including other PEPFAR areas (e.g. OVC) as well as non-PEPFAR programs such as the current task order to integrate HIV with other programs.

Despite recent scale-up of HIV testing and counseling in Malawi, only 15% of adults know their HIV status. At the National level, USAID provides technical assistance with MoH to strengthen national leadership and coordination for HTC scale-up. In addition to stimulating demand for HTC, USG is expanding equitable access to HIV testing by promoting provider initiated testing and supporting HTC service delivery for 139,351 persons at 160 sites. As services scale-up, USG works on enhancing quality of HTC through training and supervision and in this task order, will look to integrate HIV and FP even further and in both directions (FP in HIV and HIV into FP).

3. USAID MALAWI'S CURRENT HEALTH PROGRAMS

USAID/Malawi's current health programs are designed to achieve **Increased Use of Improved Health Behaviors and Services.** The programs have both a national and targeted focus in the following interventions:

- **Community and Clinic-Based FP Project:** USAID through a Flexible Fund grant supports a Faith Based NGO working on community and clinic FP strengthening in fourteen health centers and their catchment areas in the three regions of the country.

- **Health Policy Initiative** with core funds will work with the Reproductive Health Unit to initiate policy dialogue and advocate for policy change in Malawi to remove legislative and operational barriers that limit contraceptive methods available through CBDs and prepare an implementation strategy for effective delivery including social marketing of injectable contraceptives and counseling by distributors. The Task Order is expected to build on old and new Health Policy Initiative work.

- **Improved Reproductive Health:** Support to MOH's RH program with focus on post abortion care; performance and quality improvement in infection prevention and RH; emergency contraception; and reinvigorating the IUCD.

- **Procurement of Contraceptives:** USAID procures all contraceptives except injectables for the MOH. In the near future USAID will provide some support in the procurement of injectables

- **Logistics Systems Strengthening**: USAID provides technical assistance in health commodity logistics system strengthening to MoH with particular focus on contraceptive logistics systems support.

- **HIV/AIDS Program:** USAID provides support through six cooperative agreements to increase awareness, promote health behaviors and offer care and support to people living with HIV/AIDS including impact mitigation. These include national behavior change projects for A, B and C, orphans and vulnerable children support, comprehensive HIV programs at community levels, care and support for HIV affected and infected people, systems strengthening, infection prevention and counseling and testing.

- **Reducing Child Mortality and Strengthening Health Care Systems** in Malawi by improving routine supervision, strengthening referral systems, developing adequate health data for planning and monitoring and improving child health care and treatment practices.

- **President's Malaria Initiative (PMI):** Malawi has been named a PMI country and the resources available to combat malaria have substantially increased to scale-up of proven preventive and therapeutic interventions including insecticide-treated nets (ITNs), intermittent preventive treatment (IPT) of malaria in pregnancy, indoor residual spraying (IRS) and artemisinin-based combination therapies (ACTs).

- **Maternal and Newborn Health:** USAID/Malawi will respond to the MOH's Roadmap for Accelerating Reduction in Maternal and Neonatal Morbidity and Mortality by supporting a few high-impact, evidence-based interventions that would address the leading causes of maternal and neonatal death.

- **Strengthening TB Control:** USAID will assist the GOM strengthen DOTS programs by increasing case detection and treatment success, including the prevention and control of multi-drug resistance TB (MDR-TB) and dually infected individuals to reduce TB morbidity, mortality and transmission.

4. USAID/MALAWI STRATEGY AND PROGRAM

In line with identified priorities of the Government of Malawi for the health sector, the goal of the USAID integrated health, population and nutrition (HPN) program (SO8) is to help achieve healthier Malawian families. The Strategic Objective of USAID Malawi's HPN program is **Increased Use of Improved Health Behaviors and Services**. SO8 contributes to progress in three critical areas: 1) Reducing fertility and population growth, which are essential for attaining broad based economic growth; 2) Lowering the risk of HIV/AIDS to mitigate the enormous impact on human resources and productivity; and 3) Lowering infant and under-five mortality rates. The program goal is achieved through the following Intermediate Results:

1) Behavior change enabled
2) Quality of services improved
3) Access to services increased
4) Health sector capacity strengthened

This Task order shall directly support the four intermediate results (IRs) by providing technical assistance to improve health service delivery at community levels and referral health facilities and increase utilization and decrease stigma for key FP and HIV services.

D. SCOPE OF WORK

The overall purpose of this task order is to promote through informed choice, safer reproductive health practices by men, women and young people, including increased use of high quality, accessible FP/RH and HIV/AIDS services. In achieving the purpose, the program shall undertake various activities necessary to accomplish the following deliverables:

1. Program Deliverables

- Fully functional community based FP services initiated in the eight target districts.
- Community knowledge and interest in FP and HIV/AIDS services increased.
- Social norms including gender norms for SRH/FP/HIV/AIDS improved.
- Quality of FP service delivery by health providers at the facility, community and local level improved.
- Access and utilization of FP/HIV/AIDS services in communities increased.
- Increased integration of HIV issues into FP services and vice versa.
- Linkages between point of service and the community and household levels improved.
- Enabling social environment for FP/RH and HIV/AIDS services and behaviors strengthened.
- Policy and Guidelines to enable social marketing and community based distribution of injectables developed.

Achievement of these results shall be carried out principally through partnerships with the district health offices in Malawi. All activities implemented under this award shall take place within the current government system; government structures will retain and exercise their normal authorities.

2. Program Indicators

This program shall result in reduced fertility and increased utilization of FP/RH and HIV/AIDS services. Indicators or measures of performance proposed for the overall direction of this award include.

a) Number new approaches (e.g. tools, technologies, operational procedures, information systems etc) successfully introduced
b) Couple years of protection in USG supported programs
c) Number of people trained in FP/RH with USG funds (women and men)
d) Number of counseling visits for FP/RH as a result of USG assistance (women and men)
e) Number of people that have seen or heard a specific FP/RH message
f) Number of policies or guidelines developed or changed to improve access to and use of FP/RH services
g) Number of USG assisted service delivery points providing FP counseling or services

h) Number of USG-assisted service delivery points experiencing stock outs of specific tracer drugs.
i) Number of people reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful (sex disaggregated).
j) Number of people trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and and/or being faithful (sex disaggregated).
k) Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful (sex disaggregated)
l) Number of people trained to promote HIV/AIDS prevention programs through abstinence or being faithful (sex disaggregated).
m) Number of targeted condom service outlets.
n) Number of individuals trained in HIV related stigma and discrimination reduction (sex disaggregated)
o) Proportion of men or women among beneficiary group who believe that violence (specify behavior) is not an acceptable way of dealing with intimate partners.
p) Number of service providers trained in gender based violence.
q) Proportion of clinics with private consultation areas that cannot be overheard or seen from outside; have written confidentiality policies and secure places to store records; collect intake information in public areas; and have a majority of providers who follow written confidentiality policies.
r) FP/RH and HIV/AIDS programs that monitor whether practices minimize the risk that female patients experience violence from family members after learning their HIV status or upon disclosure of their HIV status or upon knowing that they are using a family planning method.
s) Service delivery points that evaluate whether providers are prepared to care for survivors of sexual violence in a compassionate and competent way.

3. Program Activities and Outcomes

Under this task order the contractor shall undertake the following activities:

a) ***Increase access to community FP/RH and HIV/AIDS services:***

The contractor shall initiate community based family planning services in eight districts and scale up current operations by expanding coverage, access, and consistent use of FP/RH and HIV services. The focus for expansion should be in rural and underserved areas and among high risk populations defined by high unmet demand for services or marginalized groups. Considerations should be given for cost effectiveness and potential health impact in identifying areas and population for expansion. A majority of users of reversible methods of contraception discontinue use of their method within one year; such a high rate of discontinuation often reflects dissatisfaction with the method or the service. In addition to side-effects, two of the most common reasons why family planning clients stop using their method are concerns about their health and safety of the method, and about method failure. The Contractor should adequately focus on promoting consistent use of family planning services and look for windows of opportunity to leverage increased access to HIV/AIDS services and utilization of in particular testing and counseling, and positive living (i.e. dual protection.); as well as addressing gender related reasons for lack of access, such as women's limited financial resources and lack of partner support for contraceptive use.

b) ***The Contractor shall strengthen contraceptive delivery systems, where voluntarism and informed choice are assured and quality is uncompromised.*** A balanced FP/RH program, where all contraceptive methods are available at different program levels, is a critical ingredient to success of family planning. The Contractor shall focus on achieving a balanced program that has community- based distribution (CBD) at the community level provided by frontline workers and clinical methods at all health facilities within the targeted districts, offered by skilled providers. Clinical methods should include sterilization, IUD, injectables and Norplant where appropriate.

c) ***Use of innovative approaches to expand contraceptive methods*** available to women through community-based distributors (CBDs), thereby increasing women's access to family planning (FP) in rural areas shall be strengthened. Some women currently receiving clinic based services would probably have preferred community based provision of their method of choice. Access to long-term and permanent methods of contraception (LTPC) is problematic for most women and the contractor should address these issues. Following approval of the community based injectable by the Ministry of Health; the contractor shall pilot provision of injectable contraceptives to poor, rural women at the community level through an alternative health delivery system including use of a modified social franchising and public/private partnership approach as well as social marketing of oral contraceptives. Messages as part of this should include addressing restrictions to women's access, such as societal pressures or norms related to FP and attitudes toward women making decision to access and use contraception. CBDAs should also be including HIV/AIDS prevention messages, support testing and treatment seeking and adherence behaviors. The contractor should improve access to long term and permanent contraception to rural communities.

d) ***Behavior change communication (BCC):*** While information is important, it is often not enough to change behaviors. BCC shall adequately portray family planning and HIV testing and treatment as mainstream health interventions, and influence the hearts and minds of individuals to make informed decisions about family planning and HIV/AIDS and promote them to their fellow community members. The contractor shall direct efforts towards individuals, families, communities or health institutions. Community based services will help influence the creation of a social atmosphere where family planning and HIV/AIDS are open and relevant topics among influential individuals, groups and communities. The Contractor shall promote community involvement in generating the demand for services at the community level and adopt a gender sensitive approach to stigma reduction. BCC messages should include those targeted at men - as clients, allies/supportive partners, and agency of change toward more positive norms. The Engender Health Men as Partners program provides useful curricula. Also, the IGWG Systemaletizing electronic document provides several resources/tools for working with men. It is available at: http://www.igwg.org/pdf/IGWG_SysteMALEtizing.pdf

e) ***Increasing demand for family planning and HIV/AIDS services***, including behavior change communications, encompassing interpersonal communications, targeted mass media (posters, job aids, murals etc.) and promotion of community involvement. The contractor shall undertake activities to revitalize family planning through expanding

knowledge and awareness of family planning methods and integrate HIV/AIDS issues. The contractor shall expand the communications portfolio to include generic behavior change communication and service promotion. USAID/Malawi is already in full compliance with the Tiahrt provisions governing informed consent. Mass media efforts and community involvement should include gender-equitable message, emphasizing women's ability to make decisions about FP and the importance of constructive male involvement. Once availability and quality have been improved, the contractor should align clients' knowledge, attitudes and practice more closely with the services that are offered.

f) ***The contractor shall enhance quality of family planning services***, including training, interpersonal communications, quality assurance; incorporation of a gender approach into family planning and HIV/AIDS service provision by training providers to address gender-related barriers/issues, including identifying signs of gender-based violence that should be addressed as part of family planning and HIV/AIDS counseling, such as women's concern about not being able to get partner's consent to use FP and women's hesitancy to disclose status because of fear of abandonment or violence; record-keeping; and monitoring and evaluation. As services prepare to screen for gender-based violence, steps should be taken at the institutional level, including ensuring that that confidentiality is guaranteed, that providers have been appropriately trained, that protocols address what should be done to mitigate impact (e.g. partner testing and notification to support disclosure) and that there is some information about legal and support services in the community to the extent they exist. Health worker performance improvement is an essential ingredient to enhancing the quality of FP/RH services, and should be a pillar of this program in order to provide back up for referral by CBD agents. Within this context, the contractor shall invest in in-service training for clinic based staff where referrals are made in order to improve clinical and counseling skills and ultimately the quality of care provided as well as linking to quality improvement activities for HIV support by USAID.

g) ***The contractor shall integrate family planning and HIV/AIDS and Sexually Transmitted Infections STI prevention*** through promotion of dual protection, encompassing condom promotion and other behavioral change efforts to reduce pregnancy and STI/HIV risk and integration of family planning counseling and services (or referral for services) into HIV testing and counseling centers for women and men who wish to avoid future childbearing, including programs focused on mother to child transmission .This is necessary not only to avoid pregnancy but to help plan and to meet the RH needs of HIV positive men and women, whether or not they choose to have more children. This is important because of the stigma associated with HIV positive women who want to have more children or at least want information on full range of contraceptive methods available. The contractor should consider integration of services both ways HIV into FP as well as FP into HIV

h) ***The contractor shall strengthen District and Community Provision and Management of FP/RH and HIV and AIDS Services by s***upporting the district health management team so that they provide their mandated supervisory and support functions to the health centers. By directing efforts towards this level, the program can create sustainable supervision and management capacity. The Contractor shall link to BASICS working in the five zones.

E. SPECIAL CONSIDERATIONS

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

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

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

4. **Building Human Resources and Sustainability.** The Contractor shall implement measures to develop competencies for decision-making among an increased number of Malawi counterparts at all levels to develop long-term sustainability.

5. Gender: difference in women's and men's roles and responsibilities and gender inequities in access to resources, information and power are reflected in gender differences and inequalities in their vulnerability to illness; health status; access to prevention and curative measures; burdens of ill health and quality of care. The Contractor shall take into consideration the impact of gender on intended objectives as well as the potential effect of proposed interventions on gender relations and inequities, and will ensure that equity concerns will be an integral element of all program activities. Appropriate internal and external management structures and personnel processes are required to demonstrate that gender issues are incorporated into all program interventions.

6. Development Alliances: USAID strongly encourages public-private alliances in implementing its programs, as illustrated in USAID's Global Development Alliance. In order to achieve the "***Increased use of improved behaviors and services***", there is need for greater involvement of private sector and civil society in the delivery of health care services. While the MOH provides about 60% of health care the remaining 40% is critical and needs to be recognized as being critical to health care delivery. The contractor is encouraged to look for opportunities for public private partnerships.

F. KEY PERSONNEL

The key personnel positions under this Task Order shall include the following: Chief of Party; Director of Administration and Financial Management; Monitoring and Evaluation Advisor and Technical Advisors with experience in multiple aspects of community based family planning and HIV/AIDS services strengthening. Key personnel can be expatriates, Malawi citizens or some combination of the two. USAID/Malawi must approve all Key Personnel and any changes to the Key Personnel under this Task Order. Required qualifications and functions for Key Personnel include the following:

1. **Chief of Party (COP).** The COP shall be responsible for the overall management and Implementation of the program and report directly to the designated USAID Cognizant Technical Officer (CTO). S/he shall supervise project implementation, serve as the principal interlocutor with USAID and the GOM and ensure the program meets stated goals and reporting requirements. The COP shall have an advanced degree (master's degree or equivalent) in a relevant field from an accredited university. The COP shall have at least 10 years of experience in managing and implementing Family Planning and HIV/AIDS programs in developing countries and specifically in the areas outlined above. S/he shall have demonstrated exemplary diplomatic and interpersonal skills to ensure internal coherence amongst diverse team members as well as relations with the GOM, donors and the international community. The COP shall possess excellent English writing skills. The COP shall be in-country two weeks after the task order is signed. 'The Chief of Party serves as the representative of the Program and will be the point of contact in Malawi for all purposes of this project, unless delegations of authority are presented to and agreed by the Mission CTO.

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

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

4. **Technical Advisors.** The technical team shall be composed of two experienced and well-qualified Family Planning and HIV/AIDS advisors/specialists with at least five years of demonstrated expertise in their particular fields in a developing country. Special focus shall be given to experience in community based program implementation; communications and public relations and knowledge/expertise in gender, (including GBV). All technical team members shall have excellent writing skills in English.

G. ADDITIONAL ORGANIZATIONAL CONSIDERATIONS

The Contractor shall provide office space for all program staff, co-located in the program area or in program satellite offices in order to maintain one identity for the program and to facilitate teamwork and coordination. The project shall seek to co-locate with government or non-governmental partners in the District offices. The staffing pattern proposed for non-key staff should describe how additional expertise and skill mix might be obtained while attending to the necessity of cost containment and avoiding unnecessary staffing. The Contractor shall ensure that all project staff create and maintain effective working relationships with the communities and district health management teams and zones, USAID and other donor organizations; and work in a collaborative and inclusive team oriented manner. USAID places a high value on the Contractor's ability to develop partnerships and promote teamwork and on its responsiveness to the varied needs of the Mission.

Program Management

Technical Direction and Coordination: The task order shall be managed in-country. The prime Contractor's home office shall provide managerial oversight and administrative backstopping, and technical assistance as needed. The Mission CTO is responsible for all day to day management oversight and technical direction of the contractor. The CTO will provide technical direction during performance of this Task Order, both in writing and verbally. The contractor shall meet at least biweekly (via conference or in person) with the CTO or her designate to review the status of activities and should be prepared to make periodic, unplanned verbal and written briefings to USAID and American Ambassador as appropriate.

H. REPORTING REQUIREMENTS

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

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

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

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

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

b) Annual Implementation Plan (2 hard copies + electronic copy). The first implementation plan is due two (2) months after the contract is awarded. The second and third annual implementation plan is due in month 13 and 26 respectively of the activity. The first annual implementation plan will cover the 12 month period following mobilization. The implementation plan serves several purposes including a guide to program implementation, a demonstration of links between activities, strategic objectives and intended results, a basis for budget estimates and the foundation for the monitoring and evaluation plan.

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

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

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

- Explanation of quantifiable output of the programs or projects, if appropriate and applicable.
- Reasons why established goals were not met, if appropriate.

- Analysis and explanation of any cost overruns or high unit costs. (Contractors must immediately notify USAID of developments that have a significant impact on award-supported activities).

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

d) End of Program Report (3 hard copies + electronic copy). The Contractor shall submit a final report 90 days after the completion date of this Contract which includes:

- an executive summary of the Contractor's accomplishments in achieving results and conclusions about areas in need of future assistance;
- an overall description of the Contractor's activities and attainment of results during the life of the Contract;
- an assessment of progress made toward achieving results under the Strategic Objective 8;
- significance of these activities; important research findings, if any; comments
- recommendations; and a fiscal report that describes how the Contractor's funds were used.

3. Distribution of Reports: The Contractor shall submit an original and two copies of the final report to the CTO and one copy to the USAID Development Experience Clearinghouse: E-mail (the preferred means of submission) is: docsubmit@dec.cdie.org. The mailing address via U.S. Postal Service is: Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910. Reports required as described in this section will be sent to the CTO. Reports and intellectual products required as noted above will also be submitted to the USAID Development Experience Clearinghouse either electronically via e-mail (the preferred means submission) to docsubmit@dec.cdie.org or in hard copy via U.S. Postal Service to Development Experience Clearinghouse, 8403 Colesville Road, Suite 2 10, Silver Spring, MD 209 10.

I. GUIDELINES FOR DEVELOPING A PROPOSAL

1. Technical Proposal

Technical proposals are limited to 20 pages maximum (including tables and figures) with text in 12 times New Roman point font on A4 paper with one inch margins. Any pages over the 45 page limit will not be evaluated. Items such as graphs, charts, cover pages, dividers, table of contents, and attachments (e.g. executive summary, resumes, and table summarizing qualifications of proposed personnel, past performance summary table and past performance report forms) are not included in the 20 page limitation, and will be evaluated as appropriate.

The technical proposal should be organized by the technical evaluation criteria set forth below. The technical proposal should address how the Offeror intends to carry out the work statement and performance requirements contained therein. It should also contain a clear understanding of the work to be undertaken and the responsibilities of all parties involved. The proposal should convey a sound approach and dedicated team with a strong likelihood for success. The technical proposal should at a minimum include the following:

a) A two-page executive summary describing the basic elements of the Offeror's approach, planned methodologies, and implementation plan.

b) Approaches to achieving the program's objectives and tasks set forth in this SOW, including the sequencing of program tasks. This includes consortium and sub-contracting arrangements that incorporate a broad range of demonstrated experience and expertise that address all of the programming areas set forth in this SOW or tap into the regional experience and expertise that will be critical to success.

c) A draft performance monitoring and evaluation plan, which describes how the contractor will measure specified program results, utilize data for improving implementation, and report against indicators. Data sources and collection methods as well as benchmarks and baseline information will be important components of that plan.

d) For each individual ("key" personnel and professional staff) who will perform directly under the Task Order, the following information shall be required: Name, Functional Labor Category, Level of Effort, and CV(s). Each CV should not be longer than 3 pages. Please note that each contractor should determine the most appropriate positions, personnel and effort to accomplish the work. The Offeror should propose other long and short-term positions as necessary to carry out the statement of work described in this RFTOP, based on the proposed approach and keeping in mind the need for collaboration rather than duplication of efforts across other complementary USAID-funded programs.

e) Description of the organizational capacity to implement the SOW. In addition, the Offeror should describe past performance relevant to the TASC 3 IQC task order. Please limit your submission to no more than three past performances, and provide reference names and phone numbers.

f) If an Offeror proposes a consortium approach, the roles and responsibilities of each consortium member shall be clearly explained and linked to the Work

Plan. Formal relationship between/among firms with differing capabilities required to meet the requirements of this request shall be described. The Offeror shall demonstrate the skills of the proposed organization(s) with regard to project management, implementation of results, and client relations.

g) The Offeror shall provide past performance information in accordance with the following:

i) A table shall be presented that summarizes the Offeror's past performance, with a list of contracts and subcontracts including periods of performance, contract type, and dollar amount, completed within the last three years that are similar in size and complexity to this SOW. Examples of past performance that do not conform to the description above and to SOW may not be evaluated by the technical review team.

ii) The list shall include the name, telephone number, and e-mail of at least two contacts. The names of USAID CTOs should be provided for any USAID-awarded contracts. Names of CTOs submitted will count toward satisfying the minimum requirements for two contacts required. It is recommended that the Offeror alert the contacts that their names have been submitted and that they are authorized to provide past performance information when requested.

iii) If the Offeror encountered problems on any of the above mentioned contracts, they may provide a short explanation of the problem and the corrective action taken.

iv) USAID may use past performance information obtained from other than the sources identified by the Offeror. Past performance information will be used for both the responsibility determination and best value decision.

2. <u>Cost Proposal</u>

The Offeror shall submit a detailed budget estimate with detailed budget notes/narrative explaining and providing detailed justification for each cost category anticipated under the proposed task order in the following format:

a) Summary Cost Breakdown - Please provide a breakdown, by element, for anticipated costs of performing under this task order.

b) Detailed level of effort and labor cost estimates must be submitted to support the proposed implementation of the Statement of Work. Please provide a separate line item for each proposed individual and identify each by name, labor category, daily rate in accordance with the basic contract, and the level of effort for that individual. For "key" individuals and professional staff who are Cooperating Country Nationals or Third Country Nationals, Offeror should submit a salary history for the prior three years, by completing Biographical Data Sheets, Form AID 1420-17 (Annex 4) to support salary information for the past three years.

c) A current resume, in sufficient detail to support the proposed Functional Labor Category, for all U.S. and professional non-U.S. personnel;

d) A certification of salary for all proposed CCN Direct Labor;

e) A certification that no USAID employee has recommended the use of an individual or subcontractor under the proposed task order who was not initially located and identified by your organization; (as indicated in the cover page)

f) Travel/Per Diem: Provide cost estimates of travel, both internationally and in-country. Provide an overall breakdown between per diem and airfare (as applicable).

g) Other Direct Costs: Please provide a breakdown of all anticipated other direct costs (i.e., the amount, type, and unit cost), including workshops and training.

h) Indirect Costs: If any, provide a breakdown for all anticipated costs for this line item (i.e., the amount, type, and unit cost) along with the supporting documentation.

3. Subcontracting plan

Unless the Offeror is a small business concern, the Offeror must include its small business and small disadvantaged business subcontracting plan, as required by the FAR provision entitled "Small Business and Small Disadvantaged Business Subcontracting Plan" (FAR 52.219-9). The plans are required even if the Offeror does not plan to subcontract any performance, and the subcontracting goals would then be nil. The plan must contain all of the information required by paragraph (d) of said provision. If any subcontractor will perform under the Task Order and the subcontract will exceed US$500,000, the subcontractor, if it is a U.S. organization and is not a U.S. small business, must submit a U.S. small business subcontracting plan.

J. EVALUATION AND SELECTION CRITERIA

1. General

a) USAID may, without discussions or negotiations, award a task order resulting from this RFTOP to the responsive, responsible contractor whose proposal conforms to the Statement of Work (SOW) and offers the best value. "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. Therefore, proposals should contain the contractor's best terms. USAID may reject any or all proposals, accept other than the lowest cost proposal, and waive informalities and minor irregularities in proposals received.

b) The submitted technical information will be scored by a technical evaluation committee using the technical criteria shown below. 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.

2. Selection Criteria

a) Technical Approach (35)

- Proposals will be evaluated based on the contractor's technical approach to addressing the tasks and achieving the objectives contained within the Statement of Work. An integrated technical approach is essential. Creativity is a plus. Proposals with a Malawian and/or African 'face' – those which emphasize the systematic, effective utilization of Malawian expertise, human resources, institutions and knowledge to achieve project goals -- are preferred. The proposal should include a description of strategies and activities to execute each of the constituent tasks of this project.
- Technical criteria that will be assessed will include (a) Soundness of strategies and approaches, the overall design and technical focus, demonstrating full understanding of local issues and challenges, and clear articulation of how results will be achieved (note: the implementation plan will be evaluated as part of the "technical approach") (b) integration of gender issues into overall strategic design.(c) creative strategies to promote community involvement in generating the demand for services at the community level and adoption of a gender sensitive approach to stigma reduction.(d) creative strategies for promotion of consistent use of family planning services; exploration of windows of opportunity to leverage increased access to HIV/AIDS services and utilization of in particular testing and counseling, and positive living (i.e. dual protection.). (e) approaches to building districts capacity to monitor projects, creatively and strategically integrating project work within the District Implementation plans and (f) strategies to optimize the technical resource assets of the project including an integrated approach to tasks that spread across more than one institution, and use of intermittent technical assistance. Special attention will be given to the applicant's demonstrated knowledge of critical issues associated with family planning and HIV/AIDS in developing countries, especially in extremely resource constrained environments of Southern Africa.

b) Key Personnel Qualifications (20)

- The background and experience of proposed key personnel will be evaluated. USAID will look for: experience within the team or intermittent and long term advisors to manage (a) technically diverse teams of professionals, (b) community FP and HIV/ADS initiation and roll-out in contexts comparable to that in Malawi, (c) strong administrative and financial management, accounting, auditing, and budget process skills, (d) relevant skills in community based program implementation, (e) a very small participant training program, (f) ability to design, and deploy effective performance monitoring systems.

- Educational background will be considered but demonstrated successful professional experience in key fields is crucial. Familiarity with Malawi and/or southern Africa as well as demonstrated ability to work in the region or similar development environments will be viewed favorably. Proposals which demonstrate a strong local/regional staff dimension (including management) are preferred. The evaluation of proposed full-time personnel will be based on the extent to which resumes for proposed personnel submitted by the applicant clearly meet or exceed the education and experience requirements described in the RFTOP. To be considered, all key personnel must have comprehensive terms of reference, CVs and letters of commitment included as an Annex to the proposal and be available full-time.

c) Management Approach (15)

- Proposals will be evaluated for soundness of performance management plan, with clear articulation of labor and responsibilities with proposed sub-partners and understanding of necessity of local partnerships and coordination with other projects and stakeholders.

- Clear delegation of authority of overall management plan to the field personnel.

- Overall staffing plan with clear roles and responsibilities for key staff, lines of management and technical authority.

d) Award Monitoring Plan (AMP) (15)

'The AMP will be evaluated based upon the following.

- A clear description of the Awardee's established system within which the particular AMP operates including:
  - The organization-wide policy and procedures for monitoring and evaluation.
  - Roles and responsibilities of sub-partners in monitoring and evaluation.
  - A description of the system which will address lack of progress or success.

- Information on activities to be monitored under the AMP including:
  - For each component, how activities are linked to achieving required results and how performance will be monitored.
  - Assumptions being made about the relationship of each activity to the results.
  - For each component, proposed indicators which track progress over the life of the task order with annual targets for each indicator.

- Methods to be used for monitoring activities and collecting data for results reporting.
- An illustrative schedule for monitoring activities.
- A mechanism for oversight and verification of monitoring conducted by field staff.

- A realistic plan to monitor the project and proposed sub-grantees to ensure adherence to the US Government and USAID regulations, such as anti-terrorism and restrictions on family planning (i.e. Tiahrt, PD3, Mexico City policy).

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

e) Institutional Capacity and Past Performance (15)

- Proposals will be evaluated based on the applicant's demonstrated capacity to: plan, implement and manage a community based program; collaborate with key stakeholders, including national government and other international donor counterparts; monitor and evaluate large scale programs; deploy staff and resources efficiently for rapid program start-up; provide critical professional home office management and administrative support – technical and logistical – to field operations; and work effectively in development environments. The ability to meet reporting and accountability guidelines is necessary as is the ability to manage and implement community based FP and HIV/AIDS programs, training, and behavior change communications.

- Emphasis will be given to applicants with a demonstrated track record implementing similar programs in comparative environments. Other factors include the extent to which the applicant has the demonstrated ability to recruit and retain highly qualified expatriate and local technical staff; and the extent to which the applicant has the in-house technical capacity to provide intellectual leadership, promote international best practices and support program objectives. The past performance of the applicant in using small business concerns (unless the applicant is a small business) will also be considered.

3. Price/Cost Evaluation

a) Proposed cost will not be scored, but will be a selection factor and considered in terms of the total proposed amount and ceiling amount. The Contracting Officer will evaluate the cost proposal to determine if proposed costs are fair and reasonable.

In making such determination, the Contracting Officer will be especially interested in the following factors:

i. The appropriateness of salary rates in relation to the positions and individuals being proposed and the extent to which proposed salary levels are commensurate with the difficulty/complexity of the tasks to be completed;

ii. Completeness and clarity of the cost proposal;

iii. Manner and method of handling “pass through” type costs which prove greatest value and minimal administrative costs.

b) A cost realism analysis of the cost proposal will also be conducted to assess the accuracy with which proposed costs represent the most probable cost of performance, within the offeror's technical and management approach. Cost realism evaluation shall be performed:

i. to verify the offeror's understanding of the requirements;

ii. to assess the degree to which the cost/price proposal accurately reflects the approaches and/or risk assessments made in the technical and management approach as well as the risk that the offeror will provide the supplies or services for the offered prices/cost; and

iii. to assess the degree to which the cost included in the cost/price proposal accurately represents the work effort included in the technical proposal.

K. SOURCE SELECTION GUIDING PRINCIPLES

1. The overall evaluation methodology set forth above will be used by the contracting officer as a guide in determining which proposal(s) offer the best value to the U.S. Government. In accordance with Federal Acquisition Regulation (FAR) Subpart 52.215-1, award will be made by the contracting officer to the responsible offeror whose proposal represents the best value to the U.S. Government after evaluation in accordance with all factors and sub-factors in this solicitation.

2. Technical evaluation factors are significantly more important than cost factors. The closer the technical evaluations of the various proposals are to one another, the more important cost considerations become. The Contracting Officer may determine which highly ranked proposal based on the technical evaluation factors would yield the best overall value to the Government, cost and other factors considered.

3. If the contracting officer determines that competing technical proposals are essentially equal, cost/price factors may become the determining factor in source selection. Conversely, if the contracting officer determines that competing cost/price proposals are essentially equal, technical factors may become the determining factor in source selection. Further, the contracting officer may award to a higher priced offeror if a determination is made that the higher technical evaluation of that offeror merits the additional cost/price.

L. ACQUISITION SCHEDULE

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

	Date
RFTOP issued	May 21, 2007
Questions due	May 30, 2007
Answers to questions disseminated	June 4, 2007
Proposals due	June 21, 2007
Technical Evaluation Completed	July 12, 2007
Award of Task Order	o/a July 31, 2007
Performance begins	o/a July 31, 2007
Debriefings (if required)	TBD

All questions relating to this RFTOP must be submitted via email to **Ms. Nyembezi Mfune** at **nmfune@usaid.gov,** with a cc: to **Waymon A. Carroll** at **wcarroll@usaid.gov** no later than 10:00 Hours Gaborone, Botswana and Lilongwe, Malawi Time on **May 30, 2007.** 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.

ANNEX 1

CERTIFICATION AND DISCLOSURE REGARDING PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS (APR 1991)

(a) The definitions and prohibitions contained in the clause, at FAR 52.203-12, Limitation on Payments to Influence Certain Federal Transactions, included in this solicitation, are hereby incorporated by reference in paragraph (b) of this certification.

(b) The Offeror, by signing its offer, hereby certifies to the best of his or her knowledge and belief that on or after December 23, 1989--

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

(2) If any funds other than Federal appropriated funds (including profit or fee received under a covered Federal transaction) have been paid, or will be paid, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress on his or her behalf in connection with this solicitation, the offeror shall complete and submit, with its offer, OMB standard form LLL, Disclosure of Lobbying Activities, to the Contracting Officer; and,

(3) He or she will include the language of this certification in all subcontract awards at any tier and require that all recipients of subcontract awards in excess of $100,000 shall certify and disclose accordingly.

(c) Submission of this certification and disclosure is a prerequisite for making or entering into this contract imposed by section 1352, title 31, United States Code. Any person who makes an expenditure prohibited under this provision or who fails to file or amend the disclosure form to be filed or amended by this provision, shall be subject to a civil penalty of not less than $10,000, and not more than $100,000, for each such failure.

ANNEX 2

DISCLOSURE OF LOBBYING ACTIVITIES IN ACCORDANCE WITH THE CONTRACT CLAUSE ENTITLED "LIMITATION IN PAYMENTS TO INFLUENCE CERTAIN FEDERAL TRANSACTIONS" (FAR52.203-11)

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

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

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

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

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

FIRM: _____

NAME: _____

TITLE: _____

DATE OF EXECUTION: _____

ANNEX 3

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

(a) Instructions for Certification

(1) By signing and/or submitting this proposal or contract, the contractor is providing the certification set out below.

(2) The certification set out below is a material representation of fact upon which reliance was placed when the agency determined to award the contract. If it is later determined that the contractor knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

(3) For contractors other than individuals, Alternate I applies.

(4) For contractors who are individuals, Alternate II applies.

(b) Certification Regarding Drug-Free Workplace Requirements

Alternate I

(1) The contractor certifies that it will provide a drug-free workplace by:

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

(B) Establishing a drug-free awareness program to inform employees about--

1. The dangers of drug abuse in the workplace;

2. The offeror's/grantee's policy of maintaining a drug-free workplace;

3. Any available drug counseling, rehabilitation, and employee assistance programs; and

4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(C) Making it a requirement that each employee to be engaged in the performance of the contract be given a copy of the statement required by paragraph (b)(1)(A);

(D) Notifying the employee in the statement required by paragraph (b)(1)(A) that, as a condition of employment under the contract, the employee will--

1. Abide by the terms of the statement; and

2. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(E) Notifying the agency within ten days after receiving notice under subparagraph (b)(1)(D)1. from an employee or otherwise receiving actual notice of such conviction;

(F) Taking one of the following actions, within 30 days of receiving notice under subparagraph (b)(1)(D)2., with respect to any employee who is so convicted--

1. Taking appropriate personnel action against such an employee, up to and including termination; or

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

(G) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (b)(1)(A), (b)(1)(B), (b)(1)(C), (b)(1)(D), (b)(1)(E) and (b)(1)(F).

(2) The contractor shall insert in the space provided below the site(s) for the performance of work done in connection with the specific contract:

Place of Performance (Street address, city, county, state, zip code)

ANNEX 4: CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET

CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET

1. Name (Last, First, Middle)	2. Contractor's Name

3. Employee's Address (include ZIP code)	4. Contract Number	5. Position Under Contract
	6. Proposed Salary	7. Duration of Assignment

8. Telephone Number (include area code)	9. Place of Birth	10. Citizenship (if non-U.S. citizen, give visa status)

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

12. EDUCATION (include all college or university degrees)

13. LANGUAGE PROFICIENCY (See Instructions on Reverse)

NAME AND LOCATION OF INSTITUTE	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading

14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.
2. Salary definition - basic pariodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, or dependent education allowances.

POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (M/D/Y)		Annual Salary
		From	To	Dollars

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

SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (M/D/Y)		Days at Rate	Daily Rate in Dollars
		From	To		

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

Signature of Employee	Date

17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)

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

Signature of Contractor's Representative	Date

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