SECTION A – STATEMENT OF WORK

I. BACKGROUND

Sudan is the United States Government's (USG) highest foreign policy priority in Africa. Given this priority, well before the signing of the Comprehensive Peace Agreement (CPA) in 2005 USAID worked with members of the nascent Government of Southern Sudan (GoSS) at its base in Nairobi to lay out the most critical investments and needs for the new government. One of the most pressing needs was bringing health care to a population decimated by almost 50 years of war. Sudan's health indicators were – and remain – among the worst in the world. As of 2006, or two years after the CPA, infant mortality was 102 per 1000 live births; mortality for children under 5 years of age was 135 per 1000; and maternal mortality was an astounding 2,037 per 100,000 births. In 2004, due to the war there was almost a total lack of health system infrastructure, equipment, materials, and – most critically – trained human resources. The need was to urgently provide primary health care services to the population, while at the same time creating almost from scratch a functioning public health care system in Southern Sudan that could provide those services over time. Meeting the two critical needs was, and remains, a careful balancing act.

USAID launched the five-year Sudan Health Transformation Project (SHTP1) in April 2004, before the signing of the CPA. Initial planning was carried out with the nascent Secretariat for Health in Nairobi prior to the return to Southern Sudan. What health care that existed in the Southern then-three provinces (now 10 states) was undertaken by a patchwork of faith-based organizations (FBOs) and humanitarian NGOs, with no guiding framework or oversight. Given the extreme paucity of trained Sudanese in the south, the GoSS/MoH decided to take the patchwork and create a model of public-private partnership, where the FBO/NGO partners would provide services in defined geographic areas under agreement with the government, while the government geared up support policies, protocols, and systems.

The SHTP1 has been a key partner in the reestablishment of the health system. It has provided high impact health services through a network of lead NGO partners in selected underserved counties in Southern Sudan, while at the same time providing highly valued support to the GoSS/MoH in creating a basic public health policy framework. The support ranged from technical assistance to develop important policies and guidelines, to creation of basic patient logs and commodity registers at the service delivery points. Personnel training has been a priority – but was necessarily preceded by development of protocols and standards, syllabi, curricula, training materials, and rehabilitation of five health training centers. There is still a very long way to go, but the basic foundations of a primary health care system in selected areas are in place, and USAID and SHTP1 have contributed significantly to that process.

SHTP1 will end in 2009. The CPA is in force and milestones are being met. The GoSS/MoH has established many of the prerequisites for a health system, but coverage is still very low, with only 25% of the population assumed to have access to health care and still-fragile systems to support service delivery. Much of the "transformation" foreseen in the original project title has indeed taken place, but more remains to be accomplished. There is particular need to mobilize

communities to engage in community-based health preventative and basic health services, and to strengthen the critical County Health Departments (CHDs) to provide oversight and supervision of lead NGO service providers. Continuous engagement of health cadres, through in-service training, facilitative supervision, and provision of job aids, will continue to be a high priority. Although many of the policies and guidelines have now been prepared, they need to be disseminated and the practices rolled-out to the health cadres and communities they serve.

In consultation with the GoSS/MoH, USAID plans to fund a second generation Sudan Health Transformation Project, hereinafter called SHTP12. The "second generation" takes full account of the struggles and gains of the first five years, and will build on the achievements made. SHTP12 will also include new emphases on some of the areas highlighted above, and will emphasize performance-based accountability in all areas.

This document provides an overview of the major health and development issues in Sudan and describes the requirements and standards that need to be accomplished in order to achieve new results under SHTP12. Applicable documents are referenced throughout this performance work statement describing in detail the efforts that USAID and other stakeholders have pursued in the last several years to improve access to primary health care services.

The assessment of the Sudan Health Transition Program – Phase 1 (SHTP11) reported that as of the end of 2007, SHTP1 partners had initiated high impact services at 99 service delivery points (SDPs) in 6 counties in 6 states in Southern Sudan. Since that time SHTP1 has awarded agreements to an additional 3 partners in 3 additional counties. As of July 2008, SHTP1 was supporting 25 Primary Health Care Centers (PHCC) and 120 Primary Health Care Units (PHCU), for a total of 145 SDPs covering about 1.6 million people, or about 12% of Southern Sudan's estimated population of 12.5 million. By March 2009, it is expected that SHTP1 will have partners in an additional 3 counties, for a total of up to 12 counties, reaching over 2.3 million people. With reference to Figure 1 below, it is intended that through this procurement, an expanded range of high impact services will be continued at the current 145 SDPs, plus at least 12 facilities in the 3 new counties, and that by 2011, no less than 80% of the population in focus counties will utilize at least one of these high impact services.

Figure 1: Basic Information on SHTP1-Assisted Counties

State	SHTP1-Assisted County	County Population[1]	SHTP1 Lead NGO	Functional County Health Facilities	HIV VCT or PITC	Antenatal care attendance (≥ 1 visit)[2]	
						#	%[3]
Jonglei	Twic East	136,000	Care Internat'l	No CHD 2 PHCC (all SHTP1) 13 PHCU (all SHTP1)	0	708	57.6%
Unity	Panyijar	114,729[4]	Internat'l Rescue	1 CHD	0	310	12.9%

[1] Population figures based on 2004 Starbase Population Data for Southern Sudan and information from local Authorities. These figures are predicted to increase as much as 30% per year as a result of post-war returnees.
[2] Figures are for most recent reporting quarter: April – June 2008
[3] % of pregnant women (April – June)
[4] Population figure for the entire county (SHTP1 provides services in one of the two districts in this county)

			Committee	1 PHCC (SHTP1) 8 PHCU (all SHTP1)			
Western Equatoria	Tambura	100,866	Internat'l Medical Corps	1 CHD (5 members) 5 PHCC (all SHTP1) 21 PHCU (all SHTP1)	1 VCT + PITC	330	14.9%
Western Equatoria	Mvolo	215,162	Save the Children-USA & Sudan Internat'l Dev. Fund	1 CHD 3 PHCC (all SHTP1) 15 PHCU (all SHTP1)	1 VCT	499	29.1%
Western Equatoria	Mundri	125,492	Action Africa Help Interna'l	1 CHD 4 PHCC (all SHTP1) 32 PHCU (all SHTP1)	4 VCT	276	15.3%
Warrap	Tonj South	300,000	World Vision Internat'l	1 CHD 2 PHCC (all SHTP1) 7 PHCU (all SHTP1)	0	42	1.6%
Upper Nile	Malakal	105,000	Internat'l Medical Corps	1 CHD 4 PHCC (all SHTP1) 8 PHCU (all SHTP1)	0	NR[5]	NR
Northern Bahr el-Ghazal	Aweil South	336,000	Tearfund	1 CHD 2 PHCC (all SHTP1) 4 PHCU (all SHTP1)	0	915	29.3%
Central Equatoria	Terekeka	250,000	African Medical Research Foundation	1 CHD 2 PHCC (all SHTP1) 12 PHCU (all SHTP1)	0	288	10.2%
Central Equatoria	Juba	110,134	Internat'l Medical Corps	1 CHD 1 PHCC (SHTP1)[6] 3 PHCU (SHTP1) [6]	0 [7]	NR[5]	NR
Western Bahr el-Ghazal	Wau	248,288	Internat'l Relief & Development	1 CHD 1 PHCC (SHTP1) [6] 3 PHCU (SHTP1) [6]	0 [7]	NR[5]	NR
Eastern Equatoria	Kapoete	295,000	Save the Children - USA	No CHD 1 PHCC (SHTP1) [6] 3 PHCU (SHTP1) [6]	0	NR[5]	NR
TOTALS	**12 counties**	**2,336,671**	**-**	**10 Functional CHD** **28 PHCC** **129 PHCU**	**6 VCT in 3 cnties**	**3368**	**18.8%**

Legend:
CHD = County Health Department
PHCC = Primary Health Care Center
PHCU = Primary Health Care Unit

VCT = Voluntary Counseling and Testing
PITC = Provider Initiated Counseling & Testing
Source: SHTP1 Records July 2008

II. RELEVANT ASSESSMENTS AND POLICIES

[5] Programming either has not begun, or is still in start-up phase
[6] These counties have more health facilities than are listed, but these numbers indicate the numbers to be supported under SHTP1
[7] No VCT or PICT services provided by SHTP1 (other NGOs are providing HIV services in these urban areas)

This project takes into account policies and strategies of the GoSS as well as "best practices" by USAID and other donors and partners pursuing improvements in primary health care and HIV/AIDS services in Southern Sudan.

A full compendium of relevant documents is available at (tasc3@usaid.gov)

_A brief summary of the more important of these is found below.

A. Health Policy for the Government of Southern Sudan 2006-2011, Ministry of Health, Government of Southern Sudan

B. Basic Package of Health Services for Southern Sudan, 2006, Ministry of Health, Government of Southern Sudan

C. Southern Sudan HIV & AIDS Strategic Framework (SSHASF 2008-2012), Government of Southern Sudan, September 2007 (first draft)

D. Sudan Household Health Survey (Southern Sudan Report), GoSS 2006, and related PowerPoint summary.

E. Building an equitable health system for Southern Sudan: Options for GAVI HSS Funding and related GAVI Proposal.

F. Sudan Health Transformation Assessment Report, March 2008. The SHTP1 assessment should be considered a primary reference for any offeror.

G. Southern Sudan Maternal and Reproductive Health Rapid Assessment, November 2007.

H. Guidance available at http://www.pepfar.gov/guidance/ on the President's Emergency Plan For AIDS Relief (PEPFAR), with particular attention to: ABC Guidance #1 (Abstinence, Be Faithful, and correct and consistent Condom use) Indicators Reference Guide for Focus Countries and All Bilateral Programs (Updated July 2007)

There are a number of useful maps available at the website which shows the location of SHTP11 sites.

Offerors are also encouraged to look at relevant UN and other donor websites for Sudan-specific information, e.g. World Bank, WHO, and UNICEF.

III. SUDAN PROGRAM BACKGROUND

As stated above, Sudan is the United States Government's (USG) highest foreign policy priority in Africa. The USG program addresses the challenges of consolidating fragile peace agreements and supporting post-conflict reconstruction, critical concerns of counter-terrorism and regional stability, the scale of gross human rights abuses still being perpetrated, and the ongoing need for

life-saving humanitarian assistance. The historical concentration of wealth and power in the central government at the expense of the marginalized majority has been one of the main drivers of conflict in Sudan for much of the last 50 years. The 2005 Comprehensive Peace Agreement (CPA) officially ended a 21-year war between north and south, but much remains to be done given the continued high level of political, economic, and social instability in southern Sudan. The nascent Government of Southern Sudan (GoSS) remains institutionally weak and authorities in Khartoum continue to inadequately demonstrate the political will to implement the CPA, especially the Abyei Protocol and transparency in revenue sharing. Violence and atrocities continue to plague civilians in Darfur, in spite of the 2006 Darfur Peace Agreement (DPA); and the potential for conflict lingers in the East due to the tenuous Eastern Sudan Peace Agreement (ESPA) also negotiated in 2006. For these reasons, Sudan will remain a "Rebuilding" country, and the USG will continue to provide targeted assistance based on policy goals and geographic realities that help advance all five Foreign Assistance Framework objectives to which USAID contributes. (see http://www.usaid.gov/policy/coordination/stratplan_fy07-12.pdf for the full USG Strategic Plan).

Consolidating the CPA is vital to USG interests in ensuring a transition to a stable, democratic government for all parts of Sudan, promoting regional stability, and continuing effective counter-terrorism cooperation. Assistance for recovery and reconstruction, as well as humanitarian aid for returnees, will continue to provide a tangible peace dividend, and USG will continue to enhance an environment for peace regardless of the outcome of the 2011 referendum. Support will focus on war-affected regions to facilitate economic recovery and governing more justly. USG strategy emphasizes investment in community development and essential services to reduce tensions rebuild communities and encourage and sustain the return of displaced people.

IV. HEALTH SECTOR CONTEXT

A. Overview

Sudan, especially in the South and Three Areas, faces formidable health challenges as it rebuilds after decades of civil war. Childhood deaths due to infectious diseases are rampant (the infant Mortality Rate (IMR) is 102.4 per 1000, Vitamin A deficiency affects one of seven children in Sudan. DPT3 immunization among children is under 18%. Maternal mortality rates are among the highest in the world, the Maternal Mortality Ratio (MMR) ranges from 1000 to 2000 per 100,000 (2006 HHS); reproductive health is poor due to lack of access to skilled antenatal care providers (the proportion of births attended by skilled health staff is also among the lowest in the world); fertility rates are high, and rates of modern family planning use are low. (In Southern Sudan. and the fertility rate is 5.9 live births per woman (UNICEF). 94% of births take place at home). HIV/AIDS is an emerging threat due to risky sexual behaviors and Sudan's proximity to the regional pandemic. Water and sanitation infrastructure is non-existent or marginal at best, and sanitation and hygiene practices are poor. A wide range of 'tropical' diseases that are controlled elsewhere are endemic in Southern Sudan; many of these are also so-called 'neglected diseases'. Critical diseases in Sudan include tuberculosis, malaria, pneumonia and diarrhea. With few exceptions, population density is low, which remains an obstacle to both service provision and access to health care.

USAID/Sudan: Strengthening service delivery and health systems

USAID and other bilateral governments have supported International and local NGOs who have played an important role in the delivery of health services in Southern Sudan during the war. UNICEF, WFP, UNFPA, UNDP, and WHO has played a major role among the UN agencies. Recently, the World Bank-assisted Multi-Donor Fund (MDTF) with funding from other bilaterals and the GoSS is moving forward to contracting one "lead NGO" per state to implement the BHSP. The MDTF model is an adaptation from the SHTP11 model of lead NGO per county. This contracting mechanism is experimenting with some innovative elements for performance based results and forging NGO and public sector cooperation at the state level.

With the transition from emergency to sustainable health service delivery, attention is needed to address the fragmentation that has resulted from years of neglect in the health sector. Emergency response interventions were often disjointed and short term, inefficient, and the focus on first-level health services and disease specific programs – typical for humanitarian action. This has, understandably, overshadowed attention to building sustainable basic health systems and infrastructure, strengthening human capacity, and actively mobilizing and engaging civil society groups for decision making around their own health. Shortage of skilled human resources has been – and is – one of the major limiting factors to providing basic health care. The GoSS Ministry of Health (MoH) advocates an integration of the existing vertical programs in the resource pool and in the management structures of the mainstream health system. The GoSS/MoH Basic Package of Health Services (BPHS) Policy on five principles: right to health, equity, pro-poor, community ownership and good governance. The main criteria for the choice of services were the ones that would have the greatest impact on the health of the population, that would be equally accessible to the largest possible part of the population and be affordable on the short run and sustainable on the long run.

The BPHS for Southern Sudan includes curative, preventative, managerial and health promotion activities, whether provided by the GoSS/MoH, State Ministries of Health (SMoH) or contracted out to implementing partners (Faith-Based Organizations or NGOs). The World Bank-assisted MDTF is assisting GoSS/MoH in decentralizing the management of services by strengthening the State MoHs by creating public/NGO partnerships to strengthen the implementation and monitoring of health services. The improved monitoring and supervision systems will increased accountability at all levels.

USAID/Sudan's strategy focuses on supporting the CPA by assisting the GoSS to provide peace dividends and address the factors that fuel conflict. Key to that process are interventions that will provide tangible peace dividends – e.g. health dividends -- and increase the confidence of the population in their government's ability to provide basic services. In addition, improving the overall health of the Sudanese people will enable citizens to become more productive, allowing education levels to advance, promote economic growth, and reinforce stability and peace.

Under this task order, USAID will build on its current health investments under SHTP1 where constructive, and may, subject to availability of funds, implement additional quick-impact activities in areas where high refugee and internally displaced person (IDP) returns increase pressure on limited existing services. Improving essential services will allow communities to rebuild and sustain the return of displaced people without igniting further conflict. The SHTP1 assessment confirmed that longer-term investments in the future are critical to continuing along

the path of rebuilding Southern Sudan's basic health services. The future program will build on NGO efforts and deepen community and civil society participation in basic health care services.

Activities under this task order must demonstrate a focus on building County Health Department (CHD) capacity to oversee the delivery of high-impact health services/practices in coordination with other USG funded programs in the proposed area of operation. Successful applicants will be expected to participate in GoSS and other donor coordination efforts to reduce duplication, standardize approaches and support the implementation of the GoSS's decentralization of the health sector. This should result in an evident health dividend for the Sudanese population supporting the successful implementation of the CPA.

B. The Southern Sudan Health System

The Southern Sudan health system is based on four levels of administrative structure, the community (PHC unit, or PHCU), first referral (PHC center, or PHCC), second referral hospital, and the county health department (CHD). Progress has been made in some locations in establishing PHC structures, village health committees, delivering selected health services, and introducing cost sharing. However, overall, the system has critical constraints including a limited health budget with major imbalances in salaries and operating costs. This imbalance is skewed to hospitals and urban areas, which has a relatively lower disease burden that the rural areas where X% of the population live. The drug logistics supervision and information system is fragile and principally managed by NGOs, with very limited training and capacity in this area. The community level covers only about 30 percent of the population in stable areas. Other than private pharmacies and unauthorized market drug tables in urban areas, there is a near absence of formal private sector medical care.

Since the signing of the CPA, the GoSS has developed nearly a dozen policies, strategies, curricula, cadre position descriptions and guidelines for implementing different sub-sectors within the health sector. The GoSS's BPHS guidelines available at the public website associated with this offer provides an excellent overview of the desired health care system. Other guidelines and policies include: Drug Logistics Management, Maternal and Reproductive Health, Family Planning Guidelines, Human Resource Management, Management Information Systems, National Malaria Strategic Plan. (Many of these documents are available at the website associated with this solicitation) Work is underway to develop standard position descriptions for health cadres, a nutritional strategy and strengthen routine immunizations. Working with a range of NGOs/organizations offering health services and training throughout the country is a challenge. The GoSS has formed alliances with the NGO Forum for soliciting technical advice and regularly solicits guidance into formulating policies and programs to harmonize health services delivery as the government transitions from emergency to development. Current donors are working closely with the central GoSS/MoH to strengthen capacity in policy and strategic planning and with SMoHs to help build capacity for program implementation and management at the state level.

C. USG Investments in Health

USAID/Sudan: Strengthening service delivery and health systems

For two decades, the USG has supported health humanitarian relief activities; and since 2004, health development activities. In the 2009 GoSS budget, nearly $300 million is budgeted for the health sector with both public and donor resources. Out of that USAID and OFDA are providing about $35 million-- making the USG is the single largest donor in the sector.

Figure 2: USG Investments in Health in Southern Sudan

Lead Office/Sector	**Short Description**	**FY 08Funding Levels**
Office of Foreign Disaster Assistance (OFDA)	OFDA focuses on areas affected by IDPs and/or conflict, mostly in Bahr el-Ghazal, Jonglei and Upper Nile. With reference to Figure 1, under this task order USAID plans to transition remaining current OFDA SDPs within USAID focus counties to sustainable health services under the relevant county's "lead NGO" partnership.	$16 million in health in FY07
USAID/Sudan Health Office	SHTP 1: 145 SDPs in 9 counties comprising 1.6 million people. Provision of high impact services and systems strengthening. Described in Section I and Figure 1 above.	$37 million FY2004-2008
USAID/Sudan	Multi-sectoral Building Responsibility for the Delivery of Government Services (BRIDGE) program will include water, sanitation and hygiene in the Three Areas and four border states (Warrap, Unity, Upper Nile, and Northern Barh el-Ghazal), as well as activities in democracy and governance, education, and livelihoods.	$10 million in FY08 Water funds and some MCH/FP as part of multi-sectoral initiative
USAID/Sudan Health and Education Offices	Multi-sectoral funding to the Health, Education and Reconciliation Creative Associates (HEAR) project to provide Vitamin A, deworming, and improved teaching methods supported by Interactive Radio Instruction and innovative health/education curricula to ensure that teachers and health workers are equipped to provide quality health and education to children.	Almost $500,000 for Health Education in schools in S. Kordofan, Blue Nile and Abeyi
USAID/Sudan through central Field Support	Focused technical assistance and training for tuberculosis diagnosis and control in Southern Sudan through the central Tuberculosis Control Assistance Program (TB-CAP).	$552,000
USAID/Sudan through central Field Support	Procurement of pharmaceutical commodities (ACT and IPT) and related logistics management support for GoSS Malaria Control Program through the central DELIVER mechanism	$1.1 million
USAID/Sudan through central Field Support	Focused technical assistance, training, and advocacy for child spacing/family planning through the central Leadership, Management & Sustainability (LMS) mechanism	$300,000
USAID/Sudan through central Field Support	Focused technical assistance and training for nutrition through the central Food and Nutrition Technical Assistance (FANTA) mechanism	$300,000
USAID/Sudan through central Field Support	Focused technical assistance and training for immunization through the central Mother and Child Health Immunization Project.	$416,000
USAID/Sudan through central Field Support	Support to the World Health Organization for polio eradication and disease surveillance, respectively, in Southern Sudan	$1.489 million Polio $800,000 surveillance
USAID/Sudan through central Field Support	Focused technical assistance and training for human resource development with the GoSS/MoH through the central Capacity Project.	$800,000
USAID/Sudan through central Field Support	Procurement of contraceptive commodities	$500,000

USAID/Sudan: Strengthening service delivery and health systems

USAID/Sudan and the US Centers for Disease Control and Prevention (CDC)	HIV/AIDS prevention, care, treatment, and strategic information activities under the President's Emergency Plan For AIDS Relief (PEPFAR)	$9.5 million in FY08 ($6.5 million USAID, $3 million CDC)
USAID/East Africa	Activities to address domestic violence, conduct media advocacy to reduce gender-based violence, and conduct legislative advocacy in support of gender equity, male norms, and health care.	(no USAID/Sudan funding provided)

In addition, USAID/FFP provides food emergency food assistance and supplies, targeting refugees and IDPs, reaching about millions of beneficiaries. USAID also collaborates with the Department of State, Bureau for Population, Migration and Refugees, which provides estimated $20 million in primary health care services in various marginalized areas. Finally, the USG is investing natural resources management, economic growth, livelihoods, education, water and democracy and governance. Basic health services will continue to be an important complement to the many existing USAID programs and should exhibit approaches that will enhance this complementarity and promote synergy.

For more information on USAID/Sudan programs: http://www.usaid.gov/locations/sub-saharan_africa/countries/sudan/

D. Donor Funded Activities in Health

The World Bank-administered Multi-Donor Trust Fund (MDTF) has awarded contracts to one NGO per state to improve primary health care, referral hospitals, water, and sanitation for four of the ten Southern Sudan states. These funds will be matched by a one-third contribution from the GoSS/MoH.

The UN Children's Fund (UNICEF) is the primary source for vaccines and contributes significantly in strengthening health systems through training community-based health workers, developing behavior change messages, materials and health aids.

USAID collaborates with the World Health Organization (WHO) primarily on polio eradication and disease surveillance. WHO also provides TB and laboratory technical assistance to the MoH to strengthen capacity on epidemic preparedness and response. TB drugs for the national program are funded by Norway and the Global Fund for AIDS, Tuberculosis, and Malaria. Medecins Sans Frontieres (MSF) provides TB drugs in its target areas. The Global Fund has also recently approved a $72 million grant for the next five years to strengthen malaria services throughout Southern Sudan.

With USAID and WHO assistance, the MoH has successfully secured GAVI funding for health systems strengthening ($11 million). WHO has also worked with the MoH to secure GAVI funds to strengthen immunization services.

In the past several years, UNFPA has provided some contraceptives, reproductive health kits, and training in emergency obstetrics and fistula repair in selected sites in Southern Sudan. The next strategic plan (2008-2011) will focus on reproductive rights, population and development,

gender equality. Through Population Services International, the United Kingdom provides social marketing of commodities and technical assistance.

The MoH has convened a "Roll Back Malaria" partnership with international partners to improve coordination. Also, the MoH has a developed joint malaria control program for FY 2008 and secured pledges from various donors to procure and distribute over 2 million insecticide treated nets in support of the World Malaria Day campaign.

The Carter Center collaborates with other implementing partners to eradicate Guinea worm, onchocerciasis, lymphatic filariasis, and trachoma from Southern Sudan. Organizations such as MSF-Holland, MEDAIR, Malteser, and International Medical Corps work with the MoH to prevent and control visceral leishmaniasis (Kala-Azar) and trypanosomiasis (sleeping sickness).

V. USAID CROSS-CUTTING THEMES

As a key element of its support to the CPA process, USAID in Southern Sudan is strategically emphasizing a transition from relief to development in all program undertakings. Activities under this task order are expected to build on relief efforts and help to forge linkages and build capacities for government and civil society to move from immediate relief responses to more sustainable development efforts.

Another cross-cutting theme of the new health initiative is decentralization. The task order is expected to support the development of sub-national leadership to supervise, monitor, and assure the provision of quality primary health care services. The task order efforts would focus particularly at the SDP and county levels, although some continued assistance at the central and selected State levels may be indicated. The task order will complement World Bank-assisted MDTF efforts, which are more focused at the State and central levels. The task order will also reinforce USAID's democracy and governance initiatives and will increase transparency and accountability in the health sector while at the same time bringing government services closer to the people.

All activities under the task order are expected to address the cross-cutting theme of civil society capacity building by involving local community-based NGOs, CBOs and FBOs in service delivery, outreach, and demand generation. The project will also address rolling out national policies and guidelines; disseminating technical protocols; and improving capacity for supervision at the State and county levels. Modest support will continue to be provided at the central level to advocate for increased resources for the State and County Health Departments, and to deepen partnerships with NGOs – international as well as, and particularly, Sudanese, and civil society -- in the delivery of health services.

The Basic Package of Health Services includes provision for unsalaried community-level Home Health Promoters and for Village Health Committees to mobilize communities for preventative and appropriate presumptive primary care. Under earlier USAID efforts (SHTP11 and OFDA), many VHCs have been activated, with varying degrees of sustainable action. Activities under this task order are expected to focus particularly on the village level, applying "best practices" from Sudan and elsewhere to select, mobilize, supervise and support Home Health Promoters

and to energize VHCs. In some counties VHCs and CBOs provide useful oversight and feedback on quality of care to service delivery points, which is essential to increasing utilization. The Contractor will be expected to apply "best practices" to assure Southern Sudan VHCs maximize their potential to assure quality health care to their communities.

Bringing health messages and services to groups that are all ready targeted for assistance provide opportunities to link the health activities with other USG activities in basic education, decentralized governance, food-for-peace, and livelihood activities. For example, linking health messages or services to food-for-peace distributions and/or development programs provides a unique opportunity to reach out to men and out of school youth, as well as women, outside of a clinic setting. Provision of food and nutrition support near or in health clinics, provide an incentive for women to enter the health system. Likewise, health messages that are behavior change focused and stress avoidance of high risk behaviors can be incorporated into curricula (print and radio) as part of USAID's basic education program, but might be adapted for out-of school youth and other high risk groups under this task order. USAID's Democracy and Governance program distributes radios throughout Southern Sudan which could serve as a focal point for listening groups (churches, women's groups, in- school, out-of-school, other) to absorb information about high impact services. Incorporating health messages into interactive radio is a way to extend health education beyond fixed SDPs and reinforce health-seeking behaviors.

Gender is an important consideration in this task order. Although data for Southern Sudan are scant, there is concern that years of war and displacement have increased the prevalence of gender-based violence. Attention will focus on the linkages between violence against women, maternal health, healthy pregnancy outcomes and HIV/AIDS. The Sudanese constitution has provision for a minimum of 25% women in public sector positions at all levels, e.g. all the way to the VHC. Partners will be encouraged to follow this provision in their implementation and to encourage women to step forward and participate in all project-supported fora. (See Sudan Gender-Based Violence Assessment on the website associated with this procurement).

The focus on gender must emphasize male involvement and male behaviors. Experience in other countries reveals that improving men's knowledge of family planning and reproductive health and the benefits of preventive care to both men and women are important considerations in improving the health of women. Experience also suggests that in some areas, men are engaging in much higher levels of risky behavior than women, warranting a focus on male behavior in order to reduce multiple partnerships (e.g. Uganda's "zero grazing" program) and reduce occurrence of high-risk sex. Linking HIV/AIDS to family planning information can be targeted to males to encourage faithfulness and to involve them in family planning decision making with their partners.

VI. DETAILED STATEMENT OF WORK

A. Objectives

SHTP12 will build on the decentralization of primary health service to improve the health status of the Southern Sudanese people. Specifically, USAID's health investment will strengthen county and community capacity to provide health services and improve health practices at the

existing 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1. As stated in the Background section above, SHTP1 was designed and launched before the signing of the CPA. Its focus was necessarily establishment of the basic building blocks of a health system, including infrastructure rehabilitation, provision of basic equipment, training, and establishment of initial material and commodity supply systems. The second generation project – SHTP2--will accelerate progress along the relief-to-development continuum. The Contractor will have to carefully balance the quick provision of high impact services to meet growing expectations of returnees in particular, while at the same time increasing Sudanese ownership of health services and systems. The project is expected to enable CHDs to ensure high impact services are delivered and that health facilities and civil society groups take responsibility for health improvements and changing key health behaviors. In order to ensure these objectives are accomplished, the project will focus on the following results:

- Expanded access/availability of high impact services and practices;
- Increased Southern Sudanese capability to deliver and manage services; and
- Increased knowledge of and demand for services and healthy practices.

To achieve these objectives the program will include the following components: **1. Service Delivery and Community Mobilization; and 2. Health Systems Strengthening.** In the following text, these objectives are described separately; however, this program will tightly integrate systems strengthening and service delivery into its approach.

B. Duration and Illustrative Budgets

SHTP2 is expected to be implemented for a three-year period, from o/a January 2009 – December 2011.

The Contractor is expected to mobilize in Southern Sudan in the second quarter of the FY 2009. The initial activities under this solicitation will overlap and complement those of current prime Contractor. The Contractor is expected to build on the success of the SHTP1 2004-2009 project and to the extent practical, utilize the existing project infrastructure, equipment, vehicles and office space. Although the approved strategy period is 2009-2011, funding provided in 2009 is expected to fund activities through at least first quarter 2010. To the extent possible and pending the availability of funding, activities under this solicitation will continue in approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Note that the PEPFAR HIV/AIDS funding is sourced through the annual Country Operational Plan (COP) under the Office of the Global AIDS Coordinator in the Dept. of State, and conveys a separate set of budgeting and reporting requirements. The legislation for the second phase of PEPFAR (PEPFAR2) was just passed into law in late July 2008 as this solicitation was being prepared. It is possible that FY2009 and FY2010 categories and funding availability may differ.

All figures given are indicative and subject to the annual planning and budgeting process as well as Contractor performance.

Illustrative Budget

The estimated range of this procurement is $42-45 million over 3 years. The possible sources of USAID funding are listed below and the successful offeror will be required to track expenditures and results according to each funding source in providing an integrated package of high impact services in the focused counties.

Program Funding Source
PEPFAR/HIV/AIDS
3.1.1.1 PMTCT
3.1.1.2 Abstinence & Being Faithful
3.1.1.3 Other Prevention
3.1.1.14 Other Health Policy and Systems Strengthening
Malaria
3.1.3 Malaria
Child Survival Maternal Health
3.1.6.1 Birthing
3.1.6.4 EPI Services
Family Planning
3.1.7.1. FP Services
3.1.7.4 FP Communications
Water & Sanitation 3.1.8 (Year 2 & 3 only)

C. "Lead Agencies" and Local NGOs/CBOs

Building on the SHTP1 model, and following GoSS/MoH and state MoH policies and practices, NGOs are responsible for delivering health services in Southern Sudan, in partnership with CHDs and state MoHs. The evolving practice is to have one NGO or "lead agency" in each county. The Contractor is expected to develop and implement performance-based funding relationships with the "lead agency" in each focus county to achieve results described in this solicitation. The successful Offeror will be required to ensure that lead agencies work with local NGOs, CBOs and FBOs are included in as sub-contractors to strengthen local capacity during the award period.

Although historically the partner NGOs have operated under grant arrangements, experience with performance-based sub-contracts in other countries has yielded positive results.

The Contractor shall determine which arrangement is best suited to obtaining the best results, and establish monitoring and oversight mechanisms to assure that partners achieve performance standards described below.

The Contractor is encouraged to consider use of performance incentives in their relationship with lead agencies, including such concepts as performance payment for achievement of particular coverage milestones e.g. percentage of children vaccinated, increase ANC visits by pregnant women, or for increases in per-capita service provision. Experience in other countries demonstrates that a robust monitoring and evaluation system is essential for any model of performance-based financing (PBF). Offerors shall describe how they would provide for verification of results in any proposed pilot or roll-out of a PBF plan.

An estimated 75% of annual funding is expected to be allocated to these sub-contracts.

Grants Under Contract

The Contractor will be required to identify opportunities for working with non-health civil society groups such as, women's groups, parent/teacher associations, youth associations, religious groups, sporting associations, drama clubs, and dance troupes to expand advocacy and awareness for health services. The Contractor is strongly encouraged to create synergies with other USG funded local NGOs and CBOs in education, livelihoods, food security and governance to maximize impact. For budgetary purposes, an annual amount of $350,000 per year should be included in the budget to offer quick dispersing mechanisms with micro grants ranging from $10,000-$25,000. Multi year grants to the same organizations are acceptable. This GUC mechanism will take advantage of funding targets of opportunities which respond to new opportunities for expanding high impact services among groups and in areas not identified at the writing of this TO.

D. Performance Requirements for Component One: Service Delivery and Community Mobilization

The project will focus on the provision of a package of high impact services and behavior change interventions that have the greatest impact on the burden of disease and health outcome in Southern Sudan. These high impact services/practices will focus on facility-based and community interventions. Both levels are critical for improving the health of the Southern Sudanese population through the following high impact interventions:

Reorder

1) **Child Health** – Immunization (measles, DPT3, and polio), Acute Respiratory Infections (ARI) and Diarrheal Disease.
2) **Nutrition:** Exclusive breastfeeding, promotion of infant and young child feeding, twice yearly vitamin A supplementation

3) **Malaria:** Malaria control including use of long-lasting insecticide treated nets (LLITNs), intermittent preventive treatment (IPT) and prompt treatment with an effective anti-malarial.
4) **Hygiene and Sanitation Practices:** Household level water, sanitation, and hygiene**.**
5) **Maternal Health:** Ante-natal, safe delivery, and post-natal services
6) **Family Planning**: Child spacing and family planning information and services.
7) **Prevention of HIV/AIDS:** PMTCT and behavior change to delay sexual debut and reduce multiple risk behaviors.

The Contractor is responsible for tasks and results outlined in Results 1 – 7 below, over the period of performance 2009-2011. In addition the Contractor will be responsible for results under the systems strengthening component (Section E) described later in the TO

1. Child Health

<u>Summary</u>: By the end of 2011, USAID expects that more than 50% of children under the age of one who reside in the communities covered by project-supported service delivery points will be fully immunized (measles, DPT, polio) and no less than 60% of project focus counties will be achieving greater than 80% DPT3 coverage. These targets are commensurate with GoSS expectations for 2012 in its recent GAVI proposal.

By 2011, USAID also expects that trained, motivated and supervised Home Health Providers will be treating an increasing share of child diarrhea and child ARI in project focus counties relative to those treated at PHCU/Cs.

The Sudan Household Survey (SHHS) of 2006 found in the 10 Southern States that an average of about 24% among children aged 12-23 months received DPT3 vaccination at any time up to the date of the survey, which is less than half of the national Sudan average. In the Southern States, Central Equatoria (where Juba city is located) had the highest coverage, at 55%, followed by Upper Nile and United at about 36%, "… a figure at least twice as high as all the remaining Southern States that have reported a low coverage of less than 20%." (SHHS, p. 59).

The SHHS also reported that 42.9% of children under five had diarrhea in the two weeks preceding the survey, and only 22% of the children with diarrhea were managed competently at home. Similarly, 13.5% of children under five had suspected pneumonia in the two weeks preceding the survey; almost 90% of them were taken to a health care provider.

<u>USAID Standard Indicators</u>:

Indicator	Targets
Number of children less than 12 months of age who received DPT3 in areas currently assisted with USAID funds. Source: USAID PMP, 2007	Actual 2007 7,907 Target. 2008 13,000 Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
The percentage of children less than 12 months of age who received	Actual 2007 16.4% Target. 2008 21.5%

DPT3 in areas currently assisted with USAID funds Source: SHTP1 Assessment , 2008	Target. 2009 40% Target. 2010 45% Target 2011 50%
Number of health personnel trained in immunization, diarrhea management and ARI management with USG support. Source: USAID PMP, 2007	Actual 2007 1642 (all training) Target. 2008 2750 (all training) Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide

Description: This activity is implemented by the Contractor and project lead agencies in collaboration with WHO, UNICEF and the GoSS With the new GAVI proposal, the immunization system and immunization rates in Southern Sudan are expected to improve dramatically in the next four years, and USAID and its partners will be a key partner in this progress. There is a need to accompany this strengthened effort in immunization with a strengthened effort in community mobilization for immunization, as well as other key child health protocols in diarrhea and ARI.

The SHTP1 assessment records varying degrees of adherence with UNICEF and GoSS guidelines by the SHTP1 NGO partners, and varying results. The Contractor under this task order is expected to significantly increase adherence to guidelines and standards to so that there is a valid and measurable increase in vaccination of children in the focus counties. Past efforts have focused primarily on getting the supply-side moving; under this second-generation project, the supply-side must continue to be nurtured but much more attention needs to be given to generating demand. There is a particular need to mobilize Village Health Committees, other civil society organizations in the county, the County Health Departments, and Home Health Providers to assure that all children in the community receive all recommended life-saving vaccinations. Offerors should consider use of innovative approaches such as radio messaging and drama with church groups, women's groups, market settings, school-based child health programs, in- and out-of-school child-to-child health campaigns, and strengthened collaboration with CHDs.

SHTP1 has done a remarkable job at placing boreholes and latrines at most of the health facilities: in the first 6 counties, 93% of facilities have boreholes and 83% have latrines. This task order continues to emphasize clean water and sanitation and incorporate best practices funded elsewhere by USAID. Offerors may wish to consider the Madagascar Champion Communities model, with WASH-friendly facilities, schools and communities all promoting clean and safe water and sanitation.

The Contractor is also expected to increase skills and knowledge, particularly at the home and community level, of case management of diarrhea and ARI. The GoSS/MoH Basic Package of Health Services (BPHS) states that at a minimum, Home Health Promoters should be able to undertake information-education-communication (IEC) on these key health problems, as well as community-based social marketing of health products including *Water-Guard* (safe water solution). They are also to be engaged in active case finding and referral. The Contractor shall

assure that the Home Health Promoters focus on: prevention of diarrhea point-of-use (typically household or school) water treatment to ensure the safety of drinking water; and provide health education messages on improvements in key hygiene behaviors, such as correct water handling and storage; effective hand washing; and safe feces disposal. The Contractor shall promote home-based treatment with oral rehydration therapy (use of ORS, recommended home fluids, and/or increased fluids with continued feeding) to prevent severe dehydration, and treatment with zinc to reduce the severity and duration of diarrhea.

The BPHS also provides for Home Health Promoters in geographically very isolated areas to undertake an Integrated Essential Child Health Care approach that includes treatment and guidance for children with diarrhea, ARI and fever, with ORS/zinc, amoxicillin and ACT, respectively, and referral of sick children to PHCU/C. Dispensing of antibiotics at the community-level must be carefully introduced and managed, but holds great promise for increasing coverage in Southern Sudan.

USAID collaborates closely with the GoSS, state MoH, UNICEF and other donors and partners to increase immunization rates. Through other mechanisms, USAID provides annual funding to WHO as a contribution to polio eradication and will provide funding to the new USAID Global Health Bureau Maternal Child Health Integrated Project (MCHIP) to provide target TA. USAID will continue to collaborate with the MoH to ensure WHO, MCHIP, and other partners address the constraints faced in human resources (unclear roles, staff skills, management); the cold chain system and vaccines management; and monitoring and record keeping in order improve coverage. This combination of specialized resources will lead to better synergy of donor efforts, improve logistics and capacity at central, state and county levels to manage the EPI program and resuscitate routine immunizations.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to child survival interventions (immunization, prevention, and treatment of diarrhea diseases and acute respiratory infections) in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP11.

Performance Standards. At a minimum:

a) Increase current vaccination rates for children < one years old in the SDPs in project focus counties to no less than 50% and increase numbers of children vaccinated at these sites.
b) Increase outreach and community level activities to expand the availability of growth monitoring, nutrition, sanitation, and health promotion services for infants and children.
c) Assure that target PHCCs and PHCUs are staffed with appropriately trained cadres and are providing a quality standard package of immunization, nutrition, and prevention/treatment of diarrhea and pneumonia.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with Home Health Promoters and TBAs to provide outreach programs in immunization, nutrition, and prevention/treatment of diarrhea and pneumonia in communities.

2. Nutrition

Summary: By 2011, USAID expects that the percentage of children under 5 years of age who received vitamin A in areas currently assisted with USAID funds will be no less than 70%. This target is commensurate with national GAVI targets.

By 2011, USAID also hopes to increase the percentage of children 0-5 months of age benefiting from exclusive breastfeeding from 21% (SHHS, 2006) to 50%, and to improve and increase counseling on the introduction of appropriate and timely weaning foods to children.

USAID expects to increase Vitamin A distribution to children between six months and five years of age and to broaden coverage of Vitamin A and other key nutrients to children and others. As stated in the SHTP1 assessment, current data for Vitamin A coverage are questionable because Vitamin A administered on National Immunization Days is not reported on the child health card. The Contractor will work with the state and CHD as well as other partners to incorporate Vitamin A supplementation into the routine service package. Finally, USAID expects to reduce the deaths resulting from diarrhea and pneumonia through health education activities and broader and more efficient distribution of preventive health care products.

USAID Standard Indicators

Indicator	Targets
Number of children under 5 years of age who received vitamin A in areas currently assisted with USAID funds 2007, 2008 Source: USAID PMP	Actual 2007 43,263 Target. 2008 35,000 Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
The percentage of children under 5 years of age who received vitamin A in areas currently assisted with USAID funds 2007 Source: SHTP1 Assessment	Actual 2007 11.6% Target 2008 25% Target 2009 35% Target 2010 55% Target 2011 70%

Description: This activity will increase the delivery of nutrition services at health posts to children and pregnant women. These services include health education to women for preventing malnutrition, promoting exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under seven, and nutritional supplementation to reverse malnutrition. Many of the SHTP1 partners found that provision of food for mothers and children provides a good incentive to increase ANC attendance; where possible, this practice is encouraged. Use of Home Health Promoters to provide IEC on the benefits of exclusive breastfeeding and to refer children needed supplemental feeding shall be stressed.

USAID closely coordinates with other entities involved in nutrition to reduce duplication of effort and compatibility and effectiveness of services delivered. Through another mechanism, USAID will provide funding to the USAID Global Health Bureau nutrition activity FANTA2 (Food and Nutrition Technical Assistance) to provide more specialized technical assistance to the

GoSS in state-of-the art practices to provide Vitamin A supplementation to vulnerable populations. USAID does not intend to finance food under this project, but encourages the Contractor and its lead agencies to collaborate with agencies that do provide food aid for this purpose. The PL 480 Title II program expects to start Multi-Year Assistance Programs (MYAPs) in selected areas of Southern Sudan in late FY09, which would provide some complementarity with Contractor efforts under this component.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to Vitamin A, exclusive breastfeeding and promotion of infant and young child feeding in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP11.

Performance Standards: At a minimum
a) The percentage of children under 5 years of age who received vitamin A in areas assisted with USAID funds will be no less than 70%
b) The percentage of children 0-5 months of age benefiting from exclusive breastfeeding in areas assisted with USAID funds will be no less than 50%
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing IEC and counseling on Vitamin A supplementation, exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under seven, and nutritional supplementation to reverse malnutrition.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in Vitamin A supplementation, exclusive breastfeeding to 6 months and good maternal nutrition, monitoring the nutritional status of children under seven, and nutritional supplementation to reverse malnutrition.

3. Malaria

Summary: By the end of 2011, USAID expects that 95% of USG-assisted health facilities in the focus counties will comply fully with GoSS and international clinical standards for case-management of malaria.

There is no baseline for the SHTP1 counties for these data, thus the Contractor will have to establish one. The assessment found uniformly high knowledge of treatment protocols among PHCC/U staff interviewed.

The SHHS of 2006 found that only 11.6% of households had at lead one ITN but that 21.97% of children under five years of age were sleeping under ITNs. It also found that 46.99% of children under five had received anti-malarial treatment in the two weeks prior to the survey, although less than 4% received the recommended artemisinin combination therapy (ACT).

Note that malaria in pregnancy is covered under maternal health below.

<u>USAID Standard Indicators:</u>

Indicator	Targets
Assessment of USG-assisted clinic facilities' compliance with clinical standards	Actual 2007 No Data (ND) Target. 2008 25% Target. 2009 50% Target. 2010 75% Target 2011 95%
Number of ITNs distributed to USG-supported counties. (custom indicator) 2007, 2008 Source: USAID PMP	Actual 2007 19,374 Target. 2008 180,000 Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Malaria Number of people trained in malaria treatment or prevention with USG funds	Actual 2007 1642 (all training) Target. 2008 2750 (all training) Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide

<u>Description</u>: This activity is implemented by the Contractor and project lead agencies in collaboration with the GoSS, UNICEF, WHO, and GFATM partners implementing the Round 4 Malaria grant.

Much of Southern Sudan's malaria control efforts have focused on distribution of ITNs and LLITNs. To have high impact, the nets need to be distributed and their correct use ensured through practical demonstrations. Distribution of nets, demonstration of correct use, and home follow-up is an activity suited for Home Health Providers and VHCs. The SHTP1 assessment found that most PHCC/U staff correctly responded to questions about appropriate treatment and appeared to be following the national program guidance for the treatment of malaria. The GoSS/MoH is working with one lead agency on a small operations research program where Home Health Providers dispense ACT. The MoH is concerned with adequate supervision. Should the operations research effort so indicate, the expansion of Home Health Provider responsibilities, coupled with adequate supervision, should greatly help in case management of malaria.

The Contractor under this task order is expected to work closely with its sub-partners, PHCC/U staff, CHD, Village Health Committees, home health volunteers, local community groups, and others to mobilize communities to obtain and utilize LLITNs correctly, particularly for children under five and pregnant women. The Contractor is also expected to provide continued training to PHCC/U staff in new management regimes, and to collaborate closely with the CHD to establish improved supervision, quality assurance, and data gathering and reporting.

USAID is collaborating with a number of partners to assist the National Malaria Control Program. In FY06 USAID placed a long-term technical advisor in the Pharmaceutical Unit at the MoH to improve the management and distribution of malaria treatment drugs, and provided assistance in the establishment of a logistics management system at the MoH. In FY08, in

anticipation of improved logistic management systems, USAID will continue support to the advisor and supporting short-term TA and training, and will provide funding for procurement of first and second-line drugs for treatment of malaria.

These activities will complement the significant funding provided under the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). To date, Sudan has disbursed $37.8 million under Round 2 for Malaria, and has recently been approved for $72 million under Round 4. The GFATM funding will assure availability of LLITNs; the challenge for USAID partners will be to assure distribution and use by vulnerable populations. The Contractor will work with GoSS and GFATM to ensure LLITNs are provided to SHTP2 for distribution to the 145 SDPs and others that may be added.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to malaria prevention and quality case management in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum:
a) Increase USG-assisted health facilities' compliance with clinical standards in the SDPs in project focus counties to at least 95% by 2011.
b) Increase outreach and community level activities to increase correct use of LLITNs with particular attention to children under 5 and pregnant women.
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing correct case management of malaria.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in malaria prevention and case management.

4. Hygiene and Sanitation

Summary: By 2011, USAID expects the number of people in focus counties with access to improved drinking water supply as a result of USG assistance to increase to no less than 500,000 people (about 25% of the population of the focus counties).

The SHHS found that 48.3% of households in Southern Sudan use an improved source of drinking water. This varies widely, with Jonglei (22%), Western Equatoria (35%), Central Equatoria (37%) and Western Bahr el-Ghazal (37%) having particularly low rates. The primary source of water is a tubewell/borehole or an unprotected well.

USAID Standard Indicators

Indicator	Values
Number of people in target areas with access to improved drinking water as a result of USG assistance.	Actual 2007 30,000
	Target. 2008 50,000
	Target. 2009 75,000
	Target. 2010 125,000
2007, 2008 Source: USAID PMP	Target 2011 250,000

Description: The Contractor will collaborate with County Health Departments and UNICEF to assure that all service delivery points have functioning clean water supplies and sanitation facilities, including on-site hand washing facilities, latrines, and proper disposal for medical waste.

The Contractor shall assure that Home Health Promoters, Village Health Committees, and PHCC/U staff are well trained, motivated and supervised to provide IEC, counseling, and assistance to households and communities to improve water supply and sanitation. In some cases this will mean construction of a boreholes, and organization of a Water Management Committee to assure pump maintenance. In other cases this may involved well-capping; repair of existing boreholes and wells; and otherwise improving basic community water supply. In all cases the Contractor shall work closely with community groups to foster ownership of the water source so that improvements can be sustained over time.

The Contractor shall also introduce and/or expand technologies or products to assure household-level clean water. In collaboration with the GoSS/MoH, in 2006 Population Services International (PSI) in Sudan introduced WaterGuard, a chloroquine-based household water treatment tablet to ensure access to safe drinking water. The point-of-use tablet kills micro-organisms that cause diarrhea. WaterGuard is distributed and promoted through commercial retailers, CBOs, and health care facilities. The Contractor and lead partners are encouraged to collaborate with PSI to determine if some form of distribution – possibly through Home Health Promoters or VHCs – would be viable in the focus counties. The Contractor shall foster other means of protecting home-based water supply.

The activity should also promote improved community and individual hygiene and sanitation, with an emphasis on correct hand-washing; correct disposal of feces; and, in collaboration with VHCs, improved community sanitation and drainage. Where schools exist, the Contractor shall work with UNICEF and USAID's Education Office to assure that proper latrines are constructed and maintained. Use of innovative means of IEC/BCC, such as the Madagascar-model for "WASH-friendly health facilities, schools, and communities" or other in-school and out-of-school child-to-child health and/or peer educator programs, should be considered. The Contractor should build on USAID successful interactive radio program in the education sector to promote hygiene and sanitation messages throughout the focus counties.

USAID/Sudan received substantial earmarked Water and Sanitation funding in FY08 and expects to continue to receive similar levels in coming years. These funds are being provided to other partners through the "*Building Responsibility for the Delivery of Government Services (BRIDGE) Program*". A substantial amount may be focused in the Three Areas (outside of the SHTP1 target area). However, four SHTP1 current partners work in BRIDGE four southern states along the northern border: Warrap, Unity, Upper Nile, and Northern Bahr el-Ghazal. (for more information on BRIDGE, see www.grants.gov, Funding Opportunity Number M-OAA-GRO-LMA-08-715) In FY09 and FY10, it is expected that resources for Water and Sanitation will increase and be available for SHTP2. Additionally, OFDA is providing modest continuing water and sanitation efforts in some areas. The Contractor is encouraged to identify synergies

with water and sanitation efforts carried out by these other USG partners, and build on OFDA investments and best practice in Southern Sudan to reduce duplication of effort and to enhance compatibility and effectiveness of services delivered.

The overall strategy for USG-supported water-related activities was articulated in the *Paul Simon Water for the Poor Act of 2005: Report to Congress*, U.S. Department of State, June 2006; http://www.state.gov/documents/organization/67716.pdf. Among the principal objectives is to increase access to, and effective use of, safe water and sanitation to improve human health. The Act requires annual reporting on USG efforts to implement the strategy, which includes USG support to help reach the Millennium Development Goal targets in increasing access to improved water supply and basic sanitation. The Contractor for this task order will be required to assist in reporting on any water funds received, as required by the Act.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to improved drinking water supply and sanitation facilities in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum
a) The number of people in target areas with access to improved drinking water supply as a result of USG assistance (boreholes, WaterGuard, other) shall increase to at least 250,000.
b) The number of people in target areas with access to improved sanitation facilities as a result of USG assistance shall increase.
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing IEC/BCC on improved drinking water supply, hygiene, and sanitation.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in improved drinking water supply, hygiene, and sanitation

5. Maternal Health

Summary: By 2011, USAID anticipates that the basic package of prenatal, neonatal and post-partum care services are available at 50% of USG-assisted service delivery points in focus counties.

By 2011, the proportion of pregnant women who deliver in health facilities with a skilled birth attendant meeting minimal emergency obstetric and neo-natal care standards will increase to 20%.

USAID Standard Indicators

Indicator	Actual / Target
Number of deliveries with a trained TBA or MCH workers in USG assisted programs.	Actual 2007 6,581 Target. 2008 12,000 Target. 2009 15,000 Target. 2010 20,000

Source: USAID PMP, 2007	Target 2011 30,000
Percentage of assisted deliveries by trained health service providers in USG supported counties 2007 Source: SHTP1 Assessment	Actual 2007 2.5% Target. 2008 3% Target. 2009 5% Target. 2010 10% Target 2011 15%
Percentage of women with at least 1 ANC visit	Actual 2007 ND Target 2008 ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Percentage of women with at least 4 ANC visits.	Actual 2007 ND Target 2008 ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide

Description: The MoH/GoSS is just completing its Maternal, Neonatal and Reproductive Health Strategy and Action Plan for 2008-2012 which forms the basic guidance for this area of intervention. The Contractor will ensure that pre-natal care meets GoSS/MoH standards as established in existing protocols, and that all lead agencies assure that SDPs have adequate equipment (including delivery tables) and supplies (TT, iron and folic acid, STI detection materials, etc.) to meet national standards.

Post partum care is also an integral part of maternal health services. GoSS/MoH policy is moving away from TBAs and toward assistance by a trained Community Health Worker or Maternal and Reproductive Health Worker. A full description of new protocols is available in documents at the website associated with this procurement.

The key issues in maternal health can be summarized as follows:

1. About 94% of births take place at home (UNICEF).
2. Although about 77% of these deliveries are assisted by attendants, most of these are traditional birth attendants with little training.
3. Antenatal care coverage is low and usually lacks tetanus toxoid immunization and other services.
4. There is a near absence of family planning and child spacing information and services.
5. Data collection systems are poor.
6. TBAs are the key promoters of information on the importance of ANC attendance and safe deliveries
to pregnant women and only link between health facilities and pregnant women.
7. There is no access to Emergency Obstetric Care (EmOC).

The Contractor shall undertake a focused and intensive maternal health program in focus counties. Among activities to be considered are the following:

1. Assess the TBA population and select among them a cadre that can be upgraded. These upgraded cadres of TBA can be supervised by a select team of 5 to 6 midwives hired from outside Sudan on short contract basis. This team can begin to put systems in place.
2. Refocus the work of the remaining TBAs on health education (including child spacing and family planning) and recruitment for ANC attendance, in collaboration with Home Health Providers and VHCs.
3. Improve the logistics system to allow a regular supply of drugs to stock health facilities for maternal health, including all basic requirements for ANC, e.g. anti-tetanus toxoid).
4. Begin training and putting in place an *Essential* Obstetric Care package (as differentiated from an *Emergency* Obstetric Care Package, mentioned below) at facilities with appropriately trained personnel, promoting:

- Early registration (12-16 wks) for ANC
- At least 3 Antenatal Check-ups
- Prevention & Treatment of anemia
- Facility deliveries
- Postnatal Check-up

To handle obstetrical emergencies, the Contractor will collaborate with UNFPA to provide necessary training and equipment/materials comprising an Emergency Obstetrical Care Package at selected SDPs where staffs are adequately trained. In collaboration with GoSS, the Contractor may wish to consider piloting use of misoprostol at sites in selected counties where ANC coverage is high and/or there is a community health worker within an established program who can administer it correctly.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve maternal and reproductive health in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum
a) The basic package of prenatal, maternal and neonatal and post-partum care services are available at 50% of USG-assisted service delivery points in focus counties.
b) The proportion of pregnant women who deliver in health facilities with a skilled birth attendant meeting minimal emergency obstetric and neo-natal care standards will increase to 15%.
c) The proportion of facilities in focus counties upgraded to mange safe delivery or basic emergency maternal and newborn care will increase to 20%.
d) The proportion of facilities in focus counties upgraded to mange maternal and newborn complications will increase to 20%.
e) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing improved maternal and reproductive health services.

f) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide improved maternal and reproductive health services.

6. Child Spacing/Family Planning

Summary: By 2011, 75% of SDPs in USAID focus counties will have a least four methods of contraception available (pill, condom, lactation amenorrhea method (LAM), and standard days method (SDM)) and staff will meet GoSS and international standards for FP counseling and provision of services. In selected sites where there are high rates of returnees, information and supplies for injectables will be piloted.

The SHHS found that among the Southern States the mean rate of contraception used in only 3.5% (any method), as compared with almost 8% for Sudan as a whole. In the south, the highest rate is in Central Equatoria (8%) followed by Northern Bahr el Ghazal, Eastern Equatoria and Upper Nile (roughly 5%).

There is no baseline for the SHTP1 counties for these data (SHHS data are valid only to the state level), thus the Contractor will have to establish one.

USAID Standard Indicators: Due to absence of data, baselines and targets are to be established by the Contractor in the first 60 days of the contract.

Indicator	Targets
Percentage of women using a modern family planning method in areas currently assisted by USAID (Note: LAM is considered a modern method). 2006 Source: SHHS 2006 for Southern Sudan	Actual 2006: 3.5% Actual 2007: ND Target 2008 ND Target 2009 3.7% Target 2010 3.8% Target 2011 4%
Assessment of USG-assisted clinic facilities' compliance with clinical standards (in Sudan, must have at least 4 methods available)	Actual 2007 ND Target 2008 baseline + 10% Target 2009 baseline + 30% Target 2010 baseline + 50% Target 2011 baseline + 75%
Couple years of protection (CYP) in USG-supported programs	Actual 2007 ND Target 2008 ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide
Number of counseling visits for FP/RH as a result of USG assistance	Actual 2007 ND Target 2008 ND Target 2009 Offeror to provide Target 2010 Offeror to provide Target 2011 Offeror to provide

Description: The SHHS data are difficult to disaggregate by state, but the text reports that the most popular method of contraception in Southern Sudan is lactation amenorrhea method (LAM), with insignificant figures for other methods of less than 1%. There is clearly a great deal of room for improvement to assure that families have the number of children they desire, when they desire them.

Child spacing is one of the key interventions to reduce maternal mortality, and as such requires increased attention at all SDPs and in community mobilization fora. Evidence shows that spacing children up to three years can reduce infant mortality by half. With the increase in returnees coming home after living in other countries, there is increasing demand for contraceptives from people who have actually used them. These individuals can also serve as informal "peer educators" will family and friends, to help them understand the health benefits of child spacing. By the end of 2008, the GoSS BCC Framework will be in place, so that materials and media can be developed for a more active child spacing/family planning campaign geared to protecting maternal health. Also, by the end of 2008, SHTP1 will have gained more experience in promoting child spacing activities in selected counties, so that some local experience will be gained.

The GoSS/MoH has also established a policy framework and family planning guidelines. USAID and UNFPA provide limited contraceptives, and the commodity logistics system getting more attention. More work is needed to increase knowledge and demand and to expand the method mix.

The SHTP1 assessment, at an annex, provides some detailed suggestions for a re-invigorated family planning program.

USAID is providing funding in FY08 for procurement of contraceptive commodities, through central mechanisms, and will initiate technical assistance to support the new Reproductive Health Directorate to roll-out child spacing/family planning as an essential component of reducing maternal mortality. USAID is also initiating funding to the central Global Health Bureau Leadership, Management and Sustainability Program to provide technical assistance and training to the central and state MoHs to increase advocacy for family planning and assist in development and dissemination of Southern Sudan family planning protocols and guidelines to address the unacceptable high rates of maternal death in Southern Sudan.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to improve access to child spacing/family planning IEC, counseling, and contraceptives in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP1.

Performance Standards: At a minimum
a) At least four modern family planning methods (condoms, pills, LAM and SDM) are routinely available at least 80% of SDPs in project focus counties.

b) Injectables should be piloted into selected PHCCs in project focus counties with high rates of returns and/or urban areas/towns
c) Condoms available at 100% of service delivery points.
d) Family planning clinical standards are adopted and used in at least 80% of service delivery points.
e) Child spacing/family planning services and counseling become an integral part of HIV/AIDS testing services and PMTCT programs, where such exist.
c) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing IEC and counseling on child spacing/family planning.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to provide outreach programs in child spacing/family planning.

7. Prevention of HIV/AIDS

Summary: By 2011, USAID expects to integrate HIV/AIDS prevention activities into the 7 high impact services. This will include the provision of high quality prevention of mother to child transmission (PMTCT) services at selected SDPs in focused counties. This year will be the first year of PMTCT funding as a part of the high impact services. In addition, USAID also expects that the number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful in the project focus counties will increase to 200,000.

PEPFAR Standard Indicators: The Contractor will be expected to develop and provide targets for PMTCT as part of its Monitoring and Evaluation plan within 60 days of arrival in country.

Indicator	Targets
Number of health workers training in the provision of PMTCT services according to national and international standards.	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of service outlets providing the minimum package of PMTCT services according to national and international standards.	Actual 2007 NA Target. 2008 NA Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results.	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting.	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide

	Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful in the project focus counties.	Actual 2007 N/A Target. 2008 N/A Target. 2009 50,000 Target. 2010 100,000 Target 2011 200,000
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of total reached with AB, above)	Actual 2007 N/A Target. 2008 N/A Target. 2009 5,000 Target. 2010 10,000 Target 2011 20,000

Description: Southern Sudan continues to experience high levels of population movement as conflict hotspots flare up and move away, and as an increasing number of returnees come back from neighboring countries to regain their homes and their livelihoods. Commercial and employment related travel has increased dramatically, and cities like Juba are virtually flooded with people from many parts of the world, including many Sudanese from the Diaspora. Concern also exists that demobilizing soldiers, some of whom may have been at higher risk during service away from their homes, may carry HIV to their places of origin. The turbulent social context is developing in a setting of low HIV awareness and substantial behavioral risks. The consensus view is that the epidemic is likely to accelerate unless aggressive prevention and care program are implemented and strengthened.

The USG has supported a range of HIV/AIDS prevention and care programs in Southern Sudan for several years under PEPFAR. Under SHTP2, FY08 funding will be provided for PMTCT, community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful (AB), and modest systems strengthening at the CHD. In FY09 and FY10, USAID expects to continue funding in these program areas and to provide funding in other prevention – including promotion of correct and consistent condom use – as well.

PMTCT is relatively new to Sudan but is an important aspect of providing pre-natal services to women. There are currently only 18 sites providing PMTCT services, mainly in Central Equatoria and some in Lakes state. Since there are 40 VCT sites in Sudan, and the MoH is rolling out provider-initiated testing and counseling (PITC), it is important to increase PMTCT service availability to maximize women's potential to protect themselves and their children. The Contractor is expected to assure that high quality PMTCT services will be at selected SDPs in SHTP2 counties that have HIV counseling and testing sites (as they are established), and that referral systems – including transport stipends to testing sites – are available for women who present with high-risk factors (e.g. STIs).

The Contractor will introduce PMTCT that meets national and USG guidelines (ref. www.pepfar.gov) in sites with reasonable access to VCT and/or PITC sites in the focus counties. The Contractor may also link with other USAID and CDC partners working in HIV and AIDS; where possible linkages with USAID cross-border initiatives and CBO and PLWHA networks shall be pursued.

Southern Sudan's Abstinence and being faithful (AB) interventions target abstinence primarily on in-school youth and those youth who are not known to be sexually active. Efforts should be expanded to target church groups as a way to increase awareness among non-sexually active youth. The partner reduction (being faithful) efforts are linked to couples centered counseling and testing for other target groups, including military personnel and their families, truck drivers and their associates, and all couples who do not know their HIV status. The USG and other donors support aggressive mass media campaigns, including radio, billboards, TV and digital recording devices.

The Contractor for this TO is expected to take existing USG and other donor activities into account and to propose an AB effort for the focus counties that is well-integrated with other activities. This could include, for example, integrating AB counseling into pre- and post-natal counseling and PMTCT (where provided); assuring that schools and youth groups in the focus counties have Anti-AIDS Clubs or other AIDS awareness activities, and appropriate posters and media to promote abstinence; and community outreach through Home Health Promoters and peer educators to out-of-school youth and populations at risk, particularly mobile men. Both VHCs and CHDs should be considered key partners in this prevention effort.

Performance Requirement: Building on lessons learned under SHTP1, best practices in similar settings elsewhere and other applicable documents that are available on the web page for this solicitation, the Contractor will continue or initiate activities to provide community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful in the approximately 145 delivery points in 9 focus counties, as well as SDPs in 3 additional counties currently in process, that have been supported under SHTP11. The Contractor will selectively initiate PMTCT services in counties where there is a reasonable volume of ANC clients and reasonable access to VCT or PITC.

Performance Standards: At a minimum
a) Home Health Promoters in higher-risk areas (e.g. near borders or military camps; with large markets; along transport routes) will be trained and have IEC/BCC materials to promote abstinence and being faithful particularly focused at youth.
b) Civil society groups and clubs (e.g. churches, sports clubs, and drama groups) will be trained to provide peer education in abstinence and being faithful at population meeting spots (sports events, dances).
c) High quality prevention of mother to child transmission (PMTCT) services will be available at all SDPs in selected counties that have HIV counseling and testing sites, and that referral systems – including transport stipends to testing sites – are available for women who present with high-risk factors (e.g. STIs).

d) Assure that target PHCC and PHCUs are staffed with appropriately trained cadres and are providing community outreach that promotes HIV/AIDS prevention through PMTCT, abstinence and/or being faithful.
d) Assure that PHCC/PHCU staff in targeted areas work in partnership with home health promoters and TBAs to community outreach that promotes HIV/AIDS prevention through PMTCT, abstinence and/or being faithful.

E. PERFORMANCE REQUIREMENTS FOR COMPONENT TWO: HEALTH SYSTEMS STRENGTHENING

<u>USAID Standard Indicators</u>:

Indicator	Actual/Target
OPHT Number of policies drafted with USG support 2007, 2008 Source: USAID PMP	Actual 2007 4 Target. 2008 4 Target. 2009 1 Target. 2010 1 Target 2011 1
Number of health personnel trained with USG support 2007, 2008 Source: USAID PMP	Actual 2007 1642 (all training) Target. 2008 2750 (all training) Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Actual 2007 N/A Target. 2008 N/A Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide
Number of individuals trained in HIV-related community mobilization for prevention care and/or treatment	Actual 2007 NA Target. 2008 NA Target. 2009 Offeror to provide Target. 2010 Offeror to provide Target 2011 Offeror to provide

1. Health Systems Management

Over the last 50 years, relief organizations have been the main providers of health services in Southern Sudan. As Southern Sudan transitions from a relief to development environment, it is essential that the GoSS has the capacity to develop strong national policy, manage the health sector, and have strong civil society participation. While health services will likely be delivered by NGOs in the near term, the GoSS must have the capacity to plan, supervise, and manage the

sector as a whole. Thus, principle objective of USAID/Sudan's involvement in health systems strengthening is to ensure that the GoSS at the county and state level are able to manage the delivery of high-priority health services. While sub-partners will be the closest to local governments, it is essential that the Contractor develop an assessment-based approach to strategically identify areas of system strengthening in each county and offer lead NGOs and their local government counterparts tools and strategies for effective management.

Performance Standard, at a minimum, in USAID focus counties:
a) 50% of County health departments are able to effectively produce strategic plans based on reliable health information
b) 80% of County health departments conduct routine monitoring and supervision visits to health facilities jointly with lead NGOs
c) 50% County health departments can effectively produce and defend county health budgets
d) 80% County health departments can effectively conduct aggregate forecasts of pharmaceutical and commodities, and are directly linked to all available supply chain channels

2. Health Sector Governance

Fundamental to the successful transition from a relief to development environment is the development of strong governance channels. It is essential that scare government resources are allocated in a cost-effective manner. These allocation decisions must be open to public participation and public scrutiny. The strengthening of civil society groups is fundamental to improving the responsiveness of service providers and government. A strong system of checks-and-balances must be in place to ensure the integrity of scarce resources.

Performance Standard, at a minimum, in USAID focus counties:
a) 80% of health facilities have an actively-engaged, well-functioning Village Health Committee that is involved in resource allocation, priority-setting, and dispute resolution.
b) Community groups, such as women's groups, youth groups, and church groups are involved in priority-setting and health promotion activities in at least 80% of focus counties.
c) 80% of County Health Departments hold meetings or other public fora (e.g. radio programs) to disseminate annual County plans and budgets.

3. Health Policy Dissemination/Roll-Out

With SHTP1 and other USAID and donor assistance, the GoSS has made impressive progress in improving health services and developing systems to support them. This work has included formulation, consensus-building, and issuance of a large number of policies and protocols. There is now backlog of need to disseminate and/or roll-out the policies and protocols, both to health personnel as well as key State and county government official and interested civil society organizations.

Performance Standard. At a minimum, in USAID focus counties:
a) All basic policies and guidelines rolled out in focus counties through a variety of ways including radio, town hall meeting, training, etc. as appropriate to target audiences.

b) 100% of CHDs and SDPs in focus counties have copies of key MoH policies, strategies, and protocols.

4. Human Resource Capacity

The capacity of human resources is the greatest challenge in Southern Sudan. To strengthen the human resources ability to provide quality health services, SHTP2 will focus primarily at the county and community levels through a "continuous engagement" strategy that includes formal and on-the-job training via supportive supervision. The Contractor will, as necessary, collaborate with MDTF lead agencies placed at the State level to improve States' capacities to strategically plan for county/community services. Additionally, the Contractor will work with the national level to ensure standard training, curricula and program lessons are transferred to other States/counties and communities for broader impact. At the primary health care level, CHWs, MCHWs, TBAs, nurses, medical assistants, traditional healers and Home Health Promoters will be the capacity building focus. At the County and State levels, health personnel capacity will be strengthened to plan and ensure effective delivery of health care services.

Under SHTP1 USAID funded rehabilitation of five Regional Training Centers (RTCs) for health workers in Hakim (Nuba Mountains), Adol (East Rumbek), Maridi (Maridi), Yei (Yei), and Ganyiel (Panyijar). The GoSS is encouraged to support another five RTCs in the remaining five states. The Contractor will provide technical assistance to support this process, as requested by GoSS/MOH.

USAID's central Capacity Project is supporting the GoSS to develop a human resource policy for the health sector, which will include harmonization of position description and names among all of the NGO partners working in Southern Sudan. This effort is expected to continue through the three years of SHTP2.

Performance Standard:

a) No less than 5 CHW/MCHW Training Institutes providing quality pre- and in-service training for focus county personnel.
b) Standard curriculum developed for Home Health Promoters utilized in focus counties
c) 80% of CHWs, MCHWs and HHPs, CHD and program staff trained and providing the package of high impact services at facilities and community levels.
d) Village Health Committees trained and providing feedback and oversight to at least 80% of health facilities and CHDs.
e) 50% of CHDs able to strategize plan and collaborate with State and communities levels on health care delivery.

VII. QUALITY ASSURANCE PLAN

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

1. Monthly meetings with the CTO.
2. Review of Contractor's scheduled reports.
3. Feedback from GoSS, MoH, NGO counterparts and collaborating donors.
4. Site visits/TDYs by USAID personnel.
5. Meetings to review and evaluate work plans, annual and semi-annual progress reports.
6. Periodic impact assessments or performance evaluations.

The CTO will conduct periodic performance reviews to monitor the progress of work and the achievement of required results under this contract. These reviews will form the basis of the Contractor's permanent performance record with regard to this contract

VIII. WORK PLAN

The Work Plan/Performance Milestone Plan (PMP) is the key document for contract performance against which Contractor performance shall be monitored and evaluated by both USAID and the Contractor. The Contractor will propose the Work Plan/PMP as part of the technical proposal, and the final format will be agreed on during negotiation. During contract performance, the Work Plan will be up dated as required, subject to CTO approval. Contracting Officer approval of Work Plan updates shall be required if the proposed changes impact on the use of available contract funds. It is anticipated that USAID, GoSS, and key personnel will form a "Core Group Management Committee" to provide oversight during project implementation; review progress; and recommend changes. Such comments and changes, however, if accepted by the Contractor, shall not constitute a change from the terms of this contract. Annual Work Plans shall specify a time table for the implementation of planned activities and a summary program budget (by result category). The updates shall include a brief summary report on contract performance to date. The Work Plan is intended to be a working document for the use of the Contractor and USAID. Annual updates to the work plan will be discussed with USAID and adjusted accordingly. Much of the information may be presented in tabular format, and there is no expectation of widespread public dissemination.

The Work Plan should include, at a minimum:

- Proposed accomplishments and expected progress toward achieving the results and performance measures tied to the Monitoring and Evaluation Plan (M&E).
- A time line for implementation of the years proposed activities.
- Information on how activities will be implemented.
- Major equipment to be procured.
- Details of collaboration with MoH (central and department) and other USAID-funded partners

IX. MONITORING AND EVALUATION PLAN

The Contractor will be responsible for developing and executing a Monitoring and Evaluation (M&E) Plan, which includes the relevant indicators found in USAID/Sudan's Performance Monitoring Plan (PMP) and the results indicated in each component area in this TO. The

Contractor will propose the Work Plan/PMP as part of the technical proposal, and the final format will be agreed on during negotiation. Special attention should be paid to recommendations from the SHTP1 Assessment (March 2008). Expected program results with illustrative indicators, mid-term benchmarks, end of project results provided partially in this document, should be further elaborated in the M&E plan. The M&E plan should be submitted to the USAID CTO within 60 days of the award of the contract. To the extent possible the M&E plan will be integrated into, and enhance, existing MoH management systems. The M&E plan will be updated and revised as appropriate in collaboration with USAID.

BRANDING AND MARKING:

In accordance with ADS **320.3.2.2 Branding Implementation Plan, and ADS 320.3.2.3 Marking Plan, t**he successful offeror will be expected to submit branding and marking implementation plans within 45 days of signing the award.

X. REPORTS

All work under this contract shall be completed by December 31, 2011. During the length of the contract the following reports are due in English according to the following schedule:

Type of Report	Date Due	Distribution
Annual Work Plan and Budget (final format will be provided)	60 days after signing of the award and a month before the ending of the current work plan during the life of the project.	3 copies CTO, CO, Task Order CTO
Monitoring and Evaluation Plan	60 days after signing of the award	2 copies CTO, Task Order CTO
Financial Quarterly Reports	SF 296 30 days after end of the reporting period	3 copies CTO, FM/USAID Sudan, Task Order CTO
Monthly Meeting with minutes	During the first week of the month	1 copy CTO 1 week after meeting
Performance Monitoring Reports	Quarterly for the first year and semi-annually thereafter; (October 31 and April 30), to coincide with the USAID annual reporting cycle; dates and format TBD within the first 30 days of the award	1 copy to CTO
Equipment Plan	Annually (as part of the work plan)	CTO, CO
Foreign Tax Reporting	TBD	2 copies CTO, FM
Final Financial Report	90 days after completion of	4 copies

	contract	CTO, CO, Task Order CTO and CDIE
Final Performance Monitoring Report	90 days after completion of the contract; first draft is due 30 days after completion of the contract	Same as above
Success Stories (format will be provided)	Minimum of one per month with photographs	1 copy to CTO

N.B. Workshop/Conferences/Training reports will be included in the semi-annual reports.

- The Monthly Meeting: The Contractor will meet on a monthly basis with the CTO and provide monthly summarized implementation and financial reports (NTE 5 pages) to the CTO.

- Quarterly GoSS/USAID/Contractor Core Group Meeting with minutes circulated back to group with action points now later than 5 working days.

- Quarterly Financial Report: The quarterly financial report should contain at a minimum:

  1) Total funds committed to date by USAID into the contract.
  2) Total funds expended by the Contractor to date.
  3) Pipe-line (committed funds-expended funds).
  4) Funds and time remaining in the contract.

- Semi-annual Performance Reports: every six calendar months, for the periods of April – September and October –March, to be provided within 30 days of the end of each period. At a minimum, semi-annual reports shall describe: current progress to date relative to the goals and objectives of the procurement’s activities, achievement of results, performance of requirements, and progress on result indicators within this procurement (Results 1, 2, 3, 4, and 5), beneficiaries disaggregated by gender; identification of problems or delays; a proposal to remedy these problems or delays.

- Success Stories: Once a month the Contractor will be required to submit success stories concerning the people level impact of their activities. These success stories should be accompanied by photographs of the activities described.

USAID/Sudan: Strengthening service delivery and health systems