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1. Country of Performance: **Mozambique** Advisory & Assistance Services Yes [] No [X]
2. Contract No.: **GHS-I-00-07-00004-00** Task Order No.: **GHS-I-01-07-00004-00**

(Incorporating FAR and AIDAR Clauses)

NEGOTIATED PURSUANT TO THE FOREIGN ASSISTANCE ACT OF 1961, AS AMENDED, AND EXECUTIVE ORDER 11223

3. CONTRACTOR:
Chemonics International Inc.
1717 H Street NW
Washington DC 20006

DUNS: 86-771-4768

4a. ISSUING OFFICE:
Procurement Management Unit
USAID/Mozambique
JAT Complex, Rua 1231, No.41
Bairro Central "C"
Maputo, Mozambique

4b. ADMINISTRATION OFFICE:

Same as 4a

5. TECHNICAL OFFICE:
Health Team (SO 8)
USAID/Mozambique
JAT Complex
Rua 1231, No.: 41
Bairro Central "C"
Maputo, Mozambique

6. PAYING OFFICE: Submit Invoices to:

See Section G.4

FUNDS AVAILABLE

7. EFFECTIVE DATE:

April 18, 2008

8. COMPLETION DATE:

April 17, 2011

9. [redacted]

10. The United States of America, represented by the Contracting Officer signing this Order, and the Contractor agree that: (a) this Order is issued pursuant to the Contract specified in Block 2 above and (b) the entire Contract between the parties hereto consist of this Delivery Order and the Contract specified in Block 2 above.

11a. CONTRACTOR:

By:

Title:
Date

11b. United States of America
Agency for International Development

By: Victoria Ghent

Title: Regional Contracting Officer
Date

Regional Contracting/Agreement Office

100 Totius Street
P.O. 43, Pretoria
Pretoria 0027
South Africa

Tel: +27-12-452-2166
Fax: +27-012-452-2399

SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

The United States Agency for International Development (USAID) Mozambique requires support to provide the services detailed in Section C.

B.2 CONTRACT TYPE

This is a Cost-Plus-Fixed-Fee Task Order. For the consideration set forth in the task order, the Contractor shall provide the deliverables or outputs described in Sections C and F and comply with all task order requirements.

B.3 BUDGET

END OF SECTION B

SECTION C – DESCRIPTION/SPECIFICATIONS/STATEMENT OF WORK

C.1 BACKGROUND

Infant, child, and maternal mortality are all high in Mozambique, among the highest in Africa and the world and health infrastructure and service provision remains extremely weak. Malnutrition, infectious diseases and parasites, especially malaria, and the rapid spread of AIDS dominate the country's epidemiological profile.

In July 2005, the United States Government announced a new five-year, $1.2 billion initiative to rapidly scale up malaria prevention and treatment interventions in high-burden countries in sub-Saharan Africa. The goal of the President's Malaria Initiative (PMI) is to reduce malaria-related mortality by 50% after three years of full implementation. This will be achieved by reaching 85% coverage of the most vulnerable groups---children under five years of age and pregnant women---with proven preventive and therapeutic interventions, including artemisinin-based combination therapies (ACTs), insecticide-treated nets (ITNs), intermittent preventive treatment of pregnant women (IPTp), and indoor residual spraying (IRS). Mozambique is one of 15 countries included in the PMI.

In order to successfully implement this RFTOP SO8 aims, through this award, to support and strengthen the capacity of the MOH at the central and provincial levels to increase the quality of health services, especially related to malaria.

On-going Program

Although infant, child, and maternal mortality rates in Mozambique have been decreasing in recent years, they are still among the highest in Africa and the world. While the Government of Mozambique is committed to building an equitable health system that is affordable and sustainable, the health infrastructure, provision of services, and networks are not sufficiently developed to meet the health needs of a highly dispersed population, resulting in poor quality healthcare.

SO8 provides several tiers of support to the MOH. Interventions are being implemented through an integrated program that will strengthen the policy and management environment, increase access to proven and effective primary health services, and increase community demand for and participation in managing and influencing the availability and quality of health care services. The focus of the SO8 program at the provincial/district/community level is on selected districts in the four provinces (Nampula, Zambezia, Gaza and Maputo) whose combined population accounts for 40% of the total population in Mozambique. Activities include a combination of interventions at the national and central level and within the four provinces within SO8's geographical focus area.

At the national level the USAID DELIVER PROJECT´s four main strategies are: i) improve the Human Resource Capacity in Logistics and Management at Central de Medicamentos e Artigos Medicos (CMAM); ii) maintain and improve contraceptive logistics management throughout the integrated supply chain; iii) improve advocacy for contraceptive security for future sustainability; and iv) support logistics for malaria prevention and treatment activities. CMAM is the MOH's unit responsible for the central level logistics functions of forecasting, procurement, and distribution of all medicines and consumables for the MOH. The Project works in close partnership with the National Malaria Control Program and the Reproductive Health Program in activities relating to logistics of malaria and reproductive health commodities.

At the central level the Forte SAUDE contractor, is responsible for strengthening the ability of the MOH to manage its large and comprehensive programs, establish new and improved CS/RH policies, and help ensure overall transparency and accountability.

Through PVO partners, SO8 provides community-level interventions designed to strengthen health service delivery through increasing access to proven and effective child survival and reproductive health (CS/RH) services, and increase community-level demand for these services.

The specific objective of support to be provided to Provincial Health Directorates (DPS) and District Health Directorates (DDS) in the four focus provinces of Nampula, Zambezia, Gaza and Maputo is to:

1. Provide technical assistance to DPS and DDS to *improve the quality* of CS/RH services delivery to Health Centers and hospitals, especially concerning malaria; and
2. Provide technical assistance and *support to the overall management* of service delivery at the Provincial, District and facility level, especially concerning malaria.

Presidential Malaria Initiative

Malaria in Mozambique accounts for about six million reported cases per year, 44% of all outpatient consultations, and 65% of all pediatric hospital admissions. The estimated malaria prevalence among children 2-9 years of age in Mozambique ranges from 40% to 80%. Malaria is reported by the Ministry of Health (MOH) to be the primary cause of death among children admitted to pediatric services in Mozambique (32% in 1998, 42% in 1999 and 40% in year 2000). Approximately 20% of pregnant women in rural areas are infected with malaria parasites and, among primigravidae (first pregnancies) this figure can reach 30%. Anemia due to malaria is a major cause of morbidity and mortality in children and pregnant women and malaria is a leading cause of low birth weight in the newborn.

Although the World Health Organization reports that 100% of Mozambique's population of 19.4 million is at risk of malaria, it is unlikely that there is malaria transmission in central urbanized areas of the capital, Maputo, where approximately 1 million (5% of the population) people reside. Thus, for the purposes of establishing targets for the PMI in Mozambique, it will be assumed that 95% of the population (or 18 million people) are at risk of malaria.

According to the most recent Demographic and Health (DHS) survey, carried out between September and December 2003, 18% of women between 15 and 49 years of age had a bed net, but only 12% of pregnant women and 10% of children under five had slept under an ITN the previous night. A survey in Manica and Sofala Provinces following the large measles-ITN distribution campaign in November 2005 showed >90% usage rates among residents who had a bed net. Indoor residual spraying supported by the MOH and the Lubombo Spatial Development Initiative covers parts of 46 districts, but the proportion of households covered is not known. No up-to-date information exists on national or provincial coverage with ACTs or IPTp.

The goal of the PMI is to reduce malaria-related mortality by 50% compared to pre-Initiative levels by 2010. The following targets will be reached for populations at risk of malaria in Mozambique:

1. More than 90% of households with a pregnant woman and/or a child under five (in areas not covered by IRS) will own at least one ITN;
2. 85% of children under five (in areas not covered by IRS) will have slept under an ITN the previous night;
3. 85% of pregnant women (in areas not covered by IRS) will have slept under an ITN the previous night;
4. 85% of houses in geographic areas targeted for IRS will have been sprayed;
5. 85% of pregnant women and children under five will have slept under an ITN or in a house that has been sprayed with a residual insecticide within three months before the last transmission season;
6. 85% of pregnant women who have completed a pregnancy in the last two years will have received two or more doses of SP for IPTp during that pregnancy;
7. 85% of government health facilities will have ACTs available for the treatment of uncomplicated malaria; and
8. 85% of children under five with suspected malaria will have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of the onset of their symptoms.

C.2. OBJECTIVES

This task order is intended to focus on the following objectives in collaboration with the MOH:

a. Under the guidance of the National Malaria Control Program (NMCP), and contingent on the availability of funding through the PMI:

1. It will provide training/supportive supervision to health workers in the prevention and treatment of malaria in pregnancy and in treatment of uncomplicated and severe malaria;
2. It will develop and disseminate IEC messages for malaria in pregnancy and for children under 5 years of age;
3. It will develop implementation strategies for microscopy and Rapid Diagnostic Test (RDT) use and provide pre-/in service training in laboratory diagnosis and quality control for malaria;
4. It will support ACT implementation at provincial, district and health facility levels; and,
5. It will work closely with other malaria implementing partners, including sub-grants to NGOs FBO, and potential public/private partnerships.

b. Under the guidance of each Provincial Health Directorate, and contingent on the availability of funding through PMI and MCH:

1. It will strengthen the capacity of supervision, monitoring and evaluation in the areas of CS/RH, EPI, nutrition and malaria at the provincial and district levels;
2. It will assist the four focus (Nampula, Zambezia, Gaza and Maputo) provincial health directorates to strengthen staff management, leadership and planning skills to sustain effective health service delivery; and
3. It will facilitate the coordination of USAID health funded activities between provincial and district levels and work in collaboration with the current FORTE Saude contractor or any future contractor to facilitate the communication between the four provincial health directorates and the central MOH.

C.3 SCOPE OF WORK

A. Specific Tasks

The contractor shall undertake the following tasks:

Task 1: Preventive Activities

According to the 2003 DHS survey, 84% of pregnant women attend an antenatal clinic (ANC) at least once during their pregnancy in Mozambique. Approximately 81% of pregnant women make two or more visits, although these visits tend to take place late in pregnancy. As would be expected, ANC attendance rates were found to be lower in rural than in urban areas. Several partners have reported that ANC attendance rates increased following distribution of free ITNs in those clinics. It is new MOH policy to provide ITNs to all pregnant women receiving care at public ANCs.

Intermittent preventive treatment for pregnant women was approved as a national policy in May 2004. Because of high HIV seroprevalence rates, the NMCP recommends that women receive three doses of SP during their second and third trimesters. Implementation started in 2006 in provincial and district capital hospitals and NMCP and MOH Family Health Section are expanding this intervention to all 1,000 health facilities nationwide that provide ANC services this year. The NMCP and Family Health Unit staffs have collaborated in developing and implementing the policy, while the reproductive health officials have provided training on IPTp to the Provincial Coordinators for HIV/AIDS Tuberculosis and Malaria, staff from NGO implementing partners, and MOH maternal and child health nurses who provide ANC services that include IPTp, ITN distribution as well as prevention of mother-to-child transmission of HIV/AIDS (PMTCT).

In FY07, many of the President's Emergency Plan for AIDS Relief (PEPFAR) PMTCT partners will introduce cotrimoxizole prophylaxis for seropositive women, which will preclude the provision of SP because of an increased risk of adverse drug reactions. Close coordination with the MOH Family Health Section to develop appropriate ANC protocols and guidelines will be required, while PEPFAR and PMI implementing partners will assist in training and supervision of ANC providers to make sure that these two important interventions are delivered in a coordinated and complementary manner.

Principal Sub-Task:

a. Training/supportive supervision of health workers in prevention/ treatment of malaria in pregnancy

As the MOH plans to expand IPTp to more peripheral health facilities over the next year, a review of existing training and IEC materials related to malaria in pregnancy will be needed and the MOH will require additional support in training and supportive supervision of health workers and for disseminating health messages about malaria in pregnancy.

In collaboration with non-governmental organizations (NGOs), private voluntary organizations, (PVOs) and Faith-based Organizations (FBOs) this sub-task will provide training and supportive supervision to health care workers in IPTp and the diagnosis and management of malaria in pregnancy. Materials for such training and supervision have already been developed by WHO and others, but may need to be adapted to the local situation. It will optimize delivery of the full package of ANC services which includes PMTCT by linking PEPFAR and PMI implementing partners working in the same health facilities and technical advisors working with central level reproductive health staff to review and refine protocols and guidelines to include pregnant women who are HIV positive.

Performance indicators:

- Intermittent preventive treatment with SP in pregnant women will have been implemented in all health facilities in 11 provinces
- 85% of pregnant women who have completed a pregnancy in the last 2 years will have received 2 or more doses of SP for ITPp during that pregnancy
- 90% of households with a pregnant woman (in areas not covered by IRS) will own at least one ITN

Task 2: Case Management

Diagnosis: Malaria diagnosis in most MOH facilities in Mozambique is based on clinical grounds. Only about 20% of all malaria diagnoses are based on microscopic examination and the quality of those diagnoses is unclear. The Instituto Nacional de Ciências da Saúde has been responsible for the training of malaria microscopists. Senior microscopists from the Instituto Nacional de Ciências da Saúde and the NMCP have made periodic supervisory visits to provincial laboratories for refresher training. The most recent refresher training conducted in November/December 2005 included two microscopists from each province. The Secção de Laboratórios of the MOH is responsible for evaluating laboratory equipment and reagent needs and for the training of staff in the use of new equipment. A plan for laboratory diagnosis, including which tests will be recommended and quality control, has been drafted and was recently approved (see annex 1).
With this newly drafted policy on the role of microscopy and rapid diagnostic tests (RDTs) in malaria diagnosis the NMCP has as it's goal to introduce the use of RDTs in public health facilities in 2007 and strengthen microscopic diagnosis were it already exists. RDTs have already been introduced at health facilities in Maputo Province as part of the LSDI Project in 2003.

Treatment: Over the last four years, Mozambique has undergone two changes in national malaria treatment policy. In 2002, AQ-SP was introduced as an interim first-line treatment until ACTs could be adopted. In late 2004, the policy was changed to AS-SP, with another ACT, artemether-lumefantrine (AM-LUM) as the second-line therapy. Sulfadoxine-pyrimethamine was chosen over AQ because of the side effects of AQ and the potential for cross resistance with chloroquine. Quinine is the third-line drug and is recommended by the NMCP for the treatment of severe malaria. New MOH treatment guidelines for malaria were recently released and distributed to all provinces (see summary of guidelines attachment). Although not included in the written guidelines, the NMCP has stated that artesunate rectal suppositories can be used for the emergency treatment of severe malaria in children in settings in which intramuscular or intravenous quinine can not be administered, as recommended by the WHO. The treatment guidelines also state that AS-SP should not be used in children under six months of age but no alternative is offered (see Annex 2).

Implementation of AS-SP started in Maputo Province in late 2002 as part of the LSDI. The MOH began to scale up implementation of AS-SP in the remainder of the country beginning in early 2006, but the level of

ACT roll out varies from province to province, being most advanced in Maputo, Gaza, Sofala, Zambézia, and Nampula Provinces. The Provincial Coordinators for HIV/AIDS, TB and Malaria were trained on the new policy in 2006 as part of a one-day workshop and they were then made responsible for training health workers at the district and health facility levels. At the present time, only those health facilities with a physician are using AS-SP. It is expected that all levels of health facilities (including community health posts) will be implementing ACTs by 2007. Problems with ACT implementation have also been reported, including drug stock outs, AM-LUM being using as the first-line drug, and frustration on the part of patients because of poor health worker attendance at health facilities.

The Central de Medicamentos e Artigos Medicos (CMAM), under the direction of the National Health Directorate within the MOH, has primary responsibility for supplying the national public health system with medicines and medical supplies. Currently, antimalarials are distributed through two mechanisms: the kit system, which is considered a "push" system, and the 'via classica,' which is a "pull" system.

The kit system distributes three different kits (A, B and C), each with its own pre-defined set and quantity of essential medicines. Kits are delivered directly to provinces, from which they are then sent out to the health centers, health posts and community health workers on a monthly basis. Hospitals do not receive medicine kits. All of the kits being procured this year for distribution in 2007 will contain AS-SP. Artemether-lumefantrine and quinine (tablets and ampoules) are not used at the lower levels of the health system, and therefore are not included in any of the kits.

The so-called "via classica" is the system for distributing antimalarials to warehouses and hospitals at the central, provincial, and district levels. In the "via classica," warehouses, hospitals, and facilities submit requisitions to the distribution point above them for the medicines they will need for the next quarter.

Ensuring prompt, effective, and safe ACT treatment to 85% of patients with confirmed or suspected malaria in Mozambique will represent one of the greatest challenges for the NMCP, given the need for training of health workers and education of patients about the new treatment policy. In addition, it is likely that the current guidelines for first and second line treatment will change in the coming year. This new change would address the concerns of the potential for SP resistance to emerge, because of the recently widely implemented ITPp SP regimen. Since increasing ACT coverage rates is a high priority both for the NMCP in their National Malaria Strategic Plan for 2006-2009 and the PMI, the PMI will coordinate its activities with those of the NMCP and other partners.

Principal Sub-tasks:

With the increased cost of ACTs compared with AQ-SP, accurate diagnosis will be critical to target antimalarial drug use to infected patients and reduce the unnecessary use of these drugs that occurs when patients are presumptively treated for malaria. The PMI views malaria laboratory diagnosis as a key component of good case management and will support strengthening of malaria diagnosis in MOH facilities with diagnostic laboratories. The PMI also recognizes the benefits of combining malaria laboratory training with training done by partners working on other diseases, such as tuberculosis.

a. Microscopy/RDT strategy development

Under the guidance of NMCP and in collaboration with CDC, the MOH, and other partners, this sub-task assists the NMCP to develop a national implementation strategy and plan for the use of microscopy and RDTs at different levels of the health system and in different clinical settings in the country, including decisions on which age groups should be targeted for malaria laboratory diagnosis.

b. Procurement of microscopes and refurbish central malaria reference laboratory

Under the guidance of the NMCP, procure and distribute 80 binocular microscopes, and 80 microscopy kits among 11 provincial/district hospital laboratories. Refurbish, through construction, laboratory equipment, including a multi-headed teaching microscope, and office supplies, the primary reference diagnostic training center at the Institute of Health in Maputo.

c. Pre-/in service training in laboratory diagnosis and quality control

In collaboration with CDC, this sub-task will work with the NMCP and the Instituto Nacional de Saude (INS) to strengthen pre-service and in-service training for MOH laboratory technicians in malaria diagnosis, including both microscopy and RDTs. Close coordination will also take place with the HIV/AIDS activities. This will include the following:

1. Development of a plan for microscopy training of MOH laboratorians, including pre-service training for incoming laboratory workers and refresher training for current technicians;
2. In collaboration with the CDC, Provision of an in-depth refresher course on malaria for senior laboratory staff at the reference diagnostic and training center. These will be the professionals responsible for training laboratory technicians at the provincial level, quality control, and other activities related to malaria diagnosis;
3. Provision of support for on-the-job training for MOH laboratory workers in malaria microscopy and the use of RDTs at the province level (all 11 provinces). This activity should be coordinated with other planned activities related to improving laboratory diagnosis of other diseases, e.g., HIV/AIDS, tuberculosis, etc.; and
4. Provide assistance to the NMCP with the Development and implementation of a plan on quality control of microscopy and RDT diagnosis, including regular supervisory visits, systematic review of a predetermined percentage of positive and negative blood smears, and simultaneous use of both tests in a small percentage of cases to check accuracy.

d. Training/supportive supervision of health workers in treatment of uncomplicated and severe malaria and malaria in pregnancy and children under 5 years of age

Under the guidance of the NMCP, and through sub-grants to NGOs/FBOs and working with the MOH/NMCP, this sub-task will support the MOH and NMCP in pre- and in-service training and supportive supervision of health workers to ensure safe and effective ACT prescribing and dispensing practices according to NMCP guidelines and in coordination with the MOH Integrated Management of Childhood Illness (IMCI) program. It will also support training on the recognition and management of severe malaria according to NMCP guidelines, which conflict with the stock of AS-SP that are now being distributed as a blister through the "via classica" and in the medicine kits. This will require additional training and attention. In addition, this sub-task will need to be closely linked with the activities of other implementing partners already supporting training related to IMCI and maternal and child health, including IPTp.

Performance indicators:

- 85% of government health facilities will have ACTs available for the treatment of uncomplicated malaria;
- 85% of children under five with suspected malaria will have received treatment with an antimalarial drug in accordance with national malaria treatment policies within 24 hours of the onset of their symptoms

Task 3. Behavior Change and Communication (BCC) and Information and Education and Communication (IEC) for malaria with focus on pregnancy and children under 5 years of age

Both the NMCP and partners agree that BCC/IEC related to malaria advocacy, prevention, and control is in need of strengthening. The NMCP reports that public awareness about how to prevent and treat malaria is low, particularly in rural areas, in spite of the MOH's twice yearly promotion of National Malaria Awareness Days.

The MOH has taken some steps to begin addressing this problem. A draft communication strategy called, "Moving from Malaria Awareness to Behavior Change Communication" has been developed. In addition to the draft communication strategy, the MOH has included a section on "Health Promotion and Mobilization" in its interim 2006 Strategic Plan for Malaria Control. These two documents offer a starting point for developing a unified and comprehensive national plan for BCC related to malaria. The MOH also plans to work more closely with NGOs, traditional healers, community leaders, and community-based organizations to improve local residents' understanding of and ability to deal with malaria.

Principal Sub-Tasks:

a. **Facilitate the development of locally appropriate/plan for dissemination of IEC messages for malaria in pregnancy**
This sub-task will work through sub-grants to NGOs/FBOs to support a review of existing information on knowledge and perceptions related to malaria in pregnancy in Mozambique and, based on already existing IEC/BCC materials for malaria in pregnancy, development of locally appropriate messages to make women aware of the risk of malaria during pregnancy, conduct pre-delivery testing of malaria knowledge promote early and regular attendance at ANCs, (more than 2 visits, early first visit, etc.) and the use of IPTp beginning early in the second trimester of pregnancy, and completion of the recommended three treatment doses.

b. **Provide technical assistance for IEC/BCC activities**
Provide experienced BCC advisors to assist the Health Education Department (RESP) at the central MOH and the Provincial Health Educators to implement IEC/BCC activities that are culturally suitable and appropriate to increase the acceptance of and access to the key malaria interventions--ITNs, IPTp, ACTs, and IRS.

c. **Expand partners capable of effectively reaching communities**
Provide a mechanism to increase and expand the role of faith-based organizations (FBO), community-based organizations, local in educating, promoting and facilitating the adoption of behaviors that will result in significant decreases in malaria in urban and rural communities.

Performance Indicators:

- 30% of districts that organized IEC activities (with exception of community radio programs)
- 90% of Health facilities with MOH approved IEC material
- Greater than 60% of schools with MOH approved malaria IEC material

Task 4: Monitoring and Evaluation (M&E)

Malaria is included in the reporting system of notifiable diseases managed by the Departamento de Epidemiologia which requires all public health facilities to report on the number of malaria cases on a weekly basis. Although cases are stratified by age group (<5 years old and ≥5 years old), no effort is made to distinguish clinically diagnosed cases from those that are confirmed by laboratory testing. The data are transmitted to the provincial and, subsequently, to the national level. While this program is considered to be the best functioning health information system in the country, it has limited capacity and there are concerns about the accuracy, completeness, and timeliness of the data.
The NMCP also collects information on malaria case fatality rates from a sentinel surveillance system based in provincial, general, and rural hospitals throughout the country. UNICEF has recently completed an exercise to map the geographic location and extent of malaria control interventions nationwide, but with the rapid scale-up and evolution of malaria interventions in Mozambique, information will need to be updated on a regular basis.

Strengthening monitoring and evaluation capabilities is a high priority for the NMCP and its partners. A nationwide Malaria Indicator Survey that will provide baseline information for the 2007-2009 Strategy and Plan is planned for early 2007. In late 2007, Mozambique will conduct a mortality survey in follow-up to the 2007 National Census with funding from PEPFAR and technical assistance from the U.S. Bureau of Census and the University of North Carolina MEASURE/Evaluation Project. The INCAM survey will determine the levels of HIV and malaria mortality over the previous twelve months as initially reported during the Census. A total population of approximately 844,000 residents in all 11 provinces will be covered by the INCAM survey.

Principal Sub-Tasks:

a. **Assess/strengthen MOH malaria sentinel site surveillance system**
In collaboration with CDC and other partners, this sub-task will assist the Departamento de Epidemiologia and the NMCP to assess and improve the quality, accuracy, completeness, and timeliness of malaria-related surveillance data (cases of malaria and anemia, severe malaria, and

malaria- and anemia-related deaths) and reporting at the district, provincial, and national levels, with particular emphasis on supporting sentinel malaria surveillance sites.

b. Development and implementation of an integrated M&E plan

Following on the UNICEF mapping exercise on the status of malaria interventions throughout the country, this sub-task will work with the NMCP, the CDC, and other partners to develop and implement a single, comprehensive and integrated monitoring and evaluation plan for malaria in Mozambique that would make use of data from various sources, including:

- Large-scale, population-based household surveys (e.g., DHS, MICS, MIS);
- Routine data from sentinel sites;
- Data from occasional surveys or evaluative activities that are designed to answer a specific question (e.g., antimalarial drug efficacy testing; insecticide resistance testing); and
- Other data sources.

It will also include supportive supervision of health workers and strengthening of the capacity of the NMCP (through either direct support or assistance) to collect and analyze data, reach conclusions, and respond in a rational and timely fashion.

c. Assist NMCP improve Information and Communication Technology (ICT) systems and infrastructure

The Contractor will assist the NMCP to assess the current ICT systems and how these meet current ICT needs for advocacy, decision-making and communications.

- Support NMCP to more effectively use available health information for M&E decision-making at all levels and to communicate within different departments in the MOH and at all levels, including provincial levels.
- Support NMCP to streamline routine operational tasks, training and reassigning human resources to focus on health sector information analysis and application.
- Support the NMCP to acquire needed ICT equipment (including computers, copier machines, and fax machines) and technical assistance to maintain these equipment and systems.
- Assist the NMCP to improve the quality and use of information collected routinely for M&E and through the heath information system.
- Assist MOH to use ICT to enhance information sharing.

d. Antimalarial efficacy studies at sentinel sites

This sub-task will support antimalarial drug efficacy studies first- and second-line drugs at geographically-representative sites throughout the country in coordination with the NMCP in using standard WHO protocols for such testing.

Performance indicators:

- A functioning malaria sentinel surveillance system
- Development and implementation of a cost-effective plan for ongoing monitoring of antimalarial drug efficacy.

Task 5: Focus Provinces Health Services Strengthened

In the second year of implementation, activities under this task order will be expanded to include areas related to maternal and child health, reproductive health/family planning and nutrition through the provision of technical assistance (TA) to support the four focus Provincial Health Directorates (DPSs). This task will: a) strengthen supervision capacity; b) improve the quality of monitoring and evaluation in the areas of CS/RH, EPI, nutrition and malaria; c) strengthen staff management, leadership and planning skills to sustain effective health service delivery; and d) facilitate coordination and M&E data quality collection of USAID funded activities in the four focus provinces by working in collaboration with the current FORTE Saude contractor or any future contractor which provides technical assistance to MOH central level staff.

This task will focus on improving the efficient and transparent management of scarce health resources at the Provincial level to enable Mozambique's health sector to derive maximum benefit from all available

support. The task will strengthen critical systems within the four geographically focused (Nampula, Zambezia, Gaza and Maputo) Provincial Health Directorates (DPSs) for planning of health services and for monitoring program performance.

The USAID health team interventions implemented through four separately awarded Cooperative Agreements will strengthen and improve the quality of service delivery and use in select districts, in the four focus provinces, working with District Health Directorates (DDS) and community outreach programs. The responsibility of this task will be to ensure MOH policies and priorities are communicated from the DPS level down to the DDS level and that quality data is collected from the lowest levels, to be consolidated into the Health Information Systems at the DPS level and then transmitted to the central level at the MOH, facilitated by the current FORTE Saude contractor or any future contractor.

Sub-tasks will be more thoroughly specified during formation of the second year's annual work plan to include Task 5, but below is an illustrative indication of activities to be performed under this award:

Principal Sub-Tasks

a. Strengthen the capacity of supervision, monitoring and evaluation

In working with the current FORTE Saude contractor or any future contractor and USAID-funded health PVOs, the contractor must assist the four focus DPSs to implement policies and strategies defined at the central level in areas related to MCH, RH, nutrition and malaria. This support will include technical assistance, training and supervision of health workers, at provincial and district levels.

b. Strengthen staff management, leadership and planning skills

In collaboration with the current FORTE Saude contractor or any future contractor and other USAID health partners, provide assistance to the Provincial Health Directorates to sustain effective health service delivery as follows:

- Assist the provincial health directorates to develop a curriculum based on a review of key management and leadership issues negatively impacting on service delivery;
- Assist the provincial health directorates to train core teams that will implement the management, leadership and participatory supervision programs. These teams will be encouraged to seek other resources to develop cascade training system to reach all health units in the districts;
- Assist the provincial health directorates to train core teams that will sustain the promotion of quality assurance;
- Assist the provincial health directorates to institutionalize quality and efficiency of service delivery as a key tenet of its MCH, RH, nutrition and malaria services;
- Assist the provincial health directorates to perform multi-year strategic planning.

c. Coordination at provincial level

Coordination will need to be done at three levels for all four focus provinces.

The first level will be to coordinate activities to support the DPS, especially concerning trainings to be provided at provincial level for provincial and district level staff.

The second level will be, through Memorandums of Understandings, to coordinate USAID health funded PVOs providing support to each focus province, especially concerning data quality and collection and training to be provided at the district level.

The third and final level will be to work in collaboration with the current FORTE Saude contractor or any future contractor to facilitate the communication between each of the four DPSs provincial health directorates and the central MOH.

Performance Indicators:

- Percentage of primary health care facilities fully implementing IMCI protocols;
- Number of people trained in maternal/newborn health through USG-Supported programs
- % of health centers meeting quality assurance standards
- Development of an integrated M&E plan for Malaria in Mozambique

B. Capacity Building

Programs should strengthen in-country capacity and foster collaboration as in-country capacity is the foundation for long-term success. Sustainable health systems and services at the national and local level depend critically on the engagement and commitment of key stakeholders - local people, government, civil society, enterprises, NGOs and donor institutions.

C.4 PERFORMANCE STANDARDS

The following are the measurable performance standards that have been established for this task order. The performance standards are consistent with the objectives for the Project:

Technical competence: Performance shall be measured by the Contractor's effectiveness on the assignment in achieving the project objectives. Effective technical competence will implement all principal sub-tasks to achieve the program results/targets described by the performance indicators and produce reports that contain actionable recommendations. Ineffective technical competence is marked by failure to achieve the project objective and/or by superficial or theoretical findings and recommendations, which are irrelevant or cannot be implemented.

Ability to assemble or prepare effective expertise: Performance shall be measured in several different ways. For example, superior contractor recruitment ability goes beyond a simple review of candidate's resumes before submission to USAID. Some candidates might appear qualified on paper, but may lack effectiveness in action. Superior recruitment processes shall be based on references and first-hand contacts with the technical expert proposed. Similarly, in team building, superior contractor performance will be demonstrated by assembling teams that function smoothly in accomplishing the required objective. Superior contractor performance shall take into consideration how each individual will contribute to create positive group chemistry when assembling teams. Inferior performance is marked by disruptive team relations and high staff turnover, notwithstanding the sometimes stellar reputation of individual members on the team.

Contractor responsiveness: Performance shall be measured by the Contractor's ability to maintain open, direct, and responsive communications channels with USAID/Mozambique and the host country contact staff. Superior contractor performance is marked by a rapid, helpful response to clients without undue delays. Inferior performance may result from a lack of strong communications efforts with USAID and it clients.

Client satisfaction with the finished product: Performance shall be measured in many ways. Superior contractor performance is distinguished by achieving the project objectives and the high quality of the deliverables. High quality deliverables should be clear, concise, accurate, well-structured, and easily comprehended.

Proficiency of the client: Performance shall be measured based on the increased ability of the client (USAID Mission and/or host country government) to understand and act on the technical subject matter subsequent to Contractor's provision of services.

C. 5 IMPLEMENTATION AND MANAGEMENT PLAN

The Contractor shall provide contract management necessary to fulfill all the requirements of this task order. This includes cost and quality control under this contract.

END OF SECTION C

SECTION D – PACKAGING AND MARKING

D.1 AIDAR 752.7009 MARKING (JAN 1993)

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

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

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

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

D.2 BRANDING

The Contractor shall comply with the requirements of the USAID "Graphic Standards Manual" available at www.usaid.gov/branding, or any successor branding policy.

END OF SECTION D

SECTION E - INSPECTION AND ACCEPTANCE

E.1 TASK ORDER PERFORMANCE EVALUATION

Task order performance evaluation shall be performed in accordance with Section C.4, Performance Standards. Evaluation of the Contractor's overall performance against the performance targets and indicators established pursuant to Section C of the task order shall be in accordance with the performance standards set forth herein, and shall be conducted jointly by the CTO and the Contracting Officer. The evaluation report shall form the basis of the Contractor's permanent performance record with regard to this task order.

E.1.(a) Quality of Work.

E.1. (b) Cost Control/Effectiveness.

E.1. (c) Timeliness.

E.1. (d) Customer Satisfaction by USAID.

E.1.(e) Customer Satisfaction by End-Users.

E.1.(f) Effectiveness of Key Personnel and Subcontractors.

E.1.(g) Compliance with Small Business, U.S. Small Disadvantaged, U.S. Woman-Owned Small Business, and U.S. HUBZone small business subcontracting goals and U.S. small disadvantaged business participation targets.

In accordance with FAR 42.15 and corresponding USAID procedures, the Contractor's performance will be evaluated annually and at task order completion, utilizing the performance standard set forth above. The Contractor shall have the opportunity to respond to such performance evaluations.

END OF SECTION E

SECTION F – DELIVERIES OR PERFORMANCE

F.1 PERIOD OF PERFORMANCE

The estimated period of performance for this task order is three years.

Subject to the ceiling price of this task order and the prior written approval of the CTO, the Contractor may extend the estimated completion date, provided that the extension does not cause the elapsed time for completion of the work, including the furnishing of all deliverables, to extend beyond 30 calendar days from the original estimated completion date. Prior to the original estimated completion date, the Contractor shall provide a copy of the CTO's written approval for any extension of the term of this delivery order to the Contracting Officer; in addition, the Contractor shall attach a copy of the CTO's approval to the final voucher submitted for payment.

It is the Contractor's responsibility to ensure that CTO-approved adjustments to the original estimated completion date do not result in costs incurred that exceed the ceiling price or the total obligated amount of this task order, whichever is less. Under no circumstances shall such adjustments authorize the Contractor to be paid any sum in excess of the delivery order or the total obligated amount, whichever is less.

Adjustments that will cause the elapsed time for completion of the work to exceed the original estimated completion date by more than 30 calendar days must be approved in advance by the Contracting Officer.

F.2 KEY PERSONNEL

The individuals below are designated as key personnel.

NAME	POSITION
Patricio Murgeytio	Chief of Party
Elizabeth Streat	Senior Malaria Technical Officer

Any replacement for these positions must be approved in writing, in advance, by the Contracting Officer. The key personnel identified above were proposed by the Contractor in its original proposal which was accepted by USAID through award of this task order, and are considered to be essential to the work being performed hereunder. Unless otherwise agreed to by the Contracting Officer, the Contractor shall be responsible for providing such personnel for performance of this task order for the term required hereunder. Unless failure to provide the designated key personnel as specified above is beyond the control, and without the fault or negligence, of the Contractor (*e.g.*, non-acceptance or termination of employment by the individual, illness or death of the individual), failure to provide such key personnel as specified above shall be considered nonperformance by the Contractor. If the Contractor, at any time, is unable to comply with these requirements, the Contractor shall simultaneously notify, in writing, the Contracting Officer and the CTO reasonably in advance of the individual's departure or non-acceptance of employment and shall submit written justification and explanation in sufficient detail (including implications for the total estimated cost of this contract) to permit evaluation of the impact on the program. No replacement of personnel shall be made by the Contractor without the written consent of the Contracting Officer; provided that the Contracting Officer may ratify in writing such replacement and such ratification shall constitute the consent of the Contracting Officer required by this clause. Proposed substitutions must be submitted simultaneously to the Contracting Officer and the CTO not later than 30 days after the departure of, or non-acceptance of employment by, any of the approved individuals, and the proposed substitute personnel must have at least the same qualifications as the applicable key personnel specified above. Failure to do so shall be considered nonperformance by the Contractor. The listing of key personnel may, with the consent of the contracting parties, be amended from time to time during the course of this task order to add, change or delete personnel and positions, as appropriate.

F.3. DELIVERABLES

The following sub-sections describe the nature and content of plans and reports required for planning, implementation and monitoring of the Task Order. Most of these deliverables are interrelated. The format of all of the different plans and reports should be compatible with the National Malaria Control Program (NMCP) and USAID plans and designed to allow analysis among the completed activities, expenditures, and results for each year of the program.

F.3.1 ACTION PLANS

F.3.1.1 Three-Year Strategic Plan

Within the first 60 days after the arrival of the first long-term TA team member in Mozambique, the Contractor will submit a "draft" three-year strategic plan that encompasses the activities required to achieve results, the corresponding time frames, and an estimated budget required to achieve the five tasks. In contrast to the Annual Action Plans (described in F.3.1.2 below), the three-year Strategic Plan will focus on the three-year chain of actions needed to achieve the targeted end results of the PMI and NMCP strategies. The Contractor will work closely with the NMCP and other stake holders in developing the final plan. This three-year Strategic Plan will be submitted in a format mutually agreed among the NMCP, the Contractor and USAID/Mozambique.

F.3.1.2 Annual Action Plans

Within the first 60 days after the arrival of the first long-term TA team member in Mozambique, the Contractor will submit an Annual Action Plan for Year 1, designed with input from NMCP and USAID. This Annual Action Plan, and Annual Action Plans for subsequent years, will describe the activities and interventions to be carried out and the corresponding time frames. The Annual Action Plans will include as an integral component the Annual Capacity Building/Training Plan (described in F.3.1.3 below). The Annual Action Plan will also incorporate a Financial Report. The Annual Action Plans will provide information in a format mutually agreed with the NMCP and USAID/ Mozambique.

The Contractor will develop annual action plans in collaboration with the NMCP and the PMI team. The plans are subject to first the endorsement by the NMCP and MOH before receiving approval from the USAID/Mozambique CTO for the TASC3 Task Order. The CTO, will review and approve plans to ensure that they are within the TASC3 Scope of Work and contribute to the PMI Malaria Operational Plan.

F.3.1.3 Annual Capacity Building/Training Plans

As part of the Annual Action Plan submissions, the Contractor will submit an Annual Capacity Building/Training Plan for all Contract-funded training activities. The plan will be based on the Annual Action Plan and consist of pre-service and in-service or more formal training designed to support achievement of MOH PES and MOP. The timing of actions will be shown in the Annual Action Plan. The separate Capacity Building/Training plan will be used to meet USAID review and reporting requirements. The plan will include a brief description of the relationship to the MOH PES and Human Resource Development Plan, types of capacity building/training proposed by category (international, national or provincial); expected cost; source of training; and proposed timing. The Annual Capacity Building/Training Plans will provide information in a format mutually agreed with the NMCP and USAID/Mozambique, and will be included in the USAID Tracking System for training in accordance with ADS.

F.3.1.4 Small Grants Management Plan

The Contractor will submit a final small grants management plan within 60 days after the arrival of the first long-term TA team member in Mozambique. This plan is expected to be developed in collaboration with the CTO and should describe: the grant solicitation process, grant oversight responsibility, and evaluation of grant results.

F.3.2 MONITORING AND EVALUATION

F.3.2.1 Performance Monitoring Plan

Expected program results with illustrative indicators are provided in this task order document. However, during the initial program planning period and within the first 60 days after the arrival of the first long-term TA team member in Mozambique, the contractor shall work closely with the NMCP and the PMI team to select final indicators, establish and/or select baseline data and performance targets for each indicator, and finalize a Performance Monitoring Plan (PMP), based on the MOP, which monitors progress towards achieving results. The PMP will be developed in accordance with USAID guidelines. To the extent it is

possible, performance-monitoring systems will be integrated into, and will enhance existing MOH management information systems.

The PMI and NMCP teams and the contractor will conduct monthly meetings to monitor the progress of work and identify and resolve constraints. There will also be bi-annual joint USAID/MOH performance reviews involving all USAID funded health partners to monitor the achievement of results based on the targets specified in the PMP and MOH expected results.

F.3.2.2 Six Monthly Performance Monitoring Reports

All Performance Monitoring Reporting will be in a format compatible with USAID's format of the Mission's Annual Performance Report to USAID/Washington. The report shall discuss progress against the Performance Monitoring Plan, results achieved, constraints affecting implementation and proposed solutions.

Performance monitoring reports will include program outcomes, and results based on the three-year strategic plan, annual action plans, and the indicators and targets in the MOP. As specified in these plans, the data for performance monitoring may be from a variety of sources, including: (i) the MOH HIS; (ii) facility and community level assessments; (iii) field visits; (iv) other relevant analyses and reports; and (v) the Contractor's primary monitoring and reporting system for this Task Order. Every six months the contractor shall report against appropriate indicators included in the PMP. These reports should not exceed ten pages (refer to attached sample report format).

The Performance Monitoring Report format should contain at a minimum the following information:

- Activities and interventions implemented in last six months;
- Reported Results;
- Planned activities and interventions for next six months;
- Expected future results;
- Performance;
- Compelling individual-level success stories; and
- Documentation of better practices that can be replicated or taken to scale.

F.3.2.3 Monthly Performance Reports

The Monthly Performance Reports shall discuss progress against the Annual Action Plan (F.3.1.2), results achieved, constraints affecting implementation and proposed solutions. The report shall also address whether and how constraints reported in previous reports have been addressed and resolved and shall also include discussion of activities and events planned for the next month.

Monthly Performance Reports will include program activities, outcomes, and results based on the three-year strategic plan, annual action plans, and the indicators and targets in the SO 8 Performance Monitoring Plan. These reports should not exceed two pages (refer to attached sample report format).

The Monthly Performance Report format should contain at a minimum the following information:

- Progress (achievements) and financial resources expended by activity since the last report;
- Problems described in previous report solved or still outstanding and intentions to address outstanding problems;
- New problems encountered since previous report;
- Proposed solutions to outstanding and new problems; and
- Plan for next month.

F.3.2.4 Final Task Order Report:

This final report will highlight major successes achieved during the Task Order period with reference to established objectives and indicators, and should also discuss any shortcomings and/or constraints encountered. The Contractor will submit a detailed final report within 60 days of completion of the Task Order which includes:

- A financial report detailing how funds were expended, by line item;
- A summary of the accomplishments against work plans, giving the final tangible results; and
- A summary of deliverables/benchmarks, addressing lessons learned during implementation and suggesting ways to resolve constraints identified.

F.3.3 FINANCIAL REPORTING

Financial Status Report information will be provided in a functional format to allow an examination of the cost of carrying out major action plan activities rather than simply providing conventional "budget categories" for major expenditures.

Fifteen days before the end of each calendar quarter, the contractor shall submit a detailed quarterly financial report with separate line items illustrating all vouchered and accrued monthly expenses. The report should contain at a minimum the following information:

- Total life-of contract budget;
- Total funds awarded to date;
- Total funds expended by the Applicant to date, including direct and indirect administrative costs;
- Total expended (actual plus estimated accrued)
- Estimated expenditures for remainder of year; and

F.3.4 MISCELLANEOUS REPORTING REQUIREMENTS

Implementation problems: The Contractor shall immediately report to the USAID Contracting Officer and the Cognizant Technical Officer any implementation problems affecting work quality, price or delivery schedules.

Document specifications: All plans, reports and other documentation prepared under this Task Order shall be provided in English as a finished document both in hard copy and electronically. Documents will be prepared in Microsoft Word, Microsoft Excel and/or Microsoft PowerPoint. All project planning is encouraged to be done using Microsoft Project Planning.

Report of USAID-funded property: In accordance with USAID acquisition regulations, the Contractor is required to submit Annual Inventory Reports of all non-expendable, USAID-funded property in the Contractor's custody (based on the calendar year). Copies will be submitted to USAID/Mozambique.

F.4 PERIODIC PROGRESS REPORTS (July 1998) (CIB 98-21)

(a) The Contractor shall prepare and submit progress reports as specified in Section F.3 of this task order. These reports are separate from the interim and final performance evaluation reports prepared by USAID in accordance with (48 CFR) FAR 42.15 and internal Agency procedures, but they may be used by USAID personnel or their authorized representatives when evaluating the Contractor's performance.

(b) During any delay in furnishing a progress report required under this contract, the Contracting Officer may withhold from payment an amount not to exceed US$25,000 (or local currency equivalent) or 5 percent of the amount of this contract, whichever is less, until such time as the Contracting Officer determines that the delay no longer has a detrimental effect on the Government's ability to monitor the Contractor's progress.

F.5 AIDAR 752.7005 SUBMISSION REQUIREMENTS FOR DEVELOPMENT EXPERIENCE DOCUMENTS (JAN 2004) (AAPD 04-06)

(a) Contract Reports and Information/Intellectual Products.

(1) The Contractor shall submit to USAID's Development Experience Clearinghouse (DEC) copies of reports and information products which describe, communicate or organize program/project development assistance activities, methods, technologies, management, research, results and experience as outlined in the Agency's ADS Chapter 540. Information may be obtained from the Cognizant Technical Officer (CTO).

These reports include: assessments, evaluations, studies, development experience documents, technical reports and annual reports. The Contractor shall also submit to copies of information products including training materials, publications, databases, computer software programs, videos and other intellectual deliverable materials required under the Contract Schedule. Time-sensitive materials such as newsletters, brochures, bulletins or periodic reports covering periods of less than a year are not to be submitted.

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

(b) Submission requirements.

(1) Distribution.

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

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

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

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

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

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

(2) Format.

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

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

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

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

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

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

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

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

END OF SECTION F

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1 CONTRACTING OFFICER'S AUTHORITY

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

G.2 TECHNICAL DIRECTION

Technical Directions during the performance of this task order shall be provided by the CTO as indicated in the CTO designation letter.

G.3 ACCEPTANCE AND APPROVAL

In order to receive payment, all deliverables as defined under Section F.3, must be accepted and approved by the CTO.

G.4 INVOICES

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to the Financial Management Office at USAID/Mozambique. One copy of the voucher and the invoice shall also be submitted to the Contracting Officer and the CTO.

The SF-1034 must be signed, and it must be submitted along with the invoice and any other documentation in Adobe.

Paper Invoices shall be sent to the following address:

Local Address:

USAID/Mozambique,
Office of Financial Management
JAT Complex
Rua 1231, No. 41
Bairro Central "C"
Maputo
Mozambique

US Pouch Address:

USAID/Mozambique
Financial Management Office
2330 Maputo Place
Washington, D.C. 20521-2330
USA

SECTION H – SPECIAL TASK ORDER REQUIREMENTS

H.1 KEY PERSONNEL

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

H.2 PLACE OF PERFORMANCE

The place of performance under this task order is Mozambique, as specified in the Statement of Work.

H.3 AUTHORIZED WORK DAY/WEEK

A 6-day workweek is hereby authorized. No overtime or premium pay is authorized under this task order.

H.4 LANGUAGE REQUIREMENTS

All deliverables shall be produced in English (and in Portuguese upon request by the CTO).

H.5 AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services under this order is 935.

H.6 GOVERNMENT FURNISHED FACILITIES OR PROPERTY

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

H.7 CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY

All reports generated and data collected during this project shall be considered the property of USAID and shall not be reproduced, disseminated or discussed in open forum, other than for the purposes of completing the tasks described in this document, without the express written approval of a duly-authorized representative of USAID. All findings, conclusions and recommendations shall be considered confidential and proprietary.

H.8 CONTRACTOR'S STAFF SUPPORT, AND ADMINISTRATIVE AND LOGISTICS ARRANGEMENTS

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

H.9 AIDAR 752.7004 EMERGENCY LOCATOR INFORMATION (JUL 1997)

The Contractor agrees to provide the following information to the Mission Administrative Officer on or before the arrival in the host country of every contract employee or dependent:

(1) The individual's full name, home address, and telephone number.

(2) The name and number of the contract, and whether the individual is an employee or dependent.

(3) The Contractor's name, home office address, and telephone number, including any after-hours emergency number(s), and the name of the Contractor's home office staff member having administrative responsibility for the contract.

(4) The name, address, and telephone number(s) of each individual's next of kin.

(5) Any special instructions pertaining to emergency situations such as power of attorney designees or alternate contact persons.

H.10 INSURANCE AND SERVICES

(a) Pursuant to AIDAR 752.228-3 Worker's Compensation Insurance (Defense Base Act);

USAID's DBA insurance carrier is:

Rutherfoord International, Inc.
5500 Cherokee Avenue, Suite 300
Alexandria, VA 22312

Points of Contact:
Diane Proctor or Dalia Shontere
(703) 813-6503
(703) 354-0370 Telefax:
E-Mail: www.rutherfoord.com: Hours of Operation are: 8 a.m. to 5 p.m. (EST)

(b) Contractor's are responsible for providing medical evacuation coverage for their employees. The following State Department website, http://www.state.gov/m/dghr/flo/24051.htm, provides possible sources from which MEDAVAC coverage may be obtained. USAID does not endorse any of the listed sources. Medical evacuation costs are allowable as a direct cost.

H.11 NONEXPENDABLE PROPERTY PURCHASES AND INFORMATION TECHNOLOGY RESOURCES

The Contractor is hereby authorized to purchase the following equipment and/or resources:

4 x four-wheel drive vehicles.

H.12 AIDAR 752.7032 INTERNATIONAL TRAVEL APPROVAL AND NOTIFICATION REQUIREMENTS AND AIDAR 752.7027 PERSONNEL

In accordance with the above clauses, the Contracting Officer hereby provides prior written approval for international travel, provided that concurrence with the assignment of individuals outside the United States is obtained by the Task order, in writing, from the CTO prior to their assignment abroad, which must be within the terms of this task order, is subject to availability of funds, and should not be construed as authorization either to increase the estimated cost or to exceed the obligated amount. The Contractor shall retain for audit purposes a copy of each travel concurrence.

H.13 DISCLOSURE OF INFORMATION

(a) Contractors are reminded that information furnished under this solicitation may be subject to disclosure under the Freedom of Information Act (FOIA). Therefore, all items that are confidential to business, or contain trade secrets, proprietary, or personnel information must be clearly marked. Marking of items will not necessarily preclude disclosure when the U.S. Office of Personnel Management (OPM or The Government) determines disclosure is warranted by FOIA. However, if such items are not marked, all information contained within the submitted documents will be deemed to be releasable.

(b) Any information made available to the Contractor by the Government must be used only for the purpose of carrying out the provisions of this contract and must not be divulged or made known in any manner to any person except as may be necessary in the performance of the contract.

(c) In performance of this contract, the Contractor assumes responsibility for protection of the confidentiality of Government records and must ensure that all work performed by its subcontractors shall be under the supervision of the Contractor or the Contractor's responsible employees.

(d) Each officer or employee of the Contractor or any of its subcontractors to whom any Government record may be made available or disclosed must be notified in writing by the Contractor that information disclosed to such officer or employee can be used only for a purpose and to the extent authorized herein, and that further disclosure of any such information, by any means, for a purpose or to an extent unauthorized herein, may subject the offender to criminal sanctions imposed by 19 U.S.C. 641. That section provides, in pertinent part, that whoever knowingly converts to their use or the use of another, or without authority, sells, conveys, or disposes of any record of the United States or whoever receives the same with intent to convert it to their use or gain, knowing it to have been converted, shall be guilty of a crime punishable by a fine of up to $10,000, or imprisoned up to ten years, or both.

H.14 SECTION 508 COMPLIANCE

Section 508 refers to Section 508 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794d). Section 508 assessments are required of all systems and are intended to ensure that individuals with disabilities have comparable access to and use of information and data comparable to the access provided to individuals without disabilities (unless this would pose an undo burden on the Federal Agency). The assessment is not to include physical access at any defined-benefit technology solution-related site. The 508 assessment shall be performed by OPM. The successful Offeror must make accessible to the Government, or its designee, information systems residing in the Offeror's (or as appropriate sub-Offeror's) facilities that support the operations and assets of the Government as part of this contract, so that the 508 assessment may be performed.

All Electronic and Information Technology (EIT) procured through this RFTOP must meet the applicable accessibility standards at 29 USC 794d and 36 CFR 1194, unless an exception to this requirement exists as determined by the Government. See 29 USC 794d at http://www.section508.gov/index.cfm?Fuseaction=Content&ID=12, and 36 CFR 1194 implementation Section 508 of the Rehabilitation Act of 1973, as amended, at http://www.access-board.gov/sec508/508 standards.htm - PART 1194).

The following standards are applicable to this procurement:

1. 1194.21 Software applications and operating systems.
2. 1194.22 Web-based intranet and Internet information and applications.
3. 1194.23 Telecommunications products.
4. 1194.24 Video and multimedia products.
5. 1194.31 Functional performance criteria.
6. 1194.41 Information, documentation and support.

NOTE: The 508 standards do not require the installation of specific accessibility-related software or the attachment of an assistive technology device, but require that the EIT be compatible with such software and devices so that it can be made accessible if so required by the agency in the future.

H.15 REPORTING ON TAXATION OF U.S. FOREIGN ASSISTANCE (2003)

(a) Reporting of Foreign Taxes. The Contractor must annually submit a final report by April 16 of the next year.

(b) Contents of Report. The reports must contain:

(i) Contractor name.
(ii) Contact name with phone, fax and e-mail.
(iii) Agreement number(s).
(iv) Amount of foreign taxes assessed by a foreign government [each foreign government must be listed separately] on commodity purchase transactions valued at $500 or more financed with U.S. foreign assistance funds under this agreement during the prior U.S. fiscal year.

(v) Only foreign taxes assessed by the foreign government in the country receiving US assistance is to be reported. Foreign taxes by a third party foreign government are not to be reported. For example, if an assistance program for Lesotho involves the purchase of commodities in South Africa using foreign assistance funds, any taxes imposed by South Africa would not be reported in the report for Lesotho (or South Africa).
(vi) Any reimbursements received by the Contractor during the period in (iv) regardless of when the foreign tax was assessed plus, for the interim report, any reimbursements on the taxes reported in (iv) received by the Contractor through October 31 and for the final report, any reimbursements on the taxes reported in (iv) received through March 31.
(vii) The final report is an updated cumulative report of the interim report.
(viii) Reports are required even if the Contractor did not pay any taxes during the report period.
(ix) Cumulative reports may be provided if the Contractor is implementing more than one program in a foreign country.

(c) Definitions. For purposes of this clause:

(i) "Agreement" includes USAID direct and country contracts, grants, cooperative agreements and interagency agreements.
(ii) "Commodity" means any material, article, supply, goods, or equipment.
(iii) "Foreign government" includes any foreign governmental entity.
(iv) "Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

(d) Where. Submit the reports to: Cognizant Technical Officer, USAID/Mozambique

(e) Subagreements. The Contractor must include this reporting requirement in all applicable subcontracts, subgrants and other subagreements.

(f) For further information see http://www.state.gov/m/rm/c10443.htm.

H.16 EXECUTIVE ORDER ON TERRORISM FINANCING

The Contractor is reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the Contractor/Recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts issued under this task order.

H.17 AIDAR 722.170 EMPLOYMENT OF THIRD COUNTRY NATIONALS (TCN'S) AND COOPERATING COUNTRY NATIONALS (CCN'S)

(a) General. It is USAID policy that cooperating country nationals (CCN'S) and third country nationals (TCN's), who are hired abroad for work in a cooperating country under USAID-direct contracts, generally be extended the same benefits, and be subject to the same restrictions as TCN's and CCN's employed as direct hires by the USAID Mission. Exceptions to this policy may be granted either by the Mission Director or the Assistant Administrator having program responsibility for the project. (TCN's and CCN's who are hired to work in the United States shall be extended benefits and subject to restrictions on the same basis as U.S. citizens who work in the United States.)

(b) Compensation. Compensation, including merit or promotion increases paid to TCN's and CCN's may not, without the approval of the Mission Director or the Assistant Administrator having program responsibility for the project, exceed the prevailing compensation paid to personnel performing comparable work in the cooperating country as determined by the USAID Mission. Unless otherwise authorized by the Mission Director or the Assistant Administrator having program responsibility for the project, the compensation of such TCN and CCN employees shall be paid in the currency of the cooperating country.

(c) Allowances and differentials. TCN's and CCN's, hired abroad for work in a cooperating country, are not eligible for allowances or differentials under USAID-direct contracts, unless authorized by the Mission Director or the Assistant Administrator having program responsibility for the project.

(d) Country and security clearances. The contractor shall insure that the necessary clearances, including security clearances, if required, have been obtained for TCN and CCN employees in accordance with any such requirements set forth in the contract or required by the USAID Mission, prior to the TCN or CCN starting work under the contract.

(e) Physical fitness. Contractors are required to insure that prospective TCN and CCN employees are examined prior to employment to determine whether the prospective employee meets the minimum physical requirements of the position and is free from any contagious disease.

(f) Workweek, holidays, and leave. The workweek, holidays, and leave for TCN and CCN employees shall be the same as for all other employees of the contractor, under the terms of the contract; however, TCN and CCN employees are not eligible for home leave or military leave unless authorized by the Mission Director or the Assistant Administrator having program responsibility for the project.

(g) Travel and transportation for TCN's and CCN's. Travel and transportation shall be provided TCN and CCN employees on the same basis as for all other employees of the contractor, under the terms of the contract.

(h) Household effects and motor vehicles. USAID will not provide household effects to TCN and CCN employees; such employees may ship their household effects and motor vehicles to their place of employment on the same basis as for all other employees of the contractor, under the terms of the contract unless they are residents of the cooperating country.

H.18 CONSENT TO SUBCONTRACT

The contractor is authorized to subcontract with Malaria Consortium.

END OF SECTION H

SECTION I – CONTRACT CLAUSES

All FAR and AIDAR clauses in the IQC Contract Number GHS-I-00-07-00004-00 in full text or incorporated by reference shall apply to this task order.

END OF SECTION