ATTACHMENT 1

BASICS III
STATEMENT OF WORK
FOR TASK ORDER NO. 01
UNDER IQC NO. GHA-I-00-04-00002-00

TASK ORDER 1 (TO1)

IR 1 (80% FS/20% GH) *Estimated 90% of total activities*
A. Increased use of proven child health and nutrition interventions, achieved through on-the-ground **programming** in countries
B. Increased use of proven child health and nutrition interventions achieved through technical assistance to GH, Regional Bureaus, and Missions

IR 2 (90% GH/10%FS) *Estimated 10% or total activities*
A. Global leadership and policy for child health advanced
B. Approaches to increase the scale and impact of child health and nutrition interventions identified and applied

1. TASK ORDER 1: INTERMEDIATE RESULTS

Intermediate Result 1: Increased use of proven child health and nutrition interventions.

A. The contractor will work within the strategic frameworks of USAID's Bureaus and Missions, both directly and,

B. Through technical assistance to other mechanisms such as USAID Mission projects and NGOs to increase use of proven child health and nutrition interventions.

In A and B, the contractor, in collaboration with Missions and through a negotiated process with BGH, will define specific, quantifiable performance results in terms of Mission Intermediate Results. The results will include the corresponding indicators for the use of proven child health and nutrition interventions. In specific cases, as

part of a USAID programming initiative, USAID/Washington may direct the contractor to provide core funding to programs of USAID Missions. These programs will be designed to achieve population-based public health impact with proven child health interventions.

Intermediate Result 2: Global Leadership in child health and improved approaches to increase coverage.

A. The contractor will advance policy and global leadership for child health.

B. The contractor will identify, apply, and transfer efficient and effective approaches and strategies for achieving improved coverage and greater impact for child health and nutrition interventions.

This intermediate result, approximately ten percent of the overall activities of the project, will be funded largely by USAID Washington. The contractor will provide services to USAID/Washington and Missions for international and national forums and global and national advocacy activities and for formulating and implementing child health policies. The contractor will identify, apply and evaluate approaches to improve coverage of country programs, either directly with USAID support or through partnerships with other donors and organizations. This will include, but not be limited to, the development of effective approaches to reach the poor and other groups often unreached by current programming approaches as well as approaches that increase the effectiveness of private sector and PVO participation in delivery of child health and nutrition-related goods, services, and information.

a) New Office-wide Requirements for TO1

Monitoring & Evaluation: The contractor will be responsible for monitoring progress toward the milestones of the activities carried out within Mission or Bureau frameworks, as laid out in multi-year implementation plans developed with the responsible Mission or Bureau and reviewed and approved by the Cognizant Technical Officer (CTO). These multi-year plans will specify the expected changes and scale of coverage, quality, and/or capacity outcomes that will be realized through the project's investments and the means by which these outcome changes will be measured. The contractor, however, will not necessarily be responsible for measuring these outcome changes. This measurement typically will be carried out through other USAID-funded projects (e.g., MEASURE DHS) or partner-supported mechanisms such as UNICEF's Multiple Indicator Cluster Surveys (MICS). The contractor will be responsible for coordination with the designated mechanism that will collect the country-level impact data through joint workplans and synchronized planning. In limited cases, the contractor may be responsible for collecting country-level impact data.

Operations Research: TO1 will not be responsible for a significant amount of operations research. Under TO1 the contractor may be asked

to apply small scale operations research in the context of improving specific elements of country programs. It also may be asked to participate in specific collaborations aimed at establishing new approaches to increase the coverage and impact of child survival interventions with reasonable costs. In this capacity, TO1 will work in close collaboration with the Child Health Research Project (HARP).

New Categories of Staff: Overall, the contractor will have a smaller number of staff in comparison with USAID's previous child survival contract, BASICS II. The staff will respond to the categories of "lead," "supportive," and "on-demand" competencies for the activity. Lead, supportive and on-demand competencies for each technical area are identified below. The contractor is expected to provide highly experienced senior staff in all lead areas. Supportive competencies are areas where the contractor is expected to provide a lesser level of senior staff effort, which will be applied in close collaboration with other USAID collaborating agencies that will take the lead in this area, for example, LINKAGES in the case of breastfeeding. On-demand competencies are areas where the contractor is not expected to provide permanent staff but where the contractor is expected to be able to access staff on demand (short term and longer term) through its own staff not assigned to TO1 or through sub-contractors or other mechanisms.

Incorporation of Behavior Change: Under the previous child health framework, the CHANGE project was a separately procured and awarded cooperative agreement. Its objective was to assist USAID maternal and child health programs by developing and testing approaches to change individual, community and institutional behaviors as a key component of achieving public health impact. Under this contract, efforts under component B of Result 2 will be directed towards identifying, adapting, applying, and transferring behavioral approaches to increase coverage of child health interventions and achieve greater public health impact. The contractor is expected to incorporate an individual, community and institutional behavioral analysis and strategy as a part of all its child health programs.

Strategic Experience Transfer: Although the contractor largely will be held responsible for country-level impacts as defined by the frameworks of the USAID Missions with which it works, it also will be held responsible for participating in the process of transferring the experiences gained by the country-level programs to other USAID Missions, NGOs, partners and donors, and especially to and from USAID-supported bilaterals. This transfer will take the form primarily of participation in selected events, exchanges with other countries, appropriate "packaging of the experience" and selected technical assistance to implement experiences in other venues, rather than in the form of publications. This focus on strategic experience transfer should be part of all country-level work, although additional costs of transfer largely will be funded through core funds.

2. TASK ORDER 01 TECHNICAL/PROGRAM AREAS

USAID's Bureau for Global Health has identified strategic and intermediate results and priority areas where it will focus its investment and efforts. In the role of technical partner and source of technical assistance to BGH's global technical leadership function, the contractor will focus its efforts in these priority areas. These priority areas are identified in the following text. From time to time, in response to the evolving child survival environment, additional priority areas may be identified and agreed upon.

By focusing on priority areas of proven child survival interventions, it is understood that the contractor's programs and activities will consist to a great extent of actions that also strengthen the health systems of countries. Community delivery of antibiotics for ARI, for example, cannot succeed without strengthening human capacity development through health worker and volunteer training and ensuring that antibiotics are of good quality and available. The strengthening of multi-level health systems as the platform to deliver proven child survival interventions is a core element of USAID's approach to sustainable improvements in child health. Similarly, the promotion and facilitation of key behaviors that improve child health and nutrition is a core element of USAID's approach.

Likewise, the technical intervention areas described below should not be viewed as stand-alone, vertical programs but as elements of a more complex web of integrated child health services, adapted to the local context. One of the many differences between TO1 and the BASICS II contract is the absence of a technical intervention specifically entitled, "Integrated approaches to child health," or the like. This absence is not intended to convey the message that integration is no longer important to BGH, but precisely the opposite: since the start of BASICS II, the principle of integration has evolved to the point that its value in child health programming is no longer questioned.

In support of the program objectives of other USAID bureaus and field Missions, the contractor is expected to provide technical expertise and assistance for implementation in essentially the same technical areas as they are for BGH. The objectives and program strategies of field support or task orders from other bureaus and field Missions, however, on occasion may differ from those of BGH. Work in these technical areas, funded by other bureaus and field Missions, may involve a broader range of technical assistance, program activities, and competencies, funded in separate task orders or through field support in TO1.

USAID's approach recognizes the important role and contribution of PVOs in implementing key child health and nutrition strategies at the household, community and facility levels. During the course of TO1, the contractor will be expected to collaborate with and provide technical support to PVOs in these priority areas, to provide training

and access to the latest information, and to utilize the learning and experiences of PVOs in community-based approaches to expand coverage at regional and national levels.

a) Accelerating Child Survival - MDGs and the post-Ottawa movement

In 2003, in response to the analyses presented in The Lancet articles regarding the "unfinished agenda" of global child survival, USAID/BGH co-hosted with the Canadian International Development Agency (CIDA) and the Government of Uganda a meeting of donors, international agencies, and developing countries. The meeting took place in Ottawa and examined options for accelerating progress toward the Millennium Development Goal (MDG) for Child Survival (2/3 reduction in under-5 mortality by 2015). From this meeting an informal multi-partner Working Group formed to define and support coordinated approaches to achieve greater child health and nutrition impact in selected countries. The BASICS II Project provided technical, analytical, and administrative support to the early activities of this Working Group. It is expected that under TO1 the contractor will continue to provide such support at the request of BGH, in the context of Result 2.A.

Lead Competencies

BGH expects that the contractor will be called upon to work with GH and partners to support future activities of the Working Group. In addition to the types of support already provided, this support may include such country-oriented activities as fielding teams to carry out assessments and planning exercises, performance of policy-level analyses and short- and medium-term consultants working with, or within, partner organizations and/or the secretariat of the Working Group, as well as possible secondments of one or more staff to partner organizations or the secretariat.

b) Diarrheal Diseases

Lead Competencies

The contractor will be GH's lead technical assistance partner in maintaining and/or increasing use of Oral Rehydration Therapy (ORT) which includes use of oral rehydration solution (ORS), recommended home fluids, and increased fluids, all with continued feeding during illness. The contractor also will play an important role in USAID's participation in the introduction of zinc therapy for diarrhea, in line with recently revised international program guidance.

ORT remains an effective intervention to prevent death from acute dehydrating diarrhea, which has saved millions of children's lives. In the face of evidence that use of ORT has not been maintained in several countries where it previously was very high (e.g. Peru), BGH considers this to be an area of high priority. BGH expects to focus on guiding Field Mission investment towards successful strategies and working with partners to assure continued attention to effective

implementation of ORT in households, communities, health systems, and the private sector. Additional resources will be invested in zinc therapy introduction and scale up, in part through TO1. BGH expects the contractor to provide technical assistance and support to its own efforts and to other bureaus and field Missions in this effort.

Activities are likely to include:

- collaboration with RPM Plus and other partners in the collection and analysis of data on trends in ORT availability and use
- technical assistance to country-level health program activities, including Missions' bilateral health activities, social marketing, and behavior change/communication programs
- promoting ORT through diverse program vehicles, including integrated approaches such as IMCI and C-IMCI
- advocating for increased emphasis on ORT by partners in their related program activities;
- reinvigorating commercial approaches to Oral Rehydration Solution (ORS), particularly reduced-osmolarity ORS, where appropriate
- cooperation with HARP and other partners in the introduction of zinc as therapy for diarrheal illness, based upon ongoing USAID partnerships with WHO, the International Centre for Diarrhoeal Disease Research Bangladesh (ICDDR-B), and private sector manufacturers and marketers
- exploring with the Office of Foreign Disaster Assistance (OFDA) the more effective use of ORT in conflict and refugee settings

On-Demand Competencies

The contractor may be called upon to provide on-demand assistance in other areas related to prevention and treatment of childhood diarrheal diseases. Among these are:

- hand washing, hygiene and household water quality improvement, including the provision of technical inputs into planned expanded USAID investment in the Centers for Disease Control (CDC) - developed "point-of-use disinfection" approach
- promotion of hand washing and hygiene as elements of household and community programming approaches and private sector collaboration
- diagnosis and management of bacillary dysentery, especially in vulnerable populations

c) Pneumonia

Lead Competencies

The contractor will be GH's lead technical assistance partner in expanding appropriate care-seeking and treatment for pneumonia, especially through community-based approaches.

In response to a second global evaluation of evidence supporting the safety and effectiveness of antibiotic treatment of child pneumonia by adequately trained and supervised community health workers, USAID and UNICEF, with BASICS II, launched a New Activity for Child Health with the Government of Senegal. This activity drew heavily upon the tools, methods, and indicators developed through the USAID-supported program in Nepal. USAID intends to continue and expand this activity in Senegal and carry out collaborative community-based pneumonia treatment activities in additional countries. This line of work will be a collaborative initiative with UNICEF and other partners with the intention of achieving widespread increase in coverage in countries with low access to health services and stimulating broader investment by countries and global partners in expanding effective antibiotic treatment of child pneumonia.

BGH anticipates that the contractor will play a key role in the further development and implementation of this initiative. In countries in which malaria is also a major cause of morbidity, mortality, and care-seeking for children, GH expects that the efforts to expand appropriate care-seeking and treatment for pneumonia will be linked with efforts to expand appropriate treatment of children with malaria/febrile illness. This linkage will likely include defining appropriate responses to overlapping clinical presentations, incorporating improved treatment for either malaria or pneumonia, and developing appropriate linkages to health services, especially for children with very severe illness. At the policy level, expanding effective antibiotic treatment will require a push similar to that Roll Back Malaria (RBM) provided for treatment of malaria. Key activities in which GH expects the contractor to play an important technical role include:

- improving the country-level policy environment to allow community-level use of appropriate drugs to treat pneumonia (and malaria) in children
- expanding Community Health Worker-based approaches in selected countries, including improving training, incentives, monitoring, and links to the health system needed to ensure long-term success of these approaches
- working with UNICEF and other partners to develop international and national commitment, approaches, and resources for aggressively expanded effective treatment of child pneumonia
- working with RPM Plus and other partners to ensure availability of antibiotics and antimalarials through improved pharmaceutical management practices

On-Demand Competencies

The contractor may be called on to provide on-demand competencies in other areas related to prevention and treatment of childhood pneumonia. Among these are:

- partnership with HARP in the introduction of zinc as therapy for pneumonia/ARI, if ongoing research supports this approach
- improvement of indoor air quality/reduction of household smoke, as a part of efforts to reduce morbidity in countries where this programming approach is being supported

d) Nutrition

Lead Competencies

The contractor will be GH's lead technical assistance partner in expanding effective and scalable nutrition program approaches.

Through its project activities and cooperation with countries, Missions, and other partners, GH has become a leader in developing and defining programmatic approaches to improving overall child nutrition, integrated with child health program activities, implemented at scale as elements of national program approaches, and replicated in other countries. The contractor will build on this experience and further expand and replicate these approaches in ways that promote improved nutritional status and health of children. Specific program approaches that GH expects the contractor to help expand include Community-Based Growth Promotion (CBGP) and Essential Nutrition Actions (ENA). Other approaches that potentially fit into this category include Community Therapeutic Care, of which Positive Deviance - Hearth is one example. Key activities in which GH expects the contractor to play an important technical assistance role include:

- assessment of the appropriateness of specific nutrition programming approaches for a particular country or setting, and adaptation and application of the best program approaches
- evaluation of the possibility of an effective approach to implementation of CBGP in Sub-Saharan Africa settings
- implementation and quality control of basic program elements, including training, monitoring, supervision, links to health systems, and performance of community counselors and health workers
- collaboration with international partners in consolidating experience with nutrition approaches
- incorporation of these nutrition approaches in regional and global program and investment strategies

Support Competencies

The contractor will be expected to have competencies in several additional areas of nutrition as part of their full-time technical expertise. While the project will not have the technical lead in these supportive areas they will need to apply competency in these areas in interaction with other USAID cooperating agencies and partners and to incorporate these nutrition areas into broader child survival programming. These competencies do not necessarily require

additional nutrition staff. They may be met by having them be part of the competencies of the project's full-time nutrition staff. Further expertise may be required on-demand.

Areas in which USAID anticipates requiring supportive competency in nutrition include:

- promotion of breastfeeding and appropriate complementary feeding at both health service and household/community levels
- micronutrient supplementation, especially related to vitamin A, iron, and, potentially, zinc, as elements of child health programs at both health service and family/community levels, and the linkage of micronutrient delivery to delivery of other child survival interventions

e) Newborn survival and health

Lead Competencies

The contractor will be GH's lead technical assistance partner in developing approaches, documenting, and expanding improved care of well and sick newborns.

USAID is part of a global effort to develop, evaluate, and expand approaches to reduce illness and death among newborn infants. For several years, various components of USAID - including BGH, regional bureaus, and a number of Missions - have been working with various cooperating agencies, major PVO partners (such as Save the Children and CARE), central and regional offices of WHO, and other international partners to implement, evaluate, and expand the availability and use of effective interventions to improve neonatal health and survival. For USAID, significant effort has been directed at households and communities, recognizing that the majority of high-risk births occur, and the majority of newborns live, in settings where adequate maternal and neonatal health services are not available or utilized. At the same time, efforts to improve the availability, use, and quality of such services in the public and private sector continue to be an important component of USAID's overall approach.

Some of the key interventions that affect newborn outcomes need to be delivered to women before and during pregnancy, labor, and delivery. These will not be expected to be part of the core competency of the contractor. Other interventions, however, need to be provided to the newborn, beginning at the moment of birth and continuing through the first weeks of life. Among these newborn interventions are: stimulation and resuscitation; adequate attention to warmth and cord care; immediate and exclusive breastfeeding, and hygiene. They also include recognition, appropriate care seeking and best possible care for life-threatening neonatal infections and other complications, as well as best possible care for low birth weight and premature infants.

These interventions may be linked to other interventions such as post-partum maternal care or hepatitis B immunization.

USAID expects the contractor to have core competence in those interventions for improving neonatal outcomes that focus on care of the newborn itself (versus those that concentrate on antenatal factors or delivery capabilities). In these interventions - especially those focused on the first hours and days of life - the contractor will share responsibility for core competence with BGH's new maternal and newborn health project (ACCESS). In this way, both country programs that approach the newborn from the maternal side as well as those that approach the newborn from the child survival side can access adequate technical assistance for their program approaches. Activities in which the contractor is likely to be called upon to provide technical assistance and support include:

- developing policies, strategies, and plans to improve neonatal health and survival for countries and partners
- implementation, evaluation and expansion of program approaches
- technical inputs to international and regional forums analyzing the situation of newborns and promulgating effective approaches to improve outcomes
- defining appropriate actions for households, communities, and different levels of health systems, and demonstrating effective linkages among these elements

f) HIV/AIDS

Lead Competencies

Many potentially HIV-exposed and HIV-infected children will be born in circumstances where HIV status will not be known and special care capability will be limited. Here the approach to child nutrition, health, and development must be adapted to the resources of services, communities, and families in different and changing settings. The contractor will be BGH's lead technical assistance partner in developing and implementing child health strategies for potentially HIV-exposed and HIV-infected children in collaboration with the lead partners within the Office of HIV/AIDS.

Response to the health needs of potentially HIV-exposed and HIV-infected children includes:

- routine care for nutrition, health, and development
- treatment of common childhood illnesses
- supplemental care and treatment for children known or suspected to be HIV-exposed or HIV-infected
- care of the child with AIDS

For the many children living in HIV-prevalent communities where maternal and child HIV status is unknown, the key to improved nutrition, health, and development outcomes is strengthening basic care through families, communities, and existing health services. Exclusive breastfeeding and appropriate complementary feeding, basic immunization, vitamin A supplementation, and sleeping under ITNs in malaria-endemic areas benefit all children, and especially those who are HIV-exposed or HIV-infected. Active community-based growth promotion and care programs for children, regardless of HIV status, have the potential to improve nutrition and developmental outcomes. They also provide a platform for outreach services such as immunization and vitamin A supplementation, and for promotion of improved child care practices. Another key set of practices to be promoted relates to personal and domestic hygiene, especially in conjunction with water and sanitation improvements, since diarrheal illness is more common and prolonged among HIV-positive children and is a major contributor to malnutrition.

Whether children are HIV status is known or not, effective treatment of routine illness will be important for HIV-exposed and HIV-infected children. For affected communities, access to high quality routine primary care, including drugs and commodities, is especially important and is expected to assume a more prominent role as programs evolve. Where public sector health service capabilities are limited, community-based approaches and interaction with private sector health care providers may be effective ways of providing basic services and advice.

At the same time, all health care providers in HIV-prevalent areas require guidance and training on clinical indications for suspecting immune deficiency in a child and on appropriate management of known or suspected HIV-positive children. This guidance and training should include special care, such as cotrimoxazole prophylaxis for Pneumocystis carinii pneumonia, special supplementation and nutritional guidance, and suspicion and treatment of opportunistic infections, as feasible. Such children should be candidates for HIV testing and sustained anti-retroviral therapy, once appropriate pediatric regimens for developing countries have been established and become available. Referral level facilities should, if possible, provide HIV testing for children presenting with conditions potentially associated with HIV infection (such as generalized adenopathy, severe malnutrition, pneumonia unresponsive to first-line treatment, persistent diarrhea, or oral candidiasis). Health care service-based interventions for known or suspected HIV-infected children and for children known or suspected to have AIDS will need to be linked to community-based approaches to care of these children and support of their families.

These program interventions will need to be supported by the development and clear communication of policies and guidelines related to care, treatment, and support of children in HIV-prevalent communities. Because confusion regarding HIV infection in children,

concern about stigma, and other considerations may lead families to seek information and care from inadequate, ineffective and even harmful sources, active multi-channel communication and information programs should be developed to support appropriate care for child nutrition, health, and development in HIV-prevalent countries. Systems strengthening activities are also essential to ensure that necessary pharmaceuticals and commodities of adequate quality are available and appropriately used.

Support Competencies

The growing interaction of HIV with child health outcomes - directly and through its effects on services, communities, policies, and capacity - demands that USAID's Child Survival programming be effective in working at the interface between HIV/AIDS and child health in regions and countries most affected by the epidemic. This year, BGH has initiated a partnership with a number of countries to operationalize the linkages between PMTCT programs and key elements of maternal and child health services, focusing on improving the quality and use of antenatal care and skilled delivery services, prevention of malaria through ITNs and Intermittent Preventive Treatment (IPT), detection and treatment of syphilis, tetanus immunization, iron/folic acid supplementation, and newborn care including exclusive breastfeeding among HIV-negative mothers or mothers of unknown status. Areas in which USAID anticipates requiring supportive competency in HIV/AIDS as related to child health include:

- assisting in the identification and expansion of opportunities for ensuring adequate well and sick newborn care in PMTCT programs
- assisting in the identification and expansion of opportunities for antiretroviral therapy (ART) and care for HIV-infected infants and children within existing MCH programs
- assisting in the definition and provision of appropriate care of HIV-infected children for common illnesses (e.g., pneumonia, diarrhea and malaria) within existing MCH programs
- assisting in the definition and provision of appropriate care of children of HIV+ mothers (e.g., appropriate infant and young child feeding, support for orphans and vulnerable children)

g) Malaria

Lead Competencies

In Sub-Saharan Africa and other regions where malaria is a major cause of infant and child morbidity and mortality, the contractor will provide program and technical expertise in malaria as it relates to child health. Because of its involvement in treatment of children ill with other illnesses, especially diarrhea and pneumonia, BGH expects the contractor to take the lead role in developing and applying approaches to the detection and management of febrile illness/malaria

in children. These approaches have evolved, and will continue to evolve, both in technical content (use of new drugs and multiple drugs), but mainly in the approaches to delivering treatment (pre-packaged drugs, treatment by community workers, families, and other health care providers, etc.).

BGH expects that this competency will be applied to link treatment of children with febrile illness/malaria with other child health and nutrition interventions, including links with specific program elements such as pneumonia treatment and with programming approaches such as community and household child health programs, reduction of anemia, pharmaceutical management and others. It also will be applied to coordinate or link child health and nutrition program strategies and initiatives with major malaria-related strategies and initiatives, especially RBM.

This competency will need to be applied in addressing the policy and resource issues related to child malaria treatment, including treatment and use of new drugs by community health workers and the role of private sector providers of drugs and treatment in the health sector. To be effective, the contractor will need to stay abreast of evolving issues such as multi-drug resistance of malaria parasites, new drug regimens and delivery modalities, efforts to address substandard or counterfeit drugs and new program approaches (such as home-based treatment of febrile children).

Support Competencies

The contractor will not be the lead implementer of BGH-supported malaria prevention activities. The contractor will be expected to provide support for the work of the leading USAID partners in the malaria sphere under the Malaria Action Committee (MAC): the Rational Pharmaceutical Management Plus program (RPM Plus), ACCESS, CDC, and WHO. CDC and WHO will continue to play the lead role in setting the technical standards for detection and treatment of malaria, as well as many of the technical issues for IPT. The contractor, however, will require supportive on-staff competency for its programming that intersects with the promotion of availability and use of ITNs and ITMs and of IPT of pregnant women (as a neonatal health intervention) and, potentially, of infants (IPTi).

On-Demand Competencies

The contractor may be called upon to work alongside USAID and partner-supported activities attempting to improve the quality of care provided by private sector practitioners, who in many countries supply a majority of care to sick children.

h) Birth Spacing

On-Demand Competencies

A number of recent studies have suggested that a preceding birth interval of 3-5 years is associated with reduced mortality risk for newborns, infants and young children when compared to shorter intervals, particularly those less than 18 months. As such, BASICS III may be called on to provide technical assistance to help integrate birth spacing counseling and services into existing child survival programs. The competencies that may be required include the following:

- providing technical assistance to partners for the definition of appropriate birth spacing activities (e.g., breastfeeding/LAM /birth spacing counseling, contraceptive methods, community-based services, referral for clinical services)
- providing technical assistance to partners for the integration of these activities into existing child survival programs

i) Humanitarian Crises

On-Demand Competencies

Given the high toll that natural and man-made disasters typically take on newborns, infants and children, the contractor may be called upon to provide assistance to USAID or U.S. Government efforts in specific emergencies in a well-defined capacity. The competencies that may be required include the following:

- providing technical assistance to partners for the implementation and monitoring of key neonatal and child survival interventions
- providing support to partners for the resumption of health services during the immediate post-emergency phase and through the transition to long-term development

j) Immunization

On-Demand Competencies

While a new cooperative agreement for Immunization (BASICS/Immunization) will be the key vehicle for virtually all immunization-related activities funded by BGH, circumstances may arise that require involvement of BASICS III. Under these circumstances, BASICS III will be required to collaborate with BASICS/Immunization in any and all ways possible. Since these circumstances can not be predicted in advance, the contractor should have access to high-quality immunization-related expertise on-demand.

k) Identification and Application of Efficient and Effective Approaches to Scale up Child Survival Interventions to Achieve Population-Level Impact

Improved approaches are needed to increase the coverage of proven child survival interventions, and new strategies are needed to apply interventions on a larger scale. Some of these approaches and strategies may involve commercial marketing or branding. Others may involve streamlining community approaches to serve wider populations. Still others need OR on specific individual, collective, or institutional behavioral barriers that limit or facilitate increased coverage. The contractor will be GH's lead technical assistance partner to identify, adapt and apply improved approaches and strategies to scale up child survival interventions and will be required to house the requisite professional skill set in order to achieve this result. The following are some of the areas where improved approaches and strategies may be requested:

- promotion of continued feeding and fluid intake (ORT) during episodes of diarrhea and other infectious diseases: inclusion of ORT in large scale communication programs, using mass media, community, and interpersonal communication to reach scale and achieve sustainability
- documentation and analysis leading to policy guidelines and large-scale implementation models for community-based antibiotic treatment of pneumonia, including exploration of potential synergies with community treatment of diarrhea and malaria
- identifying, evaluating and documenting successful approaches to increase the coverage and impact of CBGP in Sub-Saharan African settings
- identifying, evaluating and documenting successful approaches to improve well and sick newborn care in the community
- identifying, evaluating and promoting approaches to improve care for potentially HIV-exposed and HIV-infected children for health promotion and the prevention and treatment of common childhood illnesses, HIV-related illnesses and AIDS
- identifying and evaluating selected interventions to increase the effectiveness and quality of care and health education provided to children and their caretakers through formal and informal private sector providers
- identifying, evaluating and promoting selected interventions to address inequities in coverage and utilization of child health and nutrition interventions
- partnership with the Child Survival Technical Support (CSTS) project to explore opportunities for evaluation, improvement and use of the CSTS tool for program sustainability

The contractor will not necessarily develop or create these approaches and strategies, which may come from the review of existing program experiences, whether USAID-supported or not. The purpose of work will be to identify promising approaches, adapt and implement them,

evaluate them in relation to the intended public health results, and - if and when effective - promote their wider adoption.

1) Cross-Cutting Areas

Families and Communities: The analysis and experience of predecessor GH child survival projects, USAID programming, and country and international partners increasingly has demonstrated the importance of reaching beyond health services to families and communities to achieve better health and nutrition outcomes for children. This is especially true for countries with high levels of unmet need and low levels of health system capacity, as well as for addressing inequities in coverage of child survival interventions in all countries. It now has become increasingly clear that in the absence of an effective strategy to reach families and communities, countries are unlikely to reach the MDGs.

Experiences in numerous country and NGO programs show that behavior change related to the promotion of health and growth, prevention of illness, and detection and treatment of child illness can be achieved through effective, systematic, community and family-based approaches. These approaches benefit from linkages to appropriate health service providers, but are themselves ways to increase healthy behaviors and care, with or without creating demand for services from outside providers. These empowering and participatory community approaches, often facilitated by NGOs and PVOs, have the greatest potential for impact when they are made part of a country's overall strategy and programming approach for improving child health and provided with commensurate levels of resources.

BGH expects the contractor to include community approaches to improving child health and nutrition as a lead competency of the contract's work. This core competency will interact with the contract's implementation and scale-up of key child survival interventions. The focus will be on making the development and implementation of at-scale community and family-based approaches elements of national and international policies, programs, and investment strategies.

Health Systems: Health systems in most developing countries require strengthening, especially countries with high unmet need for child survival interventions. Some of USAID's donor and multilateral partners invest exclusively in "systems strengthening," the assumption being that strengthened systems produce better health outcomes. BGH's perspective is that strengthened health systems, broadly defined to include community and private sector elements as parts of the system, are an important medium- to long-term goal. Investments in any health activity in a given country shall be consistent with and contribute to development of the health system. In fact, many of the programs to increase the use of key interventions are activities that strengthen health systems.

The contractor, working with GH, other bureaus, field Missions, and international partners will work to improve coverage and quality of key child survival interventions. To the greatest degree possible these approaches will strengthen key elements of countries' health systems. Achieving this balance will require fitting country policy and program approaches into a wider vision for that country's health system. The contractor will aim to achieve a consistent approach to system strengthening across its work within a given country so that support in one intervention is not inconsistent with work in another intervention.

The contractor will require access to competencies in relevant aspects of health systems (e.g., working with RPM Plus to improve the quality and availability of essential drugs) in order to achieve coverage at scale and contribute to systems strengthening. The nature of the country-specific health systems issues that might need to be addressed cannot be identified in advance. BGH considers these competencies to be both on-demands as well as integrated into approaches within each intervention area.

Elements of Effective Programs (the IMCI lesson): In 2002-2003, USAID participated in an inter-agency "Analytic Review" of global experience implementing the WHO/UNICEF Integrated Management of Childhood Illness (IMCI) Strategy. This review examined IMCI in terms of effective delivery of key child health interventions. An important lesson from this review was that to deliver interventions successfully all key elements of programming must be in place and functioning. Examples of key elements of effective programming include:

- a defined organization and management structure
- a manager with defined responsibility and accountability
- a budget line
- defined approaches and tools for key system functions, such as planning, management, skill building, supervision, assessment and provision of required drugs and commodities, communication and demand creation, and monitoring service and population-level indicators

The lesson for child survival programming and for this contract is that at-scale impact cannot be expected from interventions unless key program elements for their delivery are functioning. In countries with strong health systems, these functions routinely may be performed by the system itself. In weaker systems, lack of some or all of these elements will significantly limit the impact of investments in key interventions. One way to implement key interventions in the absence of a broader functional system would be to define and support these key elements through an actual program. Another way would be to systematically assess the status of programming elements relevant to an intervention and determine how to support those found inadequate.

The offeror is not necessarily expected to support or strengthen all the programming elements of a particular setting. The contractor, however, will be expected not to waste USAID resources on attempts to deliver interventions in situations where the lack of other program elements severely limits scale or impact. At minimum, in each setting the contractor will need to assess the functionality of programming in relation to the contractor's planned inputs. The contractor and USAID could then use this analysis of the functionality of program elements to advocate for complementary resources from the country and other partners to achieve more effective programming.

3. TASK ORDER 01 PLANNING AND MONITORING

The development of strategic implementation plans for TO1 is a critical function. The planning process shall be closely linked to periodic review of progress toward identified results and identification of human and budgetary resource requirements.

The contractor shall complete all start-up activities within 90 days after award. This shall include the hiring of necessary staff at this time, establishment of an office in the greater Washington D.C. area, furnishing and equipping the office so that it is able to support all the functions described in TO1, establishment of administrative procedures, development of reporting formats, and establishment of the management information system to be used by the contractor to report on activity progress and manage the work of TO1. Also during this time the contractor shall work with the CTO to develop a format for and agree on the process of development, review and approval of the long-range strategic plan and annual work plans.

As country programs are established, the contractor shall prepare a long-term strategic plan for each country program within 90 days of agreement on the specific country. The strategic plan shall be accompanied by annual implementation plans that specify the work to done each year. The specific content of the plans shall be developed with the CTO, but it is reasonable to expect them to contain: objectives, results, duration, required resources and technical inputs, indicators and benchmarks for measuring progress, partners, and possible cross-cutting and problem areas.

The annual workplan shall contain: expected annual results; budget; technical, material, and human resources; and implementation steps. The annual workplan also will contain a strategic plan for knowledge and events management within the program and in relation to the larger context of child health. This plan will be negotiated and approved as part of the annual implementation plan. The contractor will be expected to produce and disseminate only those key publications that directly contribute to achieving results. In general these will include articles published in peer reviewed journals and major theoretical and technical advances in the field as a result of the project, both as events and publications. Events based in the field will be given priority over US-based events. Over the life of the

project, the number of publications will not exceed ten without the approval of the CTO and their total cost will not to exceed three percent of the core funded budget.

A progress review shall be held annually to examine the progress in relation to the long range strategic plan and the annual implementation plan. This review shall inform the development of the annual workplans for the next year of the activity and provide an opportunity for input from HIDN, USAID regional bureaus, USAID field Missions, and partner organizations.

In addition to country strategic and implementation plans the contractor shall develop a long range strategic plan for global leadership activities that are largely supported through core resources. The format for this plan shall be the same as that described above for country plans. The contractor shall also develop annual workplans for global leadership activities. These plans are subject to the same review process as described above.