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**Issuance Date: July 9, 2009**

**Closing Date: August 6, 2009**

**Closing Time: 12:00 PM Eastern Standard Time**

**SUBJECT: RFTOP USAID/M/OAA-GH-OHA-09-0012 IQC TASK ORDER REQUEST FOR OFFERS UNDER AIDSTAR SECTOR 1 – TECHNICAL SERVICES**

Dear AIDSTAR Sector I (Technical Services) IQC Contractors,

USAID is requesting offers for a 5 year Cost Reimbursement Plus Fixed Fee, Level of Effort (CPFF LOE) Task Order under the referenced IQC.

Please review SECTION L - INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS for a list of submission requirements and instructions. Please submit the required information to: Keisha L. Foster **no later than 12:00 PM (Noon) EST August 6, 2009**. USAID will not accept requests for closing date extensions. Kindly send one original Technical Proposal plus 2 copies and one original Cost Proposal plus 2 copies.

Mail/hand-carry proposals to: Ms. Keisha L. Foster  
United States Agency for International Development  
Office of Acquisition and Assistance, RRB, 7.09-032  
1300 Pennsylvania Avenue, NW  
Washington, D.C 20523-7803

Offerors are permitted to submit questions no later than **11:00 AM EST Monday July 20, 2009**. Questions and USAID responses will be shared with all IQC contractors shortly thereafter. Feel free to contact either Ms. Keisha L. Foster, [kfoster@usaid.gov](mailto:kfoster@usaid.gov) (202) 712-1132, or Ms. Sandra Harrell, [sharrell@usaid.gov](mailto:sharrell@usaid.gov), (202) 712-4522, if you have any questions.

I wish to emphasize that this letter does not obligate USAID to execute a Task Order, nor does it commit USAID to pay any cost incurred in the preparation and submission of the foregoing.

Sincerely,  
/s/

Michael Ashkouri  
Contracting Officer  
M/OAA/GH/OHA

**AIDSTART SECTOR I INDEFINITE QUANTITY CONTRACT  
SECTION A –REQUEST FOR TASK ORDER PROPOSAL (RFTOP)**

***Integrated HIV/AIDS Program Task Order***

1	RFTOP Number	M/OAA/GH/OHA-09-0012
2	Date RFTOP Issued	July 9, 2009
3	Issuing Office	USAID Washington OAA/GH/OHA
4	Contracting Officer	<i>Lisa M. Bilder</i> Office: 202-712-5882 Fax: 202-216-3072 E-mail: lbilder@usaid.gov
5a.	Electronic proposals to be submitted to via email to	<i>Keisha L. Foster</i> Office: 202-712-1132 Email: kfoster@usaid.gov
5b.	Please submit 1 original technical proposal plus 2 copies; and 1 original cost proposal and 2 copies to:	<i>Keisha L. Foster</i> USAID/M/OAA/GH/OHA 1300 Pennsylvania Ave, NW, RRB 7.09-061 Washington, DC 20523
6	Proposals Due	No later than 12:00 p.m. EST August 6, 2009
7	RFTOP POC	<i>Keisha L. Foster</i> <a href="mailto:kfoster@usaid.gov">kfoster@usaid.gov</a> 202-712-1132

## **SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS**

### **B.1 PURPOSE**

The United States Agency for International Development (USAID), Office of Acquisition & Assistance requires support to AIDSTAR Sector 1 as detailed in Section C.1 Background. The purpose of this Task Order (TO) is to implement the USAID/DRC Integrated HIV/AIDS prevention, care and treatment service delivery program with a primary focus on the most-at-risk populations (MARPs) and a secondary focus on the general public. This program will address the gaps in the quality and quantity of services provided in selected areas by leveraging resources and activities provided by the USG PEPFAR implementing partners Global Fund, World Bank, United Nations, and other stakeholders in accordance with the Ministry of Health's recommended approach and in alignment with the DRC strategic plan (both the MoH and the Multi-sector strategic plan).

### **B.2 CONTRACT TYPE**

This is a Cost Reimbursement Plus Fixed Fee, Level of Effort (CPFF LOE) Contract. For the consideration set forth in the contract, the Contractor shall provide the deliverables or outputs described in Section C and comply with all contract requirements.

### **B.3 PAYMENT**

The paying office is:

USAID/DROC  
198, Isiro Avenue  
Kinshasa, Gombe  
Democratic Republic of Congo

### **B.4 OTHER RFTOP INFORMATION**

The final statement of work for the Task Order that will result from this RFTOP will be incorporated at the time of award and shall be based on the proposal by the successful offeror.

**END OF SECTION B**

## **SECTION C – DESCRIPTION / SPECIFICATIONS/STATEMENT OF WORK**

### **C.1 BACKGROUND**

This TO supports activities designed to reduce the incidence and prevalence of HIV/AIDS and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families. This entails reducing transmission among MARPs (including commercial sex workers and their clients, truckers, miners, the military and police, youth, street children, and other categories as identified through existing or future behavior surveys), as well as people living with HIV/AIDS (PLWHA).

### **C.2 OBJECTIVES**

The Integrated HIV/AIDS Prevention, Care and Treatment Service Delivery Program objectives are:

1. Improve the accessibility and quality of HIV/AIDS prevention, care and treatment services in the selected areas;
2. Increase community involvement in health issues and services beyond facility-level services through sustainable community based approaches;
3. Increase the capacity of government and local civil society partners (seeking to empower new local organizations) to plan, manage and deliver quality HIV/AIDS services;
4. Assist the government to develop, disseminate and implement evidence-based policies such as counseling and testing, adult care and treatment, and OVC policies that result in improved service quality.

The main program activities under this TO are HIV/AIDS Counseling and Testing (HCT), prevention, treatment of tuberculosis-HIV co-infection, and care and support for persons living with HIV and AIDS (PLWHA) and Orphans and Vulnerable Children (OVC). Human capacity development and health system strengthening activities will also be undertaken as part of this TO. Priority activities under this TO will follow-on and reinforce current USAID-funded activities in addition to the prevention of mother-to-child transmission (PMTCT), when appropriate, in South Kivu (Bukavu-Uvira), Bas-Congo (Matadi-Boma), and Katanga (Lubumbashi, Kasumbalesa, Likasi, Kipushi, Kolwezi) transport corridors.

Leveraging Centers for Disease Control (CDC) activities supporting laboratory and clinical services in Sendwe hospital and Department of Defense (DOD) counseling and testing activities targeting the military in Lubumbashi city will be key elements of this program. The soap opera program, Rien Que La Verite, developed by the Department of State Public Diplomacy has been published on DVDs and is currently being used in the existing sites and will be provided to

additional community and facility based counseling and testing sites supported by the program. Proposed activities should be complementary and focus on comprehensive, quality HIV prevention, care and treatment support services to enhance Sendwe hospital as a center of excellence and learning. These activities may be expanded, if funds permit, to provide similar services in Kinshasa focusing on the areas of Ndjili and Masina to complement the CDC's health facility family-centered approach.

Over the five-year program life, the contractor will introduce innovative and sustainable strategies which foster local ownership as well as expand and institutionalize proven approaches. Program activities may be expanded, if funds permit, delivering services to high-risk groups in epidemiological "hot spots" in peri-urban and rural areas such as Lodja and Lukula, developing Centers of Excellence, and documenting best practices. Expansion of activities will be data driven, based on program evaluations, studies and annual reports. The activities of this TO are intended to mitigate the gaps in service delivery identified during several assessments, recommendations from the PEPFAR core team, and the PEPFAR Treatment and PMTCT Technical Working Group leads as well as Compact framework discussions with the Government of the Democratic Republic of Congo (GDRC), Global Fund, and other key stakeholders of their current HIV and health portfolios in order to identify needs and recommend directions for the next five years of programming.

The contractor awarded this TO will be responsible for implementing country-specific support activities in key urban and rural areas during a five-year time period.

#### **THE DEMOCRATIC REPUBLIC OF CONGO AND HIV/AIDS**

The Democratic Republic of the Congo (DRC) is one of the most populous, vast and resource rich countries in sub-Saharan Africa, with nearly 65 million inhabitants, nine neighboring countries and many mineral and natural resources. Decades of mismanagement, neglected infrastructure, corruption and conflict involving seven national armies over the course of 15 years have left the Congo with an 80 percent poverty rate, and an annual per capita income of just over \$120, inadequate social and health services, and weak governmental institutions. In 2006, the country held the first democratic elections in 40 years.

The health sector's ability to respond to the health needs of the people of the DRC has declined significantly during the conflicts of the last decade. It is estimated that as much as 70% of the population have little or no access to health care. The DRC ranked in the bottom ten countries in the world on a range of basic social and quality of life indicators. From the Demographic Health Survey (DHS, 2007), it appears that some key health indicators are not as dire as previously assumed but despite a slightly improved picture, many key health indicators remain of serious concern.

The DRC was one of the first African countries to recognize HIV/AIDS when it started to register cases in 1983. The DRC has a generalized epidemic, however data from surveillance studies conducted over the past couple of years is beginning to reveal areas of high prevalence in various hotspots across the country.<sup>6 7</sup> HIV/AIDS remains one of the most serious health sector crises in DRC.

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<sup>6</sup>2008 Assessment of HIV/AIDS Program in DRC, Findings and Recommendations for Future USAID Programming, 2008-2012

<sup>7</sup> Programme National Multisectoriel de Lutte contre le VIH/SIDA/RDC 2007, Rapport national sur l'épidémie a VIH 2006 December 2007.

The 2007 DHS estimates that the HIV prevalence in the general population of DRC is 1.3%, with higher prevalence among women (1.8%) and in urban areas (1.9%). For women, the highest prevalence is between ages 40-44 (4.4%). For men, the highest prevalence occurs between 35-39 years (1.8%).

Men and women living in urban areas are at higher risk of infection than those living in rural areas (1.9% versus 0.8%, respectively). HIV prevalence is highest for both women and men in Kinshasa (2.3% for women and 1.35 for men). For women, those who are the most educated and wealthiest are at greatest risk (3.2 % and 2.3%, respectively) when compared to the least educated and poorest women (0.6% and 1.2%, respectively). In relation to marital status, widowed women have the highest prevalence (9.3%).

UNAIDS modeling program for HIV estimates (EPP Spectrum) suggest that 1.2 million Congolese are infected with HIV, over 43,000 vertical mother-to-child infections have occurred in 2008 and that 250,000 Congolese will be eligible for antiretroviral (ART) treatment by 2010. However even with Global Fund Round 8 support, only a projected 67,000 people will be covered with treatment over the next 5 years. The DRC 2009 OVC Rapid Assessment, Analysis, and Action Plan (RAAAP) Situational Analysis estimates that there are 8.2 million OVC.

Several factors fuel the spread of HIV/AIDS in the DRC including movement of large numbers of refugees and soldiers, scarcity and high cost of safe blood transfusion in rural areas, lack of knowledge regarding transmission, a lack of counseling, few HIV testing sites, high level of untreated sexually transmitted infections (STIs) among sex workers and their clients, and low availability of condoms. The low percentages of men and women who know their HIV status (9.5 and 10.6 percent, respectively) are also fueling the epidemic. The wars and hostilities have made it extremely difficult to conduct effective and sustainable HIV/AIDS prevention activities. In addition only 8% percent of people in need of ART are being treated, primarily through GF support (26,000 as of May 2009) and 4000 kids through Clinton Foundation support. This is mainly due to the weakness of the DRC health system including non-reliable lab services, lack of and unmotivated human resources, and stigma.

In addition, the DRC now ranks 10th among the world's 22 high-burden tuberculosis (TB) countries. The estimated incidence of TB was 392 cases per 100,000 population in 2007, according to the World Health Organization. HIV prevalence in adult- incident TB patients is estimated to be 17 percent.

The United Nations modeling program for HIV (EPP-Spectrum) estimates 141,500 HIV+ women in DRC delivering with 42,450 children infected through mother to child transmission in 2008. The National AIDS Control Program (PNLS) prioritizes the scale-up of PMTCT, with a goal of universal access to PMTCT with ART services for pregnant women by 2009. PNLS has revised the PMTCT policy/protocol (2007) from Nevirapine (NVP) single dose to combined ART prophylaxis for pregnant women and their newborns based on World Health Organization (WHO) recommendations. Critical to the success of this change is increasing the Ministry of Health's (MOH) capacity and supporting the National AIDS Program to disseminate and implement the new policy.

Barriers to scaling-up the PMTCT program include: low uptake and poor quality of antenatal services, limited access to rural facilities, lack of trained human capacity in PMTCT services, unreliable supply chains, fragmented and inefficient collection of essential data, stigma, reluctance to test, non-return and loss-to-follow-up, as well as women's inferior legal and cultural status. In Kinshasa, where access to health facilities is better than in most areas of the

country, 40% of HIV+ women do not return to maternity wards for delivery. In large overburdened maternities, same day HIV test results are not provided.

Challenges at the program level include lack of involvement of male partners, insufficient follow-up and support to HIV+ mothers and their infants, and poor psychosocial support to both discordant and HIV-affected couples. Insufficient nutritional support for the mother and her infant, especially after weaning at 6 months, pose additional programmatic challenges.

Stigma, discrimination, and widespread belief in sorcery as a cause of HIV/AIDS challenge the acceptance of prevention education. A weak civil society limits opportunities for organizations to engage in community dialogues around harmful social norms and risky behaviors. The U. S. Government (USG) has limited resources to meet the prevention needs of millions of Congolese in the general population. There is also evidence of high prevalence among high-risk groups, and troubling behavioral data among youth groups who need targeted, comprehensive services. Given the limited funds for prevention in the DRC and data on high-risk groups that merit continued investment, the USG will continue to prioritize targeted, comprehensive prevention programs among persons engaging in high-risk behavior while also addressing risks for youth and the general population.

Throughout the DRC, poorly paid health care workers often demand unofficial payments and are frequently unable to provide basic care. Cost of care and poor outcomes often deter clients from seeking care. Preventive measures including vaccination, hygiene, sanitation, and public infrastructure have been neglected for years resulting in recurrent epidemics of communicable diseases, such as measles and typhoid fever, and even Ebola in August 2007 and January 2009. Other challenges in palliative care include lack of disclosure, stigma, access barriers to free or highly subsidized care, poor supply chain systems, relatively few care and treatment facilities, tuberculosis, and availability of food and nutritional support for patients. Pediatric care barriers include the retention of children after birth in clinics, malnutrition, ART dosing and the socio-economic cost of care for HIV positive children.

Demand for HIV Counseling and Testing (HCT) services in the DRC is high. However the current number and capacity of HCT centers to best meet the demand needs to be assessed. Likewise, the lack of services for onward referral of those who test positive is of concern. Few individuals disclose their status to sexual partners. Provider-initiated counseling and testing has begun through a few innovative donor programs, but it is not yet a component of national policy guidelines.

A challenge in implementing evidence-based decision making is the poor quality of strategic information systems and data sources that provide information on HIV/AIDS service use patterns, quality of care, morbidity and mortality. In the last two decades, surveillance has often been interrupted by conflict. Monitoring of services is also a challenge. A USG-supported mapping survey was conducted by Kinshasa School of Public Health (KSPH) to identify HIV services. Data indicated a low capacity to collect, manage and use data for program decision-making, especially among local community organizations. As a result, there is little quality data available on HIV. The planning and coordination of the national response is limited due to an outdated HIV Strategic Plan, which is currently under revision. Currently there are no service delivery databases for PMTCT, HCT, Care and Treatment, or OVC. In addition, the World Bank reduced financial support to the Multisector AIDS Commission's monitoring and evaluation unit, reducing the capacity for national management.

Although there are several major HIV/AIDS efforts ongoing in DRC, progress on some key indicators has been slow. Less than 3% of pregnant women nationally have access to PMTCT services, fewer than 30% of PLWHAs enrolled in ART programs are receiving some form of palliative care, and only 8% of those eligible have access to ART.

### **National Response to HIV/AIDS**

In response to the HIV/AIDS epidemic, the Government of the Democratic Republic of the Congo (GDRC) has established two bodies to coordinate HIV/AIDS activities:

- The National AIDS Control Program (PNLS) – established in 1987 within the MOH to provide leadership in the health sector aspects of HIV/AIDS control; and
- The Multisector AIDS Commission (PNMLS) – established in 2004, with leadership provided by the MOH and members from the Ministries of Education, Finance, Planning, and Public Works, as well as donor, private sector, and civil society representatives and funded by the World Bank.

Even though HIV/AIDS control has been named a priority in its Poverty Reduction Strategy Paper, the GDRC lacks the necessary infrastructure and resources and have made marginal expenditures. To implement the strategy nationwide, the GDRC depends on the participation from all development partners, including the private sector and faith-based and nongovernmental organizations (FBOs/NGOs). Support from external donors has provided the majority of HIV/AIDS programs. The Global Fund and World Bank essentially provide all the adult antiretroviral drugs (ARTs), and the Clinton Foundation provides all the pediatric ARTs.

### **Other donors (Global Fund, World Bank, Others)**

DRC relies heavily on programs supported by the Global Fund and World Bank to support HIV/AIDS efforts nationwide:

The Global Fund (GF) Round 3 HIV/AIDS program is \$113.65 million over 5 years from January 2005 through December 2009, supporting prevention, care and treatment activities targeting men in uniform, sex workers, truck drivers, prison populations, youth, PLWHA,, and HIV-positive mothers and their newborns. Most work is implemented by NGOs, and the Country Coordinating Mechanism (CCM) is led by the MOH, with involvement from the National AIDS Program (PNLS). The GF Round 3 funding seeks to achieve the following four objectives;

- (1) Mobilize community leaders to join the fight against HIV/AIDS and other STIs
- (2) Prevent transmission of HIV within at-risk populations and the general population
- (3) Improve the quality of life for HIV-infected and -affected individuals
- (4) Enhance the quality of information management in relation to the epidemic

The GDRC has been awarded \$71.4 million for HIV Global Fund Round 7 to support the five-year program from 2008–2012, and an additional \$262.9 million in Round 8. The new funding will increase access to ARVs, as well as provide an integrated package of care and treatment services in an increasing number of health zones over the next five years. Ultimately HIV/AIDS prevention, care and treatment services will be available in 196 of the 511 health zones in the DRC.

## **USAID/DRC HIV/AIDS PROGRAM OVERVIEW, ASSESSMENT FINDINGS, AND PRINCIPLES**

As a partner in the PEPFAR five-year strategy for DRC, USAID is implementing, an urban-focused strategy prioritizing prevention. Other USG PEPFAR implementing agencies include CDC, DOD, and DOS, with a combined FY08 budget of about \$15 million. USAID's HIV/AIDS budget has also grown substantially in recent years, from \$4 million in FY05 to over \$10.7 million in FY08. USAID's HIV/AIDS program has been primarily focused on filling gaps at the service delivery level, providing HIV services with a focus on a few high-prevalence urban hubs. USAID/DRC's HIV/AIDS programs have traditionally been focused primarily on community-level efforts to address the epidemic. With an increasing budget, there are additional opportunities to strengthen USAID's involvement in facility-level care, the critical links between community and clinic level services, and target high prevalence hotspots which will include rural and peri urban sites. Given the extremely limited resources of the U.S. Government (USG) HIV program overall, ARTs have not been procured, nor will they be in FY09. However, several USG programs are leveraging other donors' investments in ART drugs and services to complement USG services. The USG will continue work to strengthen pharmaceutical systems with the MoH in order to avoid stock-outs of essential supplies and medications. The current USAID/DRC HIV/AIDS program supports the following activities in the focus areas of Bukavu (including Uvira), Lubumbashi (including Kasumbalesa, Kikasi, Kolwezi and Kipushi) and Matadi (including Boma):

- Prevention BCC and peer education, including socially marketing condoms (Population Services International (PSI)/Association Sante Familial (ASF))
- Community-based Palliative Care for PLWHA (Catholic Relief Services (CRS))
- Support for Orphans and Vulnerable Children (CRS)
- Counseling and Testing in a mix of clinical and community settings (Family Health International (FHI))
- Regional HIV program linked to the East Africa transport corridor initiative targeting truckers and vulnerable population around bus station including youth, low income women (FHI)
- Public-private partnerships that provide a range of prevention, care, and treatment services with mining and port companies.

USAID supports HIV programs in 57 rural health zones (HZs) in South Kivu, Katanga, East and West Kasai provinces through the following activities:

- PMTCT (Interchurch Medical Assistance/Project AXxes)
- Blood Safety (Safe Blood for Africa (SBFA))

USAID HIV/AIDS supported efforts at the national level include:

- Supporting the Rapid Assessment, Analysis, and Action Planning (RAAAP) process and capacity building with the Ministry of Social Affaires (MINAS) in conjunction with UNICEF to establish a national plan of action for OVC (Constella Futures)
- Serving as 2nd Vice-President on the Global Fund Country Coordinating Mechanism (CCM)
- Providing substantial funding and organizing donors to complete DRC's first-ever DHS, with HIV biomarker
- Counseling and Testing guidance development support (GH-Tech project and AIDSTAR-1)

- Logistic and pharmaceutical management support (Strengthening Pharmaceutical Systems (SPS))
- TB-HIV collaborative activities (TB-Control Assistance Program)

In 2005, an USG HIV assessment team in DRC recommended consolidating USAID efforts from six major cities to three in order to provide more comprehensive services in a few select sites. Matadi, Lubumbashi, and Bukavu were selected due to their antenatal care (ANC) prevalence and an established track record of USG HIV-related efforts. Although substantial efforts have been made by the USG partners between 2005 and 2008 in their focus on these three provincial capitals, assessment findings in all three cities concluded that significant gaps in the availability of comprehensive and quality HIV services persist. For Bukavu and Lubumbashi in particular, enhancing quality HIV services is critical given cross-border movement with the two focus countries of Zambia and Rwanda, both of which have substantially higher HIV prevalence and HIV/AIDS funding.

In February/March 2008, USAID/DRC conducted a joint assessment of its HIV and health portfolios in order to identify needs and recommend direction for the next 5 years of programming. General findings/recommendations of the assessment included:

- Commodities management is a major need across all health and HIV programming;
- Information, Education and Communication (IEC) and other communication campaigns addressing HIV and stigma in particular, are sparse and could be strengthened through USAID support;
- While coordination of partners in line with government priorities is a challenge in all countries, it is particularly fragmented in DRC.

In the three USAID-focused cities, the assessment suggested that USAID should consider:

- Reinforcing/expanding current programs in prevention and condom social marketing, HCT, TB/HIV, palliative care and Orphans and Vulnerable Children (OVC);
- Strengthen linkages between community and facility-level activities;
- Strengthening of HIV diagnosis and monitoring programs in the USAID-focused provinces.
- Adding access to Sexually Transmitted Infection (STI) treatment for PLWHA and some high risk populations.

In addition, in October 2008, a USAID senior Global Health team led a strategic planning visit in the DRC to help the Mission develop a rationale and practical roadmap for the programming of the Mission's health resources over the next five years. Related to HIV, given the availability of new data reflecting pockets of high prevalence, the team recommended that the Mission undertake a comprehensive HIV/AIDS prevention, care and treatment approach in high prevalence "hotspot" areas targeting most at-risk populations. The strategy would also integrate care and treatment activities which seek to maintain patients' health status so that the need for anti-retroviral therapy (ART) is obviated as long as possible. If increased funding levels and additional funding becomes available, the Mission would consider extending the program beyond the current program sites.

The HIV/AIDS specific gaps identified during the assessments include:

1. There is a need to reinforce and expand current programs in prevention, HCT, TB/HIV, palliative care, and OVC in the USAID focus areas. A more rational and comprehensive package of services delivered to PLWHA and OVC is needed for palliative care, home base care and OVC programs which address nutrition.
2. There are significant gaps in the linkages between community and facility-level activities that USAID-funded activities should help bridge.
3. Developing and strengthening capacity of local NGOs (seeking new indigenous organizations and strengthening existing ones) to plan, manage and implement HIV activities will be critical and needs to be addressed.
4. There are numerous gaps in ART services that could be addressed by future USAID programming and quality of services. USG partners are well positioned to provide quality ART ancillary services as well as TA to other organizations.
5. There is a gap in prevention activities including STI treatment for PLWHA and some of high-risk populations that should be addressed in future USAID programming as a way of providing more comprehensive services to highly vulnerable populations.
6. There is a gap in realizing the possible synergy from opportunities to integrate HIV programming with other health programming such as family planning, malaria, safe water, maternal and child health, and food and nutrition.
7. There is a need to address relevant and key policy gaps in HIV prevention care and treatment to improve service delivery through developing, updating, and disseminating identified policies.

In addition, during a country visit from PEPFAR Deputy Principals in May 2009 a list of key principles were identified to guide program development. These principles include:

1. Prioritize areas and programs with the potential for greatest impact
2. Prioritize complementary programs (among USG and with other major partners)
3. Develop programs based on strategic information and programmatic data obtained through evaluations, studies and annual reporting.
4. Facilitate ownership of activities by key stakeholders
5. Recognize the need is huge and focus on key strategic positioned programs
6. Quality programs in each area requires a system / complement of services, equipment, staff and support
7. Focus on what is feasible
8. Prioritize key geographical focus zones
9. Identify key local partners with whom to work
10. Alignment with strategic plan (using national and direct indicators)
11. Recognize the challenge of government interest that all health zones have equal access to services however given limited resources there is a need to focus on highest impact areas / programs based on epidemiology , existing programs / systems, travel challenges, and ensuring quality programs

## **CURRENT USAID HIV/AIDS ACTIVITIES BY PROGRAM AREA**

### **A. PREVENTION**

#### **Prevention of Mother To Child Transmission (PMTCT)**

Currently, PMTCT services are being implemented within the USAID-funded AXxes primary health care project which is implemented in 57 HZs in four provinces: Katanga, Kasai Occidental, Kasai Oriental and South Kivu. Services began in October 2007 and, of the 57

health zones supported by AXxes, 40 are providing PMTCT services covering 107 sites. The AXxes PMTCT program consists of five core activities: (1) provision of a balanced approach of offering HIV testing to pregnant women requesting services in supported health facilities and of their partners; (2) provision of ART prophylaxis to HIV-infected women and their newborns and prophylactic Cotrimoxazole (to all children born by HIV positive mothers regardless of the child's HIV status); (3) provision of post-birth follow-up services; (4) integration of PMTCT interventions into the health services and strengthen the linkage to other health and nutrition programs in the health facilities and communities; and, (5) engagement at the national level to finalize the PMTCT policy to include an opt-out approach to HIV testing in health centers. This TO will focus implementation of PMTCT activities in the geographic focus areas of Bukavu (including Uvira), Lubumbashi (including Kasumbalesa, Kikasi, Kolwezi and Kipushi) and Matadi (including Boma). The contractor will also work with other USAID implementing partners, providing PMTCT technical assistance to improve service quality at rural PMTCT sites.

## **B. PREVENTION OF SEXUAL TRANSMISSION**

This TO will focus on prevention of transmission in positive people at the community level with some prevention activities in health facilities. Most other activities for the prevention of sexual transmission (Abstinence and Being Faithful, Condoms and Other Prevention Activities including outreach) are being implemented through a separate mechanism. For the purpose of background, the section below summarizes USAID-supported sexual prevention programming.

### **Abstinence/Be Faithful**

As part of USAID-funded sexual prevention Behavior Change Communication (BCC) programs focusing on Matadi, Bukavu, Lubumbashi, Kasumbalesa and Boma, young people 13-18 are the target audience for a delayed sexual debut media campaign called “Je m’engage” (‘I pledge’). The campaign has been reinforced with in-school youth through interpersonal activities that encourage abstinence prior to marriage. The BCC program works in communities to mobilize CBOs/FBOs to engage youth in activities and skills building to delay sexual debut and reduce their number of sexual partners.

In the same cities as the “Je m’engage” programming for youth, mobile video units (MVU) aim to increase risk perception among adults in the general population. MVUs use interactive approaches with trained facilitators in the community. Participants are either referred to HCT or a mobile HCT at the event offers CT on-site. Community dialogue regarding transactional and trans-generational sex, alcohol and drug abuse, coercion, and other harmful practices is also taking shape within the BCC program.

### **Condoms and Other Prevention Activities**

USAID/DRC has supported BCC programs targeting CSWs, truckers, and the uniformed services in the three focus cities of Lubumbashi, Matadi and Bukavu. Through site-based peer education and mass media, correct/consistent condom use and healthy living alternatives will be promoted, and risk perceptions about multiple/concurrent sexual partnerships will be heightened. Condom social marketing is targeted to high-risk populations.

The USAID is also leveraging the regional ROADS program in Bukavu at the DRC/Rwanda border. The ROADS project targets CSW, truckers, out-of-school youth, low income women, and government workers. The ROADS program is using the regionally branded ‘SafeTStop’ to deliver coordinated messages and services to mobile populations along the transport routes.

The project works with nine transport associations to promote condom use, fidelity, partner reduction, Counseling and Testing, Sexually Transmitted Infection (STI) treatment seeking, care and treatment for other infections, as well as reduction of stigma, gender-based violence, and alcohol abuse among its members and communities. The ROADS program strengthens campaigns initiated by community associations and youth groups called “clusters” to reduce alcohol abuse and domestic violence among drivers and men in the community. In collaboration with AFL-CIO's Solidarity Center, ROADS activity is providing training teachers in adult learning techniques in order to provide transportation workers with skills and alternative activities in the evening. All programs for adults, especially mobile men with means, are comprehensive and contain condom social marketing, skills building and either referral to points of sale or free condom provision.

In response to exceptionally high HIV prevalence rates among MARPs along the Kasumbalesa-Lubumbashi-Kipushi-Likasi-Kolwezi transportation corridor, USAID recently expanded behavior change communication, condom social marketing, and HCT services in this area. The area is characterized as having high levels of commercial activity due to their concentrated mining populations, coupled with a large mobile population that moves back and forth across the Zambian border. In collaboration with local partners, the main objectives of the expanded activity are to: (1) reach over 30,000 youth and 131,000 MARP with prevention messages, (2) distribute over 8 million male condoms and 32,000 female condoms, and (3) counsel and test 12,000 clients in five new CT sites (2,400/site) with referral to appropriate follow-up services in the health district. This target will be reached through various and adapted CT services (stand alone & community-based, integrated in a health facility/health district and a mobile clinic). The HCT services will be integrated in this new TO, however social marketing of HIV/AIDS products and services and BCC activities will be covered under a different program, with which the contractor will be encouraged to collaborate.

Through the DOD prevention program, the Congolese military personnel and their families are also reached with behavior communication through community outreach and mobile video units (MVUs). Through peer education, programs focus on sexual coercion, transactional sex, and alcohol and drug abuse.

The USAID has worked with the private sector through a GDA (Global Development Alliance) to improve access to prevention services for miners, both artisanal and professional. The GDA worked with an association of mining companies in Katanga. Projects provided a prevention program for miners that include peer education, MVU, group discussion and referral to testing. The GDAs also facilitated HIV/AIDS policy development, as well as education and awareness against stigma and discrimination of persons living with HIV and AIDS. The GDA in Katanga has been comprehensive, as it leverages other USAID and private investments including education, democracy and governance, strengthening civil society, microfinance, and other health services.

## **C. CARE AND SUPPORT**

### **Palliative Care: Basic Health Care and Support**

In clinical settings USAID provides care as a component of the family-based continuum of care. USG support provides access to the following package of services: psycho-social assessments during each clinic visit; individual, couples and family counseling; home visits; support groups; and disclosure support. Coordinators are responsible for the development, training, implementation and evaluation of support activities to be carried out by clinic staff or participating local community based groups.

At the community-level through Catholic Relief Services, USAID provided support for palliative care, and home based care for PLWHA in Lubumbashi, Matadi, and Bukavu. The home-based care program offers food support, legal aid, support groups, vocational training, income generating activities, psychosocial support and limited clinical monitoring and support to adherence on treatment through both health providers and home-based care volunteers.

Community-based care programs also provide linkages to HCT services. BCC activities promote testing among high risk populations and among the general population as described above. Linkages to treatment, health and social services are provided to PLWHA and OVC through a network of home-based care providers. The home-based care (HBC) program develops capacity among community-based organizations as a key strategy to sustain community-based efforts. Additionally, OVC are provided with educational and nutritional support while their caretakers are assisted to develop income-generating activities.

USG funds have been leveraged to provide HCT and PEP as components of comprehensive palliative care programs for survivors of sexual violence. This holistic approach to care includes medical assistance (including fistula repair), psycho-social support, advocacy, socio-reintegration services, promoting judicial support and referral, and new protection laws. HCT is often a pre-requisite imposed by husbands before accepting their wives who have been raped back into the household. Women who are eligible for ART are referred to other donor treatment centers. As care for HIV-positive victims of gender based violence (GBV) is a key priority, USG HIV programs attempted to support and link with these programs that provide comprehensive services to a critically underserved population.

### **Palliative Care: HIV/TB**

The USG HIV counseling and testing program continues to support provider initiated counseling and testing (PICT) for TB patients at 14 TB health facilities in Kinshasa to assure HIV rapid testing of new TB clients and palliative care for co-infected individuals. Several of the Kinshasa TB clinics also provide other HIV services as a part of the Continuum of Care package. Service referral and linkages for those stand-alone TB clinics are being developed by UNC. Through the FHI-TB CAP program, 12 additional TB-HIV clinics have been supported by USG in the AXxes supported health zones as a way to maximize the TB investment and desired outcomes. The USG, through counseling and testing funding, also supports HIV CT in three TB clinics in Matadi, Bukavu, and Lubumbashi, within these same facilities PMTCT and ART services are offered through Global Fund support.

USG provides the National TB Program with technical assistance to train service providers on treatment protocols for co-infected individuals, assuring microscopy competence to diagnose TB, and instituting laboratory quality control efforts. With non-PEPFAR USAID TB funds, TB CAP supports TB-HIV activities in two provinces. The program was a joint project with the European Commission. USAID TB funds provided support for the development of an integrated HIV Care for TB patients living with HIV/AIDS in 21 pilot sites: nine sites in Bas-Congo province and twelve sites in North Kivu province. This program ended in 2008.

### **Orphans and Vulnerable Children (OVC)**

Since 2002, the USG has supported programming that addresses the needs of OVC by strengthening local networks to provide a client-focused holistic approach to care and support. Community based care programs for PLWHA and OVC include a cadre of direct OVC services:

assistance for education (payment of school fees), vocational training and job recruitment, referral for medical care, support in starting income-generating activities (IGA) psychosocial support and referrals for spiritual support if desired, nutritional support and community sensitization about OVC needs, rights, birth registration, inheritance and other issues.

The current USG OVC program employs innovative activities, including Community Care Coalitions to promote stigma reduction by involving youth as caregivers as well as the promotion of male involvement in home based care. Community level OVC activities are strengthened by building the capacity of community and faith leaders to respond to the needs of people affected by HIV while improving the resilience of OVC and their households. By September 30, 2008, the USG provided support to 7,558 children in Bukavu, Matadi, and Lubumbashi who received assistance for education, vocational training, nutritional support, economic strengthening support including income generating activities, and psychosocial support. A total of 3,158 orphans went to school and 1,062 saved money from their Income Generating Activities (IGA). The program encourages community leaders to ensure that OVC families are empowered to take a leading role in providing support in education, health, nutrition, child protection, income generation, psycho-social and life skills training.

USG supports the regional ROADS II project to deliver prevention, care and support services at the DRC/Rwanda and the DRC/Burundi borders. ROADS II provides core support services to 300 OVCs to meet to meet their needs through the youth association cluster.

The USG also supports community-based HIV support groups for those HIV positive families in Kinshasa. HIV positive children are vulnerable to stigma and discrimination as well as opportunistic infections. For example, many schools refuse to enroll children with facial rashes. Adolescents need to understand their status prior to becoming sexually active or entering into marriage. Activities for home visits targeting orphans, HIV positive and vulnerable children include: follow-up for missed appointments, assessments of adherence to ART treatment regimens, linkages to available social services, and instructions on home-based health care.

The USG has also supported the Ministry of Social Affairs (MINAS) to complete a Rapid Assessment, Analysis and Action Plan (RAAAP). In coordination with UNICEF, the USG will continue to support the MINAS in their child protection leadership role and assist with implementation of the National Plan of Action developed from the Rapid Assessment and Analysis findings.

USG will also coordinate with UNICEF to establish social worker OVC guidelines and principles and train a pool of social workers at both the national and provincial levels.

#### **D. COUNSELING AND TESTING**

The USG initiated HCT in the DRC and introduced rapid tests. Currently <sup>8</sup>the MOH estimates that there are 317 testing sites in DRC, of which 248 sites are linked to hospitals and 69 HCT centers located in communities. In 2008, 177,450 people were counseled, 162,976 were tested, and 156,081 received their test results. Currently, USAID supports 16 HCT sites located in Matadi, Bukavu, Lubumbashi, Kasumbalesa, Likasi and Kipushi as has supported the testing of about 30% of all people tested in the DRC during 2008.

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<sup>8</sup> PNLs 2008 annual report

The USG is also providing technical support to the GDRRC to update the national CT guidance, which includes norms and training materials to integrate PICT and couples' counseling and testing into the health facilities approach. Finger-prick testing, currently used by USG partners, is promoted as a component of national guidelines for countrywide dissemination. The updated guidance and training manuals will be finalized in April 2009 and ready for dissemination through a cascade of trainings using USG, World Bank, Global Fund and other donor resources.

USG supports the regional ROADS II project delivering prevention services at the DRC/Rwanda and DRC/Burundi borders. A mobile HCT is available at SafeTStop areas in Bukavu and Goma (Rwanda border) to target transportation workers, CSWs, young adults, and others in the surrounding community. These CT efforts are linked to prevention and treatment programs.

## **E. TREATMENT**

### **HIV/AIDS Treatment/ART Services**

Due to the special needs of pediatric AIDS cases, the USG plans to collaborate with the Clinton Foundation's program focused on pediatric treatment and care. The Clinton Foundation is working in Kinshasa, Lubumbashi, Kisangani, Mbuji Mayi, Bukavu, Matadi, Kananga and Goma and succeeded to enroll 4,000 children in ART and related HIV care programs as of April 2009. The existing funds will permit an increase in the number of children to enroll for ART through 2012. The USG's PMTCT plus program in both urban and rural health service delivery will seek to link to pediatric care services. The USG OVC program in Bukavu, Matadi and Lubumbashi also refers children to available pediatric AIDS services in each of the locations.

Through CDC, USG supported ART testing and post-birth follow-up care services will continue at the Kalembe Lembe Pediatric Hospital and in the Salvation Army clinics. A referral service will be developed to shift stabilized clients on ART from the hospital to a clinic located nearer to the client's residence. USG technical assistance to the Salvation Army for new ART services in their clinics (drugs, materials and equipment are funded by Global Fund (GF)) will be continued by the initial training of ten additional physicians in ART. USG activities at Kalembe Lembe Pediatric Hospital will be coordinated with the Clinton Foundation to increase the new cases of children on ART nationwide.

## **F. LABORATORY INFRASTRUCTURE**

USG-funded efforts through CDC concentrate on implementing quality assurance activities in provincial hospitals and key laboratory sites, including finalization of the training guide and complete training of provincial lab service providers. Funds are used to fill critical gaps in equipment purchases that are necessary to build laboratory capacities to undertake key support services. The USG will promote the validation of new laboratory techniques. The USG supports in-service and pre-service training of HIV laboratory technicians based on standardized lab procedures. Efforts target the development of an HIV quality assurance program. In addition to providing technical assistance for laboratory services, the USG continues to strengthen laboratory capacity at health facilities where models are being developed.

## **G. STRATEGIC INFORMATION**

The USG supported DRC's first ever DHS in the DRC, with field work completed and results released in 2008. The DHS was supported by USAID, DFID, UNICEF, UNFPA, World Bank and

CDC at a total cost of \$3.4M. The USG supported mobile counseling and testing to accompany the surveillance work, provided laboratory quality control of HIV test results, and actively participated in the quality control of the DHS analysis used for the final report.

USG funds technical support in conducting a UNAIDS CHAT exercise (Country Harmonization Alignment Tool) and the USG is a member of the steering committee to implement the new CHAT protocol designed to measure progress in achieving the Three Ones. In addition, the USG provided technical assistance and support in field data collection.

The USG supported geographic mapping of HIV Services through the Kinshasa School of Public Health (KSPH). The survey aimed to identify HIV services offered by public, private and NGO communities in 2006-2007. Over 2000 sites were identified by interviews with donors, programs, local authorities. The highest concentrations of HIV services were found in Katanga (19%, 2006 ANC prevalence - 5.4%) and Kinshasa (16%, 2006 ANC prevalence - 3.6%). The lowest rates of available services were found in Equator Province (1%, 2006 ANC prevalence - 5.31%). Also, the USG provided technical assistance to a second mapping exercise concluded in 2007 by GF and multi-country HIV/AIDS program (MAP). This mapping exercise provided additional information on GF and MAP supported HIV services nationwide that began in 2006 – after the KSPH report was completed.

The USG also supports program assessments to aid other bilateral and multilateral donors to strengthen their program activities: evaluation of the national blood safety program; evaluation of GFATM sub-grantees performance reporting in Phase I; evaluation of ART services; and evaluation of the MAP program supported by the World Bank.

USG continues to provide technical assistance to the National Multisectoral Programme for the Response to HIV/AIDS (PNMLS). Through this assistance, the National M&E Strategic Framework was validated and several key documents were developed: the National M&E Indicator Guide, the National M&E Training Manual, the first National HIV/AIDS Epidemic Report of 2005 and the second in 2006. However, with the review process leading up to the restructuring of the MAP program in 2007, the PNMLS M&E Unit has received minimal implementation funds. A Memorandum of Understanding (MOU) between the PNMLS (MAP program) and GF supports common performance indicators. In addition, USG provided funds to UNAIDS to conduct a data collection effort on HIV financing by donor agencies called “Making the Money Work”. Data analysis will assist major HIV decision makers to identify funding gaps.

#### **C.4 SCOPE OF WORK**

This Task Order will increase access to quality HIV/AIDS services by scaling up and enhancing evidence-based programs already being supported by USAID/DRC and by replicating these service delivery activities in priority areas in which the USG has not been able to engage fully. The activities of this TO will be a combination of home, community and facility-based prevention, care and support and treatment service delivery support

#### **TASKS**

The Contractor’s work (resources, activities, and annual targets) under this task order is expected to be developed on an annual basis dependent on the approved DRC Partnership Compact and annual Country Operational Plan (COP) and in consultation with NGO and MOH counterparts as well as other partners and key stakeholders. Given this annual process, great flexibility and access to a wide range of technical capacity across the following program areas

will be needed. A mix of in-country, ongoing technical assistance provided by locally engaged staff and short and long-term external expertise is recommended.

Consultation with the National AIDS Program (PNLS), the National Multisectoral AIDS Control Program (PNMLS), the MOH, and USAID supported NGOs to determine specific, current technical assistance and training needs, ensure alignment with the National HIV/AIDS Strategy, and promote coordination is recommended for proposal development, but will be a requirement annually in finalizing work plans.

The following is an outline of the program areas that the Contractor will work in throughout the life of project. Percentages have been assigned to each, representing the expected budget breakdown/level of effort required. Once annual funding levels are approved, final work plans and budgets can be prepared accordingly, but may change annually based on evolving needs. Targets have already been assigned for FY09 and are located with further explanation in the reporting section. Priorities below have been identified as critical needs in the National Program. The illustrative activities below are provided to give an indication of the minimum level of support the contractor shall provide, and as specific examples of the type of support that is needed in FY09. The contractor is not limited to the illustrative activities listed.

**HIV Counseling and Testing (HCT) and Prevention      Total Level of Effort   33%**

The contractor will develop and implement a community-based prevention strategy which targets MARPs and PLWHA, develops PMTCT services where critical gaps are identified and provides PMTCT technical assistance.

The USG supports a mix of prevention activities including behavior change communication, information and educational activities implemented by peer educators from the various MARPs, community relais and others. Additionally, USAID supports community-based HCT centers and facility-based services, with rapid tests at all sites. The contractor is not responsible for developing social marketing activities as they will be provided through a separate mechanism. Community HCT sites include mobile testing units which target high-risk populations that often do not use facility-based services. Integrated HCT within TB care and family planning, and youth-friendly HCT are also supported. The mix and number of sites established in each city should consider local needs and epidemiology. Support includes training and supervision of counselors, procurement of essential commodities, dissemination of prevention messages, and care and treatment services. It is a USG priority to continue HCT services in the four areas where Behavior Change Communication (BCC) currently exists (Kinshasa, Matadi, Lumbumbashi, and Bukavu).

This component of the TO is intended to build on past experience and expand prevention and HIV Counseling and Testing HCT services for at risk-populations and household members of HIV positive individuals in high prevalence areas. The services will increase coverage within the community setting and at all types of HCT sites including provider initiated counseling and testing (PICT), mobile, and community especially for high-risk groups, victims of sexual violence and TB patients. These services will have proactive linkages with other HIV/AIDS services offered through the public and private sector.

The contractor will assume responsibility for HCT centers currently administered by Family Health International as appropriate and assist in expanding and scaling up of HCT services with local NGOs and community-based organizations to link community and home-based care. This

program will address the dissemination of PICT guidance through supporting health facility based CT and couples counseling. Services will support community groups and health facilities serving at-risk populations. This will improve access to quality counseling and testing services and expand coverage and target those populations/communities at highest risk in order to identify those in need of clinical care. This will include HCT for HIV positive individuals and other family members, and provide risk reduction and family planning counseling for discordant couples.

The contractor will develop a comprehensive PMTCT program in the selected areas where critical gaps are identified. The contractor will assess the rationale and opportunity to new policy and will describe why whether or not Nevirapine or triple therapy regimen will be used in these urban and peri urban areas. The contractor will provide TA to the provincial level in the USG selected sites to implement the new PICT, couple CT in the PMTCT sites as appropriate and feasible. Additionally, the contractor will provide technical assistance to existing rural PMTCT health facilities implemented through a separate mechanism.

Key implementation activities include but are not limited to:

- Developing and implementing prevention messages and communication strategies to promote safe behaviors;
- Developing and implementing positive living strategies targeting people living with HIV/AIDS to assist them in living healthy productive lives;
- Developing and implementing prevention activities targeting MARPs especially among discordant couples and household members;
- Strengthening referral systems between the community and facilities for appropriate care and support services and follow-up;
- Provision of comprehensive PMTCT services to address service gaps;
- Enhancement and expansion of integrated HCT services within community and home-based care programs to reach family and household members where PLWHA reside;
- Enhancement and expansion of facility-based HCT services;
- Provision of individual, couple and family-oriented counseling services with a strong emphasis on HIV prevention counseling, including home-based services, particularly in high-prevalence areas and among high risk populations (CSWs, MSM, military and their families and partners and youth);
- Extensive use of community-counselors, including the training of community counselors using new modules currently under development;
- Coordinate with existing prevention and social marketing activities.

Illustrative implementation activities to expand and enhance HCT services are expected to include:

- Institutionalization of quality control systems and tools to support community-level services;
- Increasing promotion and uptake of pediatric HCT and referrals for ART where services exist;
- Provision of supplies and equipment including test kits and essential supplies for HCT service delivery;
- Strengthening universal precaution practices, specifically in the area of waste management systems,
- Strengthening of capacity to use rapid testing;

- Strengthening quality assurance system that is technically sound and feasible given the unique set of challenges in DRC;
- Increase uptake of comprehensive PMTCT services and referral of eligible pregnant women for ART services including care for women and children identified in PMTCT sites, infant feeding and nutrition support, earlier infant diagnosis, provision of CTX, gender and psychosocial support etc.
- Develop prevention with positives programs in the selected sites.

### **Care, Support and Treatment**

**Total Level of Effort (LOE) 63%**

The USG strategy promotes the integration of palliative care into the framework of the Family Centered Continuum of HIV Services, and it supports this model at the national level. The development of home-based care guidelines, standardization of training, standardization of a package of services, and provision of critical commodities (home-based care kits) have been priorities.

The contractor will assume responsibility for the PLWHA and OVC beneficiaries within the programs currently being implemented by Catholic Relief Services. It is preferred that the contractor will work through local NGOs, FBOs, and other providers of community and home-based palliative care by building technical and organizational capacity to implement innovative care programs that promote empowerment and positive living. This TO will:

- Increase access to quality community and home-based care and support;
- Improve linkages between community and clinic-base care,
- Develop a needs-based standard package of care for PLWHA (i.e. appropriate and sustainable nutritional support, psychosocial counseling, family planning counseling and services, control of opportunistic infections including prophylaxis and mosquito nets, support groups, vocational training and income generation);
- Develop networks of positive living PLWHA support groups to catalyze sustainable self-help activities including group income generating activities, gardening and recreation;
- Deliver low-cost, evidence-based preventive care with linkages to other public health interventions at the household level;
- Develop a system for monitoring the quality of care;
- Coordinate closely with ART sites supported by Global Fund, World Bank, Clinton Foundation to ensure access to needed services and community follow-up for all enrolled HIV patients;
- Ensure the availability of basic care commodities and services;
- Ensure adherence promotion and monitoring of clinical therapy in addition to supporting health facilities trace defaulters;
- Ensure support to orphans and vulnerable children (OVC), both infected and affected by HIV/AIDS, in one or more of the six intervention areas identified by PEPFAR OVC guidance.

The following are illustrative activities that the contractor will provide under this TO:

### **Illustrative Activities**

- Strengthen community-based palliative care programs through a stronger link to clinical care, as well as the provision of some basic health services by home-based care providers;

- Training for care providers with a minimum care package (safe water instruments and provision of basic hygienic materials, basic screening for TB, provision of bednets, adherence counseling for cotrimoxazole (CTX) and/or ART, condom provision and prevention BCC);
- Provide specific food and nutrition services to the HIV/AIDS program;
- Expand HIV services in facility-based settings, particularly in the Lubumbashi and surrounding sites, to improve the package of palliative care (OI commodities, nutritional needs, etc) at the facility level;
- Ensure family planning services are accessible for PLWHA;
- Develop and implement quality assurance and monitoring systems;
- Strengthen the supply chain of HIV-related commodities;
- Train and provide regular supportive supervision to care givers in OVC services;
- Develop and refine a needs-based standard package of care for OVC (e.g. school support, social protection/inheritance advocacy, vocational training, income generating activities, recreational clubs);
- Provide community-based OVC care and support services in line with the Ministry of Social Affaires (MINAS) OVC Action Plan.
- Engage MINAS in the implementation of community-based activities defined in the National OVC Action Plan and strengthen capacity to coordinate and to increase its leadership role in addressing OVC issues following-up on support currently provided by Constella Futures

**Health System Strengthening and Human Capacity Development      Total LOE      4%**

USAID plans to expand its current focus on health zones and health centers to an approach that places zonal and health facility support in the context of strengthened, effective provincial management of the sector. Planning, policy, management and the budgeting process have been devolved to the provincial level and provincial health teams require system strengthening and capacity building assistance to be able to assume these devolved functions. The Contractor will also provide assistance in strengthening the capacity of local NGOs to provide prevention, care and support and treatment services.

**Illustrative Activities**

- Strengthening referral mechanisms and pathways to community and facility services for HIV positive individuals;
- Strengthening strategic information skills at the community and facility-based levels;
- Strengthening of quality assurance and performance monitoring systems modeled on national and international service and quality standards;
- Training to improve counseling and testing skills and the deployment of community counselors;
- Increase the number of trained Congolese NGO providers of adult and pediatric home-based care to improve quality, ensure the provision of a standard package of care and expand care and support services to more PLWHA;
- The Contractor should describe how the proposed program will further strengthen the health system and build human and institutional capacity.
- Capacity building and provision of sub-grants to local partners providing them with experience implementing targeted activities; managing funding; documenting and reporting results. This support would also promote sustainability of activities through local ownership.

## **PROGRAM MANAGEMENT**

Technical Direction and Coordination: The USAID/DRC COTR is responsible for overall management oversight, and technical direction of the contractor and the overall HIV/AIDS Prevention, Care and Treatment program. The COTR will provide technical directions during the performance of this TO, both in writing and verbally. The contractor shall meet monthly (via phone call or in person) with the COTR or his/her designee to review the status of activities, and should be prepared to make periodic, unplanned verbal and written briefings to USAID/DRC, and U.S. Embassy staff as appropriate. The contractor will be prepared to provide active input as requested for USG planning and reporting processes including the annual Country Operating Plan (COP) development, quarterly reporting, etc

### **C.5 PERFORMANCE MONITORING PLAN**

The contractor's performance shall be evaluated based on the completion of specific tasks as outlined in the Task Order, adherence to the work plan, and reports submitted to the Contracting Officer Technical Representative (COTR).

### **C.6 GEOGRAPHIC CODE:**

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

**END OF SECTION C**

## **SECTION D – PACKAGING AND MARKING**

### **D.1 AIDAR 752.7009 MARKING (JAN 1993)**

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

(b) Specific guidance on marking requirements 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](http://www.usaid.gov/branding), or any successor branding policy.

### **D.3 PACKAGING AND PACKING PROVISIONS**

Packaging, packing, and marking shall be in accordance with all applicable FDA regulations or the manufacturer’s current public sector packaging for overseas distribution. Packaging and packing must ensure the safety, efficacy, and quality of the product and be appropriate for distribution to harsh climates under less than ideal transport and storage conditions. USAID reserves the right to revise the marking requirement in the final award.

**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 AIDSTAR Sector I IQC Section E.2.

**END OF SECTION E**

## **SECTION F – DELIVERIES OR PERFORMANCE**

### **F.1 PERIOD OF PERFORMANCE**

The estimated period of performance for this task order is October 1, 2009 through September 30, 2014.

### **F.2. DELIVERABLES**

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

### **F.3 TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS**

Lisa M. Bilder  
Contracting Officer  
U.S. Agency for International Development  
1300 Pennsylvania Ave. NW  
Washington, D.C. 20523  
Room 7.09-071  
Telephone: 202-712-5882  
Fax: 202-216-3072  
Email: lbilder@usaid.gov

The Contracting Officer Technical Representative (COTR) will be designated separately.

### **F.4 PLACE OF PERFORMANCE**

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

### **F.5 AUTHORIZED WORK DAY / WEEK**

No overtime or premium pay is authorized under this Task Order

### **F.6 REPORTS AND DELIVERABLES OR OUTPUTS**

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

## **REPORTING REQUIREMENTS**

### **A. Annual Work Plan**

The contractor shall develop annual work plans in concert with other USAID, PEPFAR and Ministry of Health partners, aligned to each US fiscal year of the contract. The contractor shall submit an annual work plan for the first 12 months of the TO, which will be reviewed, finalized and approved in consultation with USAID/DRC during the first 30 days following the award. Subsequent 12-month work plans through the end of the TO will be prepared and submitted to the USAID/DRC COTR no later than 30 days after the beginning of the new fiscal year.

The work plan shall include, as a minimum:

1. Proposed accomplishments and expected progress towards achieving TO results and performance targets tied to the M&E plan, annual PEPFAR COP and Country Compact;
2. Timeline for implementation of the year's proposed activities, including target completion dates;
3. Information on how activities will be implemented and supervised;
4. Personnel requirements to achieve expected outcomes;
5. Major commodities and equipment to be procured;
6. Details of collaboration with other major partners; and
7. Detailed budget.

## **B. Reporting Strategic Information**

USAID/DRC values the importance of high quality data to inform planning and guide program development, implementation and improvement. Access to reliable program data is essential to program management and facilitates effective program design, monitoring, forecasting and accountability.

The Contractor will be expected to establish and/or maintain data collection systems in order to provide monthly, quarterly, semi-annual and annual reports on the progress of implementation within the technical areas specified. Data for inclusion in USAID/DRC's semi-annual and annual reports to the Office of the Global HIV/AIDS Coordinator (OGAC) will also be requested from the Contractor.

All reports requested should include data for the indicators defined below. The contractor should carefully review the draft Next Generation Indicators Reference Guide to identify additional recommended indicators and propose targets to appropriately monitor outputs and outcomes in relation to each program objective and technical activity.

The table below shows the proposed annual targets for the essential PEPFAR indicators for the first two years. Additional indicators may be required including the addition of PEPFAR recommended indicators, following changes in PEPFAR guidance and Mission reporting needs. Targets will need to be discussed and adjusted annually as appropriate and should be proportional to potential funding increases. Reporting for these indicators will need to be disaggregated by age, gender, sero-status, and sub-groups as per the draft Next Generation Indicators Reference Guide. It is expected that mechanisms will be put in place for the collection of baseline data to inform target setting in collaboration with USAID/DRC for FY2010 reporting.

**Table 1. Cumulative Annual Targets for Essential PEPFAR Indicators**

<b>Indicator</b>	<b>Y1</b>	<b>Y2</b>
<b><i>PMTCT</i></b>		
Number of pregnant women who were tested and received their results	<b>11,500</b>	<b>23,000</b>
Number of HIV+ women who received ART to reduce risk of mother-to-child transmission	<b>250</b>	<b>500</b>
<b><i>Sexual and Other Risk Prevention</i></b>		
Number of PLWHA reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	<b>14,100</b>	<b>15,500</b>
Number of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	<b>28,968</b>	<b>40,000</b>
<b><i>Care</i></b>		
Number of eligible adults and children provided with a minimum of one care service <sup>11</sup>	<b>30,000</b>	<b>33,000</b>
Number of HIV+ adults and children receiving a minimum of one clinical service	<b>30,000</b>	<b>33,000</b>
Number of HIV+ persons receiving CTX	<b>14,000</b>	<b>15,400</b>
Number of HIV+ clinically malnourished clients who received therapeutic or supplementary food	<b>3,440</b>	<b>3,784</b>
Number of eligible clients who received food and/or nutrition services in accordance with PEPFAR food and nutrition guidelines	<b>17,200</b>	<b>18,920</b>
Number of adults and children with advanced HIV infection newly enrolled on ART <sup>12</sup>	<b>500</b>	<b>550</b>
Number of adults and children with advanced HIV infection receiving ART <sup>13</sup>	<b>500</b>	<b>1,050</b>
Percent of adults and children with HIV known to be on treatment 12 months after initiation of ART	<b>90%</b>	<b>95%</b>
<b><i>TB/HIV</i></b>		
Percent of HIV+ patients who were screened for TB in HIV care or treatment settings	<b>90%</b>	<b>100%</b>
Number of individuals who received Testing and Counseling services for HIV and received their test results	<b>144,840</b>	<b>200,000</b>
<b><i>Human Resources for Health</i></b>		
Number of community health care workers who successfully completed a pre-service training program	<b>1,720</b>	<b>1,892</b>
Number of health care workers who successfully completed an in-service training program	<b>900</b>	<b>990</b>

<sup>11</sup> The program should not ration care, rather services are need-based and as comprehensive as necessary to ensure positive outcomes

<sup>12</sup> As the Integrated HIV Program will not provide ART this indicator should capture people referred to other service providers with follow-up to confirm enrollment

<sup>13</sup> This indicator should capture the number of HIV+ individuals enrolled in ART and receiving comprehensive ancillary supportive services through the Program

The Contractor is expected to include appropriate Health Systems Governance indicators to monitor policy reform and development of PEPFAR supported activities in accordance with the draft *Next Generation Indicators Reference Guide*. The Contractor will be required to adapt data collection systems accordingly to facilitate these changes. All PEPFAR indicators will be measured according to the most current PEPFAR guidance and policy relevant to those indicators.

It is expected that the Contractor will make all necessary provisions to ensure that the quality of data reported is of a high level and should be validated and verified prior to report submission. Currently the Mission is working with Measure Evaluation to harmonize data collection across all USAID program and the contractor will need to coordinate as appropriate. In support of the "Third One", one monitoring and evaluation system, development of data collection systems should be done within the national framework, parallel data collection systems should be avoided at all costs.

### **C. Quarterly Reports**

Quarterly Financial Reports shall be submitted within 45 calendar days after the end of the reporting period. The scope and format of the quarterly reports will be determined in consultation with the COTR and the contracting officer

**END OF SECTION F**

## **SECTION G – TASK ORDER ADMINISTRATION DATA**

### **G.1 CONTRACTING OFFICER'S AUTHORITY**

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

### **G.2 TECHNICAL DIRECTION**

USAID Democratic Republic of Congo (DRC) shall provide technical oversight and direction to the Contractor through the designated Contracting Officer's Technical Representative (COTR). The contracting officer shall issue a letter appointing the COTR for the task order and provide a copy of the designation letter to the contractor.

The COTR will provide technical direction during the performance of this task order, both in writing and verbally. The contractor shall meet at least biweekly (via phone call or in person) with the COTR or his/her designee to review the status of activities, and should be prepared to make periodic, unplanned verbal and written briefings to USAID/DRC, and U.S. Embassy staff as needed.

### **G.3 ACCEPTANCE AND APPROVAL**

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

### **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 **M/FMO/CMP**. One copy of the voucher and the invoice shall also be submitted to the Contracting Officer and the COTR.

Electronic submission of invoices is encouraged. Submit invoices to the Office of Chief Financial Officer to this address: [EI@USAID.GOV](mailto:EI@USAID.GOV).

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:

USAID/DROC  
198, Isiro Avenue  
Kinshasa, Gombe  
Democratic Republic of Congo

If submitting invoices electronically, do not send a paper copy.

**END OF SECTION G**

## SECTION H – SPECIAL TASK ORDER REQUIREMENTS

### H.1 KEY PERSONNEL

The offeror is encouraged to propose a staffing pattern that can best achieve the desired results. The offeror should provide a full team of specialists appropriate to the tasks requested herein. Use of DRC personnel is encouraged to the greatest extent possible, including the use of DRC nationals as technical members of the contract team. The following positions are considered long term key program personnel:

- Chief of Party
- Deputy Chief of Party/Senior Technical Advisor
- Community based Care and Treatment Specialist
- Monitoring and Evaluation Specialist
- Finance and Admin Specialist

#### Chief of Party (COP)

The COP will have technical and management responsibility for all contractor personnel and be the contractor's representative to USAID/DRC, the Line Ministries including Health, other donors and multinationals, technical agencies and other participating organizations as required. The COP will have overall responsibility for addressing contract-related issues, including ensuring that contractor financial controls and systems comply with generally accepted accounting practices that meet USAID standards, and that all activity-procured materials and equipment are safeguarded and prudently and responsibly used. S/he will be responsible for the smooth implementation of the project and for providing general program and technical direction as well as completion of required reports.

This individual must be a senior project management specialist with at least 10 years of experience in the implementation and management of international development projects, specifically, with combined experience in two or more areas such as HIV/AIDS prevention, care and support and treatment. Given the number of organizations and institutional partners with which the program will interact, the COP should possess demonstrated capacity to build and maintain productive working relationships with a wide network of partners and stakeholders. He/she also should have experience in community development. He/she should have a good knowledge of USAID and PEPFAR regulations and procedures pertaining to activity design/implementation and substantial experience as a Chief of Party. This individual should have a broad understanding of public health and in particular must be sufficiently knowledgeable in the area of HIV/AIDS. The COP should be knowledgeable about the relevant socioeconomic, institutional and policy issues that are related to this area of work. S/he should have at a minimum a Master's Degree in public health, social sciences, international development, or a related field. S/he must have demonstrated English and French language skills (FS-3 level or higher).

#### Deputy Chief of Party/Senior Technical Advisor

The Deputy Chief of Party/Senior Technical Advisor (DCOP/STA) will work in close collaboration with the Chief of Party and the Program's technical staff to provide strategic inputs to the Program's HIV/AIDS prevention, care and support and treatment activities. In collaboration with the Program's M&E Officer, the Deputy Chief of Party/Senior Technical Advisor will monitor program results and will be responsible for ensuring that the program

provides high quality services, meets its annual targets and is maximizing positive outcomes. The DCOP/STA will serve as Chief of Party when the Chief of Party is away from the program. This position will be filled by a Congolese HIV/AIDS specialist.

An advanced degree at the Masters level or above in social science, public health or other appropriate area is required. The position requires at least five years experience with USG-funded health and HIV/AIDS project design, monitoring and evaluation methodologies including qualitative and quantitative skills, PEPFAR experience strongly preferred. Other requirements include:

- Experience in directing, managing, implementing, and evaluating large, complex projects involving the collection, analysis, and presentation of health and population data that covers the full range of technical, field and administrative skills required for successful implementation of this type of program;
- At least 5 years of supervisory experience;
- Demonstrated English and French language skills (FS-3 level or higher).
- Well-organized, attentive to detail, and able to handle multiple tasks simultaneously; and
- Works well independently and in teams; pro-active in anticipating work requirements and problem solving.

#### Community-Based Care and Treatment Specialist

The Community-Based Care and Treatment Specialist will be responsible for the implementation of capacity building and provision of technical assistance to field activities for care and treatment with a focus on those programs targeting most at risk populations. An understanding of the socio-cultural issues and nuances of working in such communities is highly desirable. S/he will work directly with partner organizations, communities and other resource users to execute the various activities. These qualifications include:

- An advanced degree at the Masters level in social science, public health or other appropriate area is required.
- At least 5 years of experience in the provision of successful, targeted community-based HIV/AIDS programming. S/he should have considerable experience and technical expertise working with community-based organizations, NGOs, and host-country governments. Demonstrated English and French language skills (FS-3 level or higher);
- Well-organized, attentive to detail, and ability to handle multiple tasks simultaneously; and
- Works well independently and in teams; pro-active in anticipating work requirements and problem solving.

#### Monitoring and Evaluation (M&E) Specialist

The Monitoring and Evaluation Specialist should have the required academic qualifications and demonstrated experience in monitoring and evaluation of public health programs to provide technical leadership to these activities under this TO. These qualifications should include:

- A graduate degree in public health, demography, sociology, epidemiology, biostatistics, psychology or a related field.
- At least 10 years of experience in monitoring, evaluating and research related to public health programs, with at least 3 years of experience with USG or PEPFAR HIV-related programming.

- Demonstrated experience in HIV/AIDS program target setting and reporting
- Excellent verbal, written, interpersonal and presentation skills
- Demonstrated experience and familiarity with behavioral surveillance surveys, research methodologies, qualitative and quantitative research methods, data analysis, sampling techniques and establishing M&E systems in developing countries.
- Demonstrated English and French language skills (FS-3 level or higher)

#### Finance & Administration Specialist

The Finance and Administration Specialist should have the required academic qualifications and demonstrated experience in finance and administration. These qualifications should include:

- Administrative project management experience and training in international settings
- Knowledge of applicable USG and PEPFAR procurement, contracting, rules and regulations, as well as administrative policies and techniques
- Excellent verbal, written and interpersonal skills
- Advanced degree in business administration, economics or finance
- Minimum Experience: 10 years related administration, with experience with an international organization
- Demonstrated English and French language skills (FS-3 level or higher)

#### Short Term and Other Technical Assistance

It is anticipated that expertise will be required in areas such as care for positive living approaches, PMTCT, OVC, home-based care for people living with HIV, health system strengthening, public private partnerships, and prevention. The Offeror should propose the estimated level of effort and number of short-term, part-time and other expatriate and local technical assistance required over the life-of-activity. Offerors are to provide for assessment an illustrative list of expertise deemed appropriate, along with required qualifications for personnel who will provide this expertise.

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

## **H.2 LANGUAGE REQUIREMENTS**

All deliverables shall be produced in English.

## **H.3 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 COTR.

## **H.4 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.5 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.

**END OF SECTION H**

**SECTION I – CONTRACT CLAUSES**

**I.1 HIV/AIDS – AIDSTAR SECTOR I – Technical Assistance IQC.**

**END OF SECTION I**

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

**SECTION J - LIST OF ATTACHMENTS**

<b>Attachment Number</b>	<b>Title</b>
J.1	USAID FORM 1420-17 Contractor Biographical Data Sheet*
J.2	Acronyms Sheet
J.3	Past Performance Report

\* A hard copy is attached at the end of this document; however, for an electronic version, please locate the form at [http://www.USAID.GOV/procurement\\_bus\\_opp/procurement/forms/](http://www.USAID.GOV/procurement_bus_opp/procurement/forms/) . The copy of the form is being provided herewith for reference purpose only

**END OF SECTION J**

## SECTION K – REPRESENTATIONS, CERTIFICATIONS, AND OTHER STATEMENTS

Not required.

## SECTION L - INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS

### L.1 GENERAL

USAID is issuing a Request for Task Order Proposal (RFTOP) under the AIDSTAR Sector I IQC to implement a task order focusing on integrating HIV/AIDS prevention, care and treatment service delivery program with a primary focus on the most-at-risk populations (MARPs) and a secondary focus on the general public for the DRC. The Government anticipates the award of one (1) Cost Plus Fixed Fee Level of Effort (CPFF LOE) as a result of this RFTOP; however, it reserves the right to make multiple awards or no award. Subject to the annual availability of funds.

### L.2 ACQUISITION SCHEDULE

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

	Date
RFTOP issued	July 9, 2009
Questions due	July 20, 2009
Answers to questions disseminated	July 31, 2009
Proposals due	August 6, 2009

**All Questions relating to this RFTOP must be submitted to Keisha Foster at kfoster@usaid.gov via email no later than 12:00 noon EST, by July 20, 2009) Unless otherwise notified by an amendment to the RFTOP, no questions will be accepted after this date. Offerors must not submit questions to any other USAID staff, including the technical office for either the Task Order or the basic IQC.**

### L.3 GENERAL INSTRUCTIONS TO OFFERORS

RFTOP Instructions: If an Offeror does not follow the instructions set forth herein, the Offeror's proposal may be eliminated from further consideration or the proposal may be down-graded and not receive full or partial credit under the applicable evaluation criteria.

- (a) **Accurate and Complete Information:** Offerors must set forth full, accurate and complete information as required by this RFTOP. The penalty for making false statements to the Government is prescribed in 18 U.S.C. 1001.
- (b) **Offer Acceptability:** The Government may determine an offer to be unacceptable if the offer does not comply with all of the terms and conditions of the RFTOP.
- (c) **Proposal Preparation Costs:** The U.S. Government will not pay for any proposal preparation costs.

#### **L.4 INSTRUCTIONS FOR THE PREPARATION OF THE TECHNICAL PROPOSAL**

The technical proposal should be no longer than 25-pages (maximum including executive summary, tables and figures) with text in 12 Times New Roman point font, on 8 ½" by 11" paper with one inch margins. An Annex for personnel related documents (CVs) will not be counted against the 25-page maximum. Additional documentation beyond the 25 page limit and personnel annex will neither be read nor evaluated by USAID. The proposal must be submitted electronically and the software must be compatible with Microsoft Office.

##### **(1) TECHNICAL UNDERSTANDING AND APPROACH**

Offerors must propose how to carry out the statement of work. They must demonstrate a clear understanding of the work to be undertaken and the responsibilities of all parties involved. Offerors must describe a clear and comprehensive plan and rationale on the technical approaches and activities to complete the tasks in the statement of work.

##### **(2) KEY PERSONNEL AND MANAGEMENT PLAN**

Evaluation of key personnel will focus on relevant and demonstrated qualifications, local experience, language competency and skills applicable to the personnel requirements contained in the statement of work.

##### **(3) PAST PERFORMANCE**

Offeror's capability will be assessed on the extent to which the offeror demonstrates successful experience in the areas described in the statement of work emphasizing organizational, management, and technical actions under previous contracts and experience implementing programs in challenging settings such as the Democratic Republic of Congo.

#### **L.5 COST PROPOSALS**

Offerors shall submit their cost proposal(s) in excel format with full access to all formulas. Detailed costs associated with each CLIN such as salaries, indirect costs, travel, equipment, and fee, shall be provided separately in the proposal for evaluation purposes. Please break out the LOE per CLIN as applicable.

Offerors shall submit a detailed budget estimate with full access to all formulas with detailed budget notes/narrative explaining and providing detailed justification for each cost category anticipated under the proposed Task Order in the format as stated in the table below. There is no page limitation to the cost proposal nor the budget narrative. In addition provide the following information:

a) Summary Cost Breakdown – Please provide a breakdown, by element, for anticipated costs performed under this Task Order.

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

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

d) A certification that no USAID employee has recommended the use of an individual or subcontractor under the proposed Task Order who was not initially located and identified by your organization.

e) USAID will set the standard of Full Time Equivalent (FTE) of 260 working days/year. USAID anticipates ordering 195.2 FTEs over the course of this 5 year task order. Please adjust proposed budgets accordingly.

**Level of Effort (LOE) for 5 years**

The total amount of LOE levels are provided below for all positions under this task order. Chief of Party, Deputy Chief of Party and/or Senior Technical Advisor, Community based Care and Treatment Specialist, Monitoring and Evaluation Specialist, Finance & Administration Officer are considered "Long Term Key Program Personnel". "LTTS Admin/Support, LTTS Professional and STTS " staff will include mid/lower level personnel involved in field implementation, data collection, data processing, and project support activities. USN/TCN/CCN staff may fall under any of these categories.

<b>FTE Core/Person Years 1-5</b>		
<b>Long-Term Key Program Personnel</b>	<b>FTE Per Year</b>	<b>FTE Total Years 1 - 5</b>
Chief of Party	1	5
Deputy Chief of Party/Senior Technical Advisor	1	5
Community based Care and Treatment Specialist	1	5
Monitoring and Evaluation Specialist	1	5
Finance and Admin Officer	1	5
<b>Long-Term Technical (LTTS) Admin/Support Staff</b>	17.5	87.5
<b>Long-Term Technical (LTTS) Professional Staff</b>	15	75

<b>FTE Core/Person Short Term Technical Staff (STTS) Years 1-5</b>						
	<b>Year 1</b>	<b>Year 2</b>	<b>Year 3</b>	<b>Year 4</b>	<b>Year 5</b>	<b>Total Years 1-5</b>
STTS United States National (USN)	.96	.57	.61	.19	.11	<b>2.44</b>
STTS Third Country National (TCN)	.84	.38	.38	.19	.15	<b>1.94</b>
STTS Congolese Country National (CCN)	.96	.76	.76	.46	.38	<b>3.32</b>

- a. Salary and Wages: Direct salaries and wages should be proposed in accordance with the offeror's personnel policies;
- b. Fringe Benefits: If the offeror has a fringe benefit rate that has been approved by an agency of the U.S. Government, such rate should be used and evidence of its approval should be provided;
- c. Travel and Transportation: The proposal should indicate the number of trips, domestic and international, and the estimated costs. Specify the origin and destination for each proposed trip, duration of travel, and number of individuals traveling. Per diems should be based on the offeror's normal travel policies;
- d. Equipment: Estimated types of equipment (i.e., model #, cost per unit, quantity);
- e. Supplies: Office supplies and other related supply items related to this activity;
- f. Contractual: Any goods and services being procured through a contract mechanism;
- g. Other Direct Costs: This includes communications, report preparation costs, passports, visas, medical exams and inoculations, insurance (other than insurance included in the applicant's fringe benefits), equipment, office rent abroad, etc. The narrative should provide a breakdown and support for all other direct costs;
- h. Indirect Costs: The offeror should support the proposed indirect cost rate with a letter from a cognizant U.S. Government audit agency, a Negotiated Indirect Cost Agreement (NICRA), or with sufficient information for USAID to determine the reasonableness of the rates. (For example, a breakdown of labor bases and overhead pools, the method of determining the rate, etc.);
- i. Fixed fee: Proposed fee, if any, not to exceed the ceiling set forth in the IQC.

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

**END OF SECTION L**

## SECTION M – EVALUATION FACTORS FOR AWARD

### M.1 GENERAL INFORMATION

USAID will award to the responsible Contractor whose proposal best meets the requirements of the Scope of Work and represents the best value to the U.S. Government, all things considered. Specifically:

- (a) The Government may award a task order without discussions with offerors.
- (b) The Government intends to evaluate task order proposals in accordance with Section M of this RFTOP and award to the responsible contractor(s) whose task order proposal(s) represents the best value to the U.S. Government. “Best value” is defined as the offer that results in the most advantageous solution for the Government, in consideration of technical, cost, and other factors.
- (c) The submitted technical information will be scored by a technical evaluation committee using the technical criteria shown below. The evaluation committee may include industry experts who are not employees of the Federal Government. When evaluating the competing Offerors, the Government will consider the written qualifications and capability information provided by the Offerors, and any other information obtained by the Government through its own research.

### M.2 TECHNICAL PROPOSAL EVALUATION CRITERIA

The technical evaluation criteria listed below are tailored to the requirements of this RFTOP and are presented by major category in descending order of importance to help Contractors identify technical areas of emphasis. Sub-criteria within each criterion are of equal importance. These criteria serve as the standard against which the Technical Evaluation Committee (TEC) shall evaluate responsive technical proposals. The specific evaluation criteria are as follows:

#### **Technical Understanding and Approach to the Statement of Work (40%)**

The extent of the offerors’ understanding of and feasibility/ability to successfully perform the activities as described in the Statement of Work, using the appropriate technical strategies, approaches, and methodologies, and including an adequate consideration of gender in all stages of activity, as appropriate.

#### **Key Personnel and Management Plan (40%)**

- a. *Key Personnel.* The demonstrated quality of the proposed Chief of Party and other key positions as well as demonstrated access to appropriate technical personnel with technical experience and expert qualifications in all the programmatic areas outlined in the Statement of Work. (20%)
- b. *Management Plan.* The offeror shall clearly describe its ability to manage activities carried out under the Statement of Work, provide technical support and necessary oversight, and work with USAID/DRC staff, other USG agencies, donors, implementing partners and key stakeholders. The offeror shall explain the potential for the management approach to effectively contribute to achieving project objectives and targets. The offeror shall describe in the proposal the proposed role of each technical staff in the program and specify the proportion of time each person will be

in the field. The offeror shall also clearly describe the role of and contractual arrangement with each subcontractor (if any), the approach for managing of proposed subcontractors (if any), and demonstrated past experience managing subcontractors (if applicable). (20%)

### **Past Performance (20%)**

Offeror's capability will be assessed on the extent to which the offeror demonstrates successful experience in the areas described in the statement of work emphasizing organizational, management, and technical actions under previous contracts and experience implementing programs in challenging settings such as the Democratic Republic of Congo. The Contractor should demonstrate a track record of quality, timeliness, good business practices, customer satisfaction and attention to cost control, all performed while working in challenging political and developmental contexts.

### **EVALUATION RATINGS**

Proposals will be evaluated based on the following adjectival ratings:

#### ***Excellent***

The proposal exceeds the fullest expectations of the Government. The Contractor has convincingly demonstrated that the evaluation requirements have been analyzed, evaluated, and should result in outstanding, effective, efficient, and economical performance under the contract. The proposal is comprehensive, thorough and of exceptional merit. No deficiencies or significant weaknesses have been found.

When applied to criteria and/or the proposal as a whole, an outstanding rating indicates that no deficiencies or significant weaknesses exist within any sub-criteria that represent a performance risk within the criteria and/or the proposal as a whole.

#### ***Good***

The proposal demonstrates overall competence, meets all TO minimum requirements and exceeds requirements in some areas but not all. No deficiencies or significant weaknesses are apparent. Strengths outbalance any weaknesses that exist. No more than a few minor weaknesses have been identified that are easily correctable and do not represent a performance risk.

When applied to criteria and/or the proposal as a whole, a good rating indicates that no deficiencies or significant weaknesses exist within any sub-criteria that represent a performance risk within the criteria and/or the proposal as a whole. No more than a few minor weaknesses have been identified within the criteria and/or proposal that are easily correctable and do not represent a performance risk.

#### ***Fair***

The proposal is reasonably sound and meets the TO minimum requirements. The proposal may contain weaknesses and/or significant weaknesses that are correctable but no deficiencies. If any weaknesses and/or significant weaknesses are noted, they should not seriously affect the Contractor's performance.

When applied to the criteria and/or the proposal as a whole, a fair rating indicates that there are no major deficiencies within the criteria and/or proposal that will represent a performance risk. Any significant or minor weaknesses that have been identified within the criteria and/ or

proposal are correctable. They should not seriously affect the Contractor's performance.

***Poor***

The proposal demonstrates a shallow understanding of the TO requirements and approach and marginally meets the minimal requirements for acceptable performance. The proposal contains weaknesses and/or significant weaknesses and may contain deficiencies. If deficiencies exist, they may be correctable with a significant revision of the proposal. The Contractor may complete the assigned tasks; however, there is a moderate risk that the Contractor will not be successful.

When applied to the criteria and/or the proposal as a whole, a poor rating indicates that there are deficiencies and/or significant weaknesses within the criteria and/or proposal that represent a moderate performance risk. Only a significant revision of the proposal would correct these areas of concern.

***Unacceptable***

The proposal fails to meet minimum TO requirements or contains one or more major deficiencies. The proposal is incomplete, vague, incompatible, incomprehensible, or so incorrect as to be unacceptable. The evaluator feels that the deficiency or deficiencies is/are uncorrectable without a major revision of the proposal. The deficiencies, weaknesses and/or significant weaknesses would seriously affect the Contractor's performance and represent a high risk that the Contractor will not be successful.

**M.3 COST PROPOSAL EVALUATION**

Cost proposal will be evaluated separately and overall costs are considered less important than the strengths of the technical proposal. However, where proposals are considered essentially equal, cost may be the determining factor in selecting a Contractor for award.

The overall standard for judging cost proposals will be whether the cost proposal presents the best value to the government for the technical approach proposed. Each cost proposal eligible for consideration will be evaluated based on whether (i) it is realistic and consistent with the technical proposal; and (ii) individual costs are considered reasonable based on an analysis to identify salaries, home office visits, or other cost categories considered to be excessive.

**END OF SECTION M**

**ATTACHMENT J.1 Contractor Biographical Data Sheet**

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**ATTACHMENT J.2 Acronym Sheet**

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**ATTACHMENT J.3 Past Performance**

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**CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET**

1. Name (Last, First, Middle)		2. Contractor's Name	
3. Employee's Address (include ZIP code)		4. Contract Number	5. Position Under Contract
		6. Proposed Salary	7. Duration of Assignment
8. Telephone Number (include area code)	9. Place of Birth	10. Citizenship (if non-U.S. citizen, give visa status)	

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

12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (See Instructions on Reverse)		
NAME AND LOCATION OF INSTITUTE	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading

14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.

2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, or dependent education allowances.

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

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

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

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

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

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

Signature of Contractor's Representative	Date
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**LIST OF ACRONYMS**

ADB	African Development Bank
ANC	Antenatal care
ART	Antiretroviral Treatment
ARV	Antiretroviral
ASF	Association Sante Familial
BCC	Behavior Change Communication
CBOs	Community-based Organizations
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control
CHAT	Country Harmonization Alignment Tool
CIDA	Canadian International Development Agency
COP	Chief of Party
COP	Country Operational Plan
COTR	Contracting Officer's Technical Representative
CRS	Catholic Relief Services
CSWs	Commercial Sex Workers
CT	Counseling and Testing
CTX	Cotrimoxazole
DFID	Department for International Development
DHS	Demographic Health Survey
DCOP/STA	Deputy Chief of Party/Senior Technical Advisor
DOD	Department of Defense
DOS	Department of State
DRC	Democratic Republic of Congo
EU	European Union
FBOs	Faith-Based Organizations
FHI	Family Health International
GBV	Gender-Based Violence
GDA	Global Development Alliance
GDRC	Government of the Democratic Republic of Congo

GF	Global Fund
GTZ	German Technical Cooperation
HBC	Home-based care
HCT	HIV/AIDS Counseling and Testing
HZs	Health Zones
IEC	Information, Education and Communication
IGA	Income-Generating Activities
KSPH	Kinshasa School of Public Health
LOE	Level of Effort
MAP	Multi-Country AIDS Program
M&E	Monitoring and Evaluation
MARPs	Most-at-Risk Populations
MINAS	Ministry of Social Affaires
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSF	Médecins sans Frontières
MVU	Mobile Video Units
PNLS	National AIDS Control Program
PNMLS	National Multi-Sector AIDS Commission
PNTS	National Blood Safety Program
NGOs	Non-Governmental Organizations
NVP	Nevirapine
OGAC	Office of the Global HIV/AIDS Coordinator
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PICT	Provider Initiated Counseling and Testing
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission

PSI	Population Services International
RAAAP	Rapid Assessment, Analysis, and Action Plan
SBFA	Safe Blood for Africa
SPS	Strengthening Pharmaceutical Systems
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TB CAP	TB-Control Assistance Program
TO	Task Order
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNC	University of North Carolina
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USG	U. S. Government
WHO	World Health Organization

**PAST PERFORMANCE INFORMATION SHORT FORM**

**Past Performance Report**

<b>CONTRACTOR PERFORMANCE REPORT - SHORT FORM</b>	
<b>PART I: Contractor Information (to be completed by Prime)</b>	
1.	Name of Contracting Entity:
2.	Contract Number:
3.	Contract Type:
4.	Contract Value (TEC): (if subcontract, subcontract value)
5.	Problems: (if problems encountered on this contract, explain corrective action taken)
6.	Contacts: (Name, Telephone Number and E-mail address)
6a.	Contracting officer:
6b.	Technical Officer (CTO):
6c.	Other:
7.	Contractor:
9.	Information Provided in Response to RFP No.:
<b>PART II: Performance Assessment (to be completed by Agency)</b>	
1.	Quality of product or service, including consistency in meeting goals and targets, and cooperation and effectiveness of the Prime in fixing problems. Comment:
2.	Cost control, including forecasting costs as well as accuracy in financial reporting. Comment:
3.	Timeliness of performance, including adherence to contract schedules and other time-sensitive project conditions, and Effectiveness of home and field office management to make prompt decisions and ensure efficient operation of tasks. Comment:
4.	Customer satisfaction, including satisfactory business relationship to clients, initiation and management of several complex activities simultaneously, coordination among subcontractors and developing country partners, prompt and satisfactory correction of problems, and cooperative attitude in fixing problems. Comment:
5.	Effectiveness of key personnel including: effectiveness and appropriateness of personnel for the job; and prompt and satisfactory changes in personnel when problems with clients were identified. Comment:

[Note: The actual dollar amount of subcontracts, if any, (awarded to the Prime) must be listed in Block 4 instead of the Total Estimated Cost (TEC) of the overall contract. In addition, a Prime may submit attachments to this past performance table if the spaces provided are inadequate; the evaluation factor(s) must be listed on any attachments.]