

**AIDSTAR Sector 1 INDEFINITE QUANTITY CONTRACT
SECTION A –REQUEST FOR TASK ORDER PROPOSAL (RFTOP)**

AIDSTAR Sector 1 Task Order 01

1	RFTOP Number	USAID/M/OAA-GH-OHA-09-07-001
2	Date RFTOP Issued	September 13th 2007
3	Issuing Office	USAID/Washington OAA/GH/OHA
4	Contracting Officer	Lisa M. Bilder (202)712-5882 lbilder@usaid.gov
5	<p>A. Electronic Proposals to be Submitted via email to:</p> <p>B. One original Technical Proposal plus 5 copies and one original Business Proposal plus 2 copies. In addition, please submit a CD-ROM for Technical & Business proposals to:</p>	<p>Anthony Raneses (202)712-4496 araneses@usaid.gov Michael Ashkouri (202)712-1818 mashkouri@usaid.gov</p> <p>Michael Ashkouri USAID/M/OAA/GH/OHA 1300 Pennsylvania Ave, RRB 7.09-032 Washington, D.C. 20523</p>
6	Proposals Due	<p>No later than 12:00 PM (Noon) EST October 15th 2007.</p> <p>USAID will not accept closing date extension requests.</p>

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.

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.4 PAYMENT

The paying office is as set in Section G.5 of the AIDSTAR Sector I IQC

B.5 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

I. Introduction

The USAID Bureau for Global Health (GH), Office of HIV/AIDS (OHA) requests task order (TO) proposals under the AIDS Support and Technical Resources (AIDSTAR) Program, Sector I Indefinite Quantity Contract (IQC). The primary focus of this task order will be to provide technical assistance services to OHA and USG country teams in knowledge management (KM), technical leadership, program sustainability, strategic planning and program implementation support. The overall goals of this task order are to:

- Create, synthesize, manage and disseminate a knowledge base of tested approaches and good and promising practices in HIV program implementation in support of PEPFAR goals.
- Advance and support state of the art program strategies to prevent HIV transmission, and provide care and treatment services to those infected and affected by HIV.
- Provide technical assistance to strengthen systems, support policies and develop guidelines to promote sustainable HIV prevention, care and treatment programs at the country level, including modes of service delivery that are cost effective and sustainable.
- Support USG country teams by implementing programs that help meet country-level targets and contribute to broader goals of the President’s Emergency Plan for AIDS Relief (PEPFAR).

This task order will be a three year cost reimbursement plus fixed fee level of effort contract with a two year option to be exercised at the discretion of USAID and will be managed out of the Implementation Support Division of USAID’s Office of HIV/AIDS. Missions will access technical services through the task order via field support transfers¹. USAID may award a Task Order (TO) to more than one IQC holder at its discretion under this Request for Task Order Proposal (RFTOP).

The task order contractor(s) will collaborate with other Washington-based OHA and GH technical assistance instruments, and with other USG implementation mechanisms at the country level. Where appropriate, and particularly for the knowledge management and technical leadership functions of the task order, close collaboration with a broad range of PEPFAR implementing partners, other donors, local and international NGOs, host country governments, multilateral agencies, and other agencies is expected so that the broadest range of programs is included as part of identifying state of the art program strategies. The TO contractor(s) will coordinate and collaborate with any centrally managed task order designed

¹ Field support transfers will be subject to guidance from OAA/P. This guidance is currently summarized in “Contract Types to Address Global Technical Leadership with Field Support and/or Cost-Contributions: An Additional Help for ADS Chapter 302”, Revision date 04/26/2006.

and implemented under AIDSTAR Sector II for local capacity building, and any core-funded task orders under Project SEARCH, which is an operations research program managed out of OHA's Technical Leadership and Research Division (TLR).

II. Background

USAID/W has provided centrally managed technical assistance to field programs in HIV/AIDS prevention, care and treatment for over two decades. In 1987, the AIDSTECH project was launched to provide technical assistance to developing countries focused on HIV/AIDS prevention. The program focused on identifying high-risk groups, delivering prevention messages, and increasing the availability and promoting the use of condoms. AIDSTECH also implemented other prevention strategies including controlling STIs, and improving blood safety. Subsequently, the AIDSCAP project (1992-1997) developed and implemented large-scale HIV prevention programs focusing on changing risk behaviors through behavior change communications (BCC), treatment of STIs and condom promotion. AIDSCAP also included a focus on capacity building of local institutions to deliver HIV prevention programs. In 1997, a new initiative was launched under the IMPACT project to extend USAID's funding for technical assistance in prevention to a more comprehensive prevention and care approach to the global HIV/AIDS epidemic. IMPACT has focused on building local capacity and involving people living with HIV and AIDS in its activities. IMPACT's focus on sustainability lead the program to collaborate with a variety of partners including the private sector, faith-based organizations, non-governmental and community-based organizations, and educational institutions.² IMPACT made the following important technical contributions that are relevant to the AIDSTAR program:

- Advanced the state of the art of behavioral surveillance surveys (BSS) to track HIV risk behaviors over time and better target prevention activities in concentrated epidemic contexts.
- Integrated BCC into the full range of prevention, care and treatment services, emphasizing local stakeholder participation, multiple channels and links to services.
- Prioritized HIV counseling and testing as an entry point to prevention, care and treatment services; promoted new approaches to counseling and testing such as provider-initiated and mobile CT to expand uptake of testing services.
- Integrated antiretroviral therapy into the continuum of care, while addressing challenges related to drug supply, healthcare infrastructure including human resources, and adherence.
- Created demonstration models of how to develop referral systems for home-based care to improve services for PLHIV and their caregivers
- Established linkages between HIV care and treatment programs and tuberculosis control programs, STI treatment, and maternal and child health service delivery systems to prevent mother to child transmission of HIV.
- Built community capacity to link orphans and vulnerable children (OVC) with a range of care, support and treatment services through partnerships with government and NGOs.

² Final Report on Implementing AIDS Prevention and Care Project, Impact: A Decade of Global Leadership and Innovation. Arlington: Family Health International, 2007.

Since 1997, another centrally funded program, AIDSMark, has used social marketing to prevent the spread of HIV/AIDS and other infectious diseases throughout the world. AIDSMark worked in 29 countries over the life of its 10 year agreement with USAID to promote and market condoms, deliver voluntary counseling and testing services, prevent mother-to-child HIV transmission (MTCT), delay sexual debut among youth, and franchise services to treat sexually transmitted infections (STIs).

AIDSMark's social marketing programs attempted to change behavioral norms through the use of mass media, peer education, school programs, community theatre, mobile multi-media events, and training sessions designed to encourage the adoption of healthy lifestyles and behaviors while communicating risks. AIDSMark also sought to alter social practices and cultural factors which served as barriers to condom use, by enlisting local leaders and members of high-risk groups. Examples of AIDSMark programmatic approaches include:

- Increasing access to condoms through the promotion and marketing of specific brands to high risk groups and a focus on non-traditional sales outlets such as bars, hotels, gas stations, and cinemas.
- IEC programs targeting mobile men involving non-traditional forms of communication such as working with local entertainers, taxi drivers, movie stars, and bartenders to deliver messages to sex workers and their male clients
- Education campaigns focusing on parent-child communication as a strategy to address involvement in cross-generational or transactional sexual relationships by young girls;
- Youth programming through youth-oriented websites, messages on abstinence and safe sex through radio, telephone help lines, street theatre, and educational events at secondary schools.

In early 2003, President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR). The Emergency Plan is a five-year, \$15 billion program aimed at combating HIV/AIDS around the world, with an emphasis on fifteen focus countries³. Through PEPFAR, the U.S. Government (USG) works with international, national and local leaders to support integrated prevention, treatment and care programs. PEPFAR supports a multisectoral national response in host countries through the principles known as the "Three Ones": - one national plan, one national coordinating authority, and one national monitoring and evaluation system. The major USG agencies involved in implementing PEPFAR programs are USAID, the Centers for Disease Control and Prevention (CDC), Peace Corps, the Departments of Defense, Health and Human Services, Commerce and Labor.

III. Goal and Purpose

The goal of the AIDSTAR Sector I Task Order I (TO 1) is to support and advance implementation of the President's Emergency Plan for AIDS Relief through technical assistance to USAID missions and the USAID/W Office of HIV/AIDS. Activities implemented under TO 1 must contribute to the goals and objectives described in this statement of work, and support the achievement of the PEPFAR targets and national

³ The focus countries are: Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, Zambia.

HIV/AIDS strategies. Actual level of effort to be undertaken for country and regionally funded HIV/AIDS activities will depend on the availability and provision of funds by USAID missions and regional bureaus.

Funds under this task order will be used to achieve the objectives listed below. Knowledge management and technical assistance activities are likely to be implemented in both focus and other bilateral⁴ countries, while program implementation through this mechanism will primarily focus in other bilateral countries. TO1 will:

- Synthesize, expand and disseminate a knowledge base of effective program approaches to prevent, provide care for and treat HIV/AIDS;
- Provide short- and long- term technical assistance (TA) to support the implementation of USG-funded HIV/AIDS programs and activities.
- Increase utilization of good and promising practices in HIV prevention, care and treatment among program implementers;
- Improve the quality and sustainability of HIV prevention, care and treatment programs;

IV. Objectives

IV. A. Knowledge Management

Currently, PEPFAR is in its 4th year of implementation and it is expected to be reauthorized for a second phase. The next phase of PEPFAR is likely to move from a focus on “emergency” response to a more sustained effort to enhance countries’ capacity to respond to HIV/AIDS-related demands within health systems and the larger society. At this important moment in the USG response to the global HIV/AIDS pandemic, the need to fully assess good and promising programmatic practices and to share those across and between country programs is particularly vital. Although the nature of the HIV epidemic varies greatly between continents, countries and communities, much can be learned from how programs in particular contexts have grappled with the myriad challenges related to delivering HIV prevention, care and treatment services to clients. Specific program areas that the task order contractor will be expected to focus on in terms of assessing promising approaches, will be identified and highlighted below. This objective responds to the important finding by the Institute of Medicine (IOM) that PEPFAR “should increase its contribution to the global evidence base for HIV/AIDS interventions by better capitalizing on the opportunity PEPFAR represents to learn about and share what works”⁵.

TO 1 will identify, compile, synthesize and make information and evidence readily available regarding promising programmatic designs and practices in HIV prevention, care and treatment. These promising programmatic approaches may be funded and implemented under PEPFAR, by local governments with their own resources, by other multilateral or

⁴ A list of PEPFAR focus and other bilateral countries is available at: http://www.usaid.gov/our_work/global_health/aids/Countries/index.html

⁵ Institute of Medicine of the National Academy of Sciences, PEPFAR Implementation: Promise and Progress. Washington, D.C.: National Academies Press, 2007, p. 14.

bilateral donors, foundations, faith-based organizations, local or international NGOs or the commercial sector. The TO 1 contractor(s) will be expected to coordinate and collaborate with other entities who are involved in compiling and sharing knowledge on effective programmatic approaches related to HIV, but particularly with any task order contractor under Project Search that performs an HIV-related research or knowledge management function. The objectives of this collaboration will be to avoid duplication of the KM function, to avoid parallel KM platforms and portals for data retrieval, and to ensure that any system developed by TO 1 is transferable at the end of the contract period. In general, TO 1 will focus on knowledge and best practices related to effective programmatic practices, while Project SEARCH will conduct formative and evaluative research of specific, PEPFAR-funded HIV programs.

The Offeror should propose a strategy for synthesizing, compiling and assessing the success of program approaches across the following program areas:

1. Prevention (PMTCT)
2. Prevention (General and Youth)
3. Prevention (Medical Transmission)
4. Prevention (High Risk Groups)
5. Food and Nutrition
6. Orphans and Vulnerable Children
7. Policy Analysis and Systems Strengthening
8. Human Capacity Development
9. Gender
10. Care (Counseling and Testing)
11. Care and Treatment (Adult and Pediatric)
12. Care and Treatment (TB & HIV)
13. Care and Treatment (Palliative Care)

The proposed KM strategy should address the criteria that will be used to define a good or promising practice; the planned method for identifying, documenting and synthesizing programmatic practices; how the contractor will collaborate with other implementing partners to identify program approaches, outline the major elements of a dissemination plan; and address how the task order will add value in the process of knowledge management and synthesis, and not merely act as a clearinghouse for information and sharing of models.

In addition to the broader knowledge management role, the TO 1 contractor(s) will perform an information synthesis, knowledge management and dissemination role for the AIDSTAR IQC as a whole. TO 1 will develop and maintain a website for the AIDSTAR IQC where technical information from central and mission-funded task orders can be posted and disseminated. The contractor(s) will be tasked with compiling monitoring information that captures the overall impact and outcomes of the AIDSTAR IQC. All AIDSTAR IQC contractors will be requested to cooperate and collaborate with the TO 1 contractor(s) to contribute these data. The TO 1 contractor(s) scope and system for collecting monitoring information from the other AIDSTAR contractors should be in accordance with the OGAC guidance on Strategic Information for the Emergency Plan. Offerors should address how

they will approach this knowledge management function for the IQC as part of their technical approach.

IV. B. Sustainability

The initial phase of PEPFAR has focused on rolling out services as part of an emergency response to those affected by HIV/AIDS in developing countries. As stated in the IOM report, there remains a need for continued coordination with global partners, harmonized strategies and plans in partner countries, comprehensive services that are integrated at the community level, sustainable programs and adequate monitoring and evaluation.⁶ The AIDSTAR IQC is designed to advance program sustainability, with Sector 1 focusing on technical and programmatic sustainability issues, and Sector II focusing on organizational and institutional sustainability at the local level. Where appropriate, TO1 will link with programs implemented through AIDSTAR Sector II, to complement institutional sustainability interventions with technical capacity building.

TO 1 is expected to advance program sustainability by:

- improving quality assurance systems for delivery of HIV/AIDS related programming and services, including prevention,
- supporting the development of policies and guidelines that facilitate sustainable delivery of HIV/AIDS services,
- integrating HIV/AIDS product and service delivery within the health system, where appropriate, and
- facilitating and promoting private and commercial sector delivery of HIV/AIDS related services.

Offers should discuss how their approach supports and advances these and other elements of sustainability in the technical proposal. This discussion should include an explicit treatment of the challenges and opportunities related to program sustainability in HIV prevention, care and treatment services within and beyond the current PEPFAR authorization period.

IV. B. 1. Quality Assurance

PEPFAR has supported the roll-out of HIV service delivery programs through a diverse array of partners, including non-governmental organizations, faith-based groups, community based organizations and the public health system in a “networked” approach to HIV-related programming. Therefore, there is a pressing need for innovative and flexible quality assurance (QA) mechanisms to ensure that the nature and quality of HIV-related services (including prevention) remain high, to ensure impact and effectiveness, as well as to promote sustainability and strategic coordination.

TO1 will link with other USG programs that are developing and field-testing quality assurance mechanisms in HIV prevention, treatment, care and support, and will work to scale up existing proven models of quality assurance. One partner in this effort has been the

⁶ Institute of Medicine of the National Academy of Sciences, PEPFAR Implementation: Promise and Progress. Washington, D.C.: National Academies Press, 2007, p. 5.

Quality Assurance Project (QAP), implemented by URC. USAID/OHA has requested that QAP perform the following types of activities related to HIV service delivery:

- Improve strategies for rapidly increasing quality and efficiency, and for scaling up best practices in AIDS-related care and treatment.
- Promote wider use of modern quality improvement (QI) methodologies in HIV/AIDS
- Adapt and introduce community based case management approaches for use by AIDS programs in Africa.
- Translate policy and clinical guidelines on pediatric HIV care into programmatic and implementation guidance for district health teams and facilities.

The role of TO1 in the quality assurance realm will be to tailor and contextualize existing tools and models, such as those generated by QAP, to particular country contexts, and to respond directly to field needs within different service delivery contexts. For example, the needs of home based care workers, health care workers in a clinical setting, individuals providing services to orphans and vulnerable children, and peer educators delivering prevention messages are very different and will require different approaches to quality assurance. Offerors should identify a key challenge related to quality improvement/assurance within HIV prevention, care and treatment arenas as part of their technical approach, and describe how those challenges would be addressed, and what types of QI/QA systems (including specific tools) would be developed, tested, scaled up and monitored.

IV. B. 2. Private Sector

Private and commercial sector portions of the health system may be part of the overall network delivering HIV/AIDS prevention, care and treatment in PEPFAR countries. In many contexts, however, linkages with this part of the health system remain relatively unexplored. PEPFAR has an explicit emphasis on partnerships with the private sector, which to date has emphasized corporate engagement and workplace programs for HIV prevention, care and treatment. Although the extent to which clients seek HIV-related care from the private sector has yet to be documented in a systematic fashion, private sector participation has been a key element of the sustainability of health system responses to other public health challenges.

A key obstacle to developing a strategic role for the private health sector in the national response to HIV is lack of information. For example, policy makers and planners lack information on which HIV/AIDS-related clinical and non-clinical services are most suited to private sector involvement, or how the market for HIV/AIDS services can be better segmented by income group in order to rationalize and maximize use of existing resources. Better models of linkages and modes of communication and interaction between the public and private health sectors are needed to integrate private providers into developing country public health systems. Lessons from private sector engagement in other health areas, such as TB and family planning may offer some valuable lessons for the HIV realm. Analyses of the market and epidemiologic conditions which facilitate private sector involvement in HIV/AIDS service delivery may also be useful, as well as an understanding of which countries meet these criteria.

Task Order 1 will be expected to support and expand private sector participation in HIV-related service delivery in particular in other bilateral countries that have an established private health sector. This may involve the following types of activities:

- Mapping private sector capacity to provide HIV-related services, documenting current utilization rates, and analyzing the market HIV-related services delivered through the private sector.
- Piloting public-private partnerships for HIV service delivery such as contracting out through performance-based arrangements, or the use of publicly financed vouchers in the private sector.
- Linking the private health sector with the public health system, particularly with regard to treatment protocols, referral systems, provider training, and reporting public health data;
- Assessing the quality and appropriateness of HIV services offered in the private sector; implementing quality improvement interventions to raise the standard of HIV-related care in the private sector;
- Providing technical support to social marketing or social franchising programs for HIV-related services, including counseling and testing and treatment.

IV. B. 3. Policies and Guidelines

More analytic work is needed to identify policies and guidelines that promote strategic approaches to prevention, support of access to comprehensive HIV/AIDS care, and assist stakeholders in advocating for and achieving positive changes in these guidelines and policies. While demand for a full range of prevention and clinical care services has evolved quickly in most developing countries, many lag behind in the development of formalized norms and guidelines. Policies and guidelines are needed to guide prevention programming, clinical management of HIV/AIDS including opportunistic infections (OIs) and nutrition, as well as palliative and end of life care.

The TO 1 contractor(s) may be requested to work independently or collaboratively with other USG implementing partners and host-country governments, and will likely provide technical assistance related to such issues as:

- Developing policies and guidelines to address stigma and discrimination against PLWHA, including within workplaces, and supporting the greater participation of PLWHA in design and implementation of HIV-related programming.
- Revising existing guidelines for antenatal care, integrated management of childhood illness (IMCI), sexually transmitted infection (STI) management and treatment, and family planning to promote HIV prevention, as well as the identification and referral of HIV positive individuals.
- Updating treatment norms for STIs to address ineffective drug regimens that are part of national guidelines;
- Developing and disseminating model policies and guidelines around palliative care, particularly related to prescribing and use of opioids for pain management, OIs, pediatric palliative care, community based services and human capacity policies (especially volunteer and community-based health worker policies).

IV. C. Service Integration and Linkages⁷

The TO 1 contractor(s) will synthesize the evidence base related to integration within the range of HIV-related services as well as between HIV and other economic and social sector interventions. Based on this analysis the contractor(s) will pilot test promising models, and/or contribute rigorous programmatic evaluation components to existing multi-sectoral HIV/AIDS interventions. Offerors should detail their approach to identifying and advancing good and promising programmatic practices in the service integration areas described below as part of the technical proposal.

IV. C. 1. Integration and Linkages Between HIV-related Services

Multiple strategies are needed to increase the number of people who know their HIV status, and to link those testing positive for HIV to treatment services. A major pathway to increasing the numbers of individuals reached by HIV-related services is to integrate the prevention, care and treatment aspects of HIV services. The IOM report identified key points of integration as ART, counseling and testing, PMTCT, diagnosis and treatment of STIs.⁸ As efforts to integrate prevention, care and treatment continue, models of integrated HIV service delivery need to be identified and advanced in the following areas:

- Integrating behavior change messages into other types of HIV programming, such as counseling and testing and OVC programming.
- Adapting prevention strategies for individuals testing negative for HIV, but identified as at high risk for HIV infection.
- Integrating HIV prevention messages and services within a variety of health service delivery points, including those providing care for OIs and ART;
- Integrating information about HIV testing and treatment into prevention programs;
- Linking HIV positive individuals to psychological, social and spiritual care services within the community as a follow-on between diagnosis and initiation of ART
- Training all types of health care providers to promote counseling and testing;
- Strengthening linkages between CT and ART and other HIV-related care such as psychosocial programs to retain HIV positives within the system of care in the interim between diagnosis and initiation of ART.

IV. C. 2. Integrating HIV and Other Key Public Health Services

In low-resource settings, there are many obstacles to seeking health services and therefore many advantages to providing access both to multiple services at a single delivery point, and within a single encounter with a health care provider. For HIV, it is particularly important to

⁷ **Integration** refers to the inclusion of either elements of one service or merging of an entire service into the regular functioning of another, for example screening for tuberculosis in HIV and AIDS care and treatment program.

Linkages refers to the systematic and effective referral of patients and their families from one service to another.

⁸ Institute of Medicine of the National Academy of Sciences, PEPFAR Implementation: Promise and Progress. Washington, D.C.: National Academies Press, 2007, p. 109.

promote/advance integration with antenatal care to prevention mother to child transmission, family planning, tuberculosis, and malaria.

A key challenge to the roll-out of Prevention of Mother to Child transmission (PMTCT) services in many PEPFAR focus and other bilateral countries is the low rate of antenatal care and institutional delivery. According to UNICEF, only 9% of women in low and middle income countries received ARV prophylaxis for prevention of mother to child transmission in 2005.⁹ Therefore, a priority for development of integrated models of service delivery is the integration of HIV services into ante-natal care and MCH services. This includes:

- Service delivery models where HIV positive women can access MCH services as well as HIV treatment;
- Strategies to improve post-partum follow-up of HIV positive women, including pilot testing service delivery models which focus linking women with services during the first seven days post-partum; and
- Integrating ANC and ARV treatment services through such strategies as measuring CD4 cell counts at the first antenatal visit and placing ARV service providers within antenatal clinics to streamline patient transition and ensure consistent messages.¹⁰

Traditionally, family planning services and HIV services have operated within separate systems of care, and have targeted different populations of interest. Family planning programs primarily focus on couples and women of reproductive age. HIV-related services are targeted at different groups, based on the local epidemiology of the epidemic, but generally target individuals at high risk of HIV infection. Effective program models are needed that both integrate HIV services (particularly counseling and testing) into FP service delivery points, and that integrate family planning into HIV-related service delivery points -- particularly care and ART. Service delivery settings that integrate HIV and FP services are thought to increase access and cost-effectiveness, enable providers to offer more convenient, comprehensive services, and increase the uptake of both types of services. The TO 1 contractor(s) may be requested by missions or OHA to implement, adapt and scale up models of good practice related to FP/HIV integration.

Tuberculosis is the leading cause of death among HIV positive individuals and one of the most common opportunistic infections. Correspondingly, TB patients generally have a high prevalence of HIV infection -- up to 80 percent in some countries. PEPFAR's support for TB/HIV-related activities has increased from \$18.8 million in fiscal year (FY) 2005 to at least \$131 million in FY2007¹¹. By the end of September 2006, PEPFAR had supported care for approximately 301,000 TB/HIV co-infected people in the 15 PEPFAR focus countries, including:

- providing HIV testing for people with TB and improving TB diagnosis for PLWHA;
- ensuring that eligible TB patients receive HIV/AIDS prevention, treatment and care including antiretroviral treatment and palliative care services

⁹ UNICEF, UNAIDS and WHO. Children and AIDS: A Stocktaking Report. New York: 2007.

¹⁰ van der Merwe K, Chersich MF, Technau K, Umurungi Y, Conradie F, Coovadia A. [Integration of Antiretroviral Treatment within Antenatal Care in Gauteng Province, South Africa](#). J Acquir Immune Defic Syndr. 2006 Dec 15;43(5):577-81.

¹¹ Tuberculosis and HIV. Web page available at: <http://www.pepfar.gov/pepfar/press/81964.htm>.

- improving TB infection control and implementing Directly Observed Therapy- Short Course (DOTS).

PEPFAR also supports expanding the capacity of the local health workforce to deal with TB/HIV. The contractor(s) may be requested to develop models of linkages between TB and antiretroviral treatment to facilitate the appropriate management of co-infected individuals.

In contrast to the clear patterns of co-infection between TB and HIV, the relationships and interactions between HIV and malaria are less clear cut. However, malaria is prevalent in geographical regions with high HIV prevalence, and remains the most common life-threatening infection in the world, resulting in over 300-500 million infections and 1 million deaths per year. The U.S. Centers for Disease Control has identified the following interactions between HIV and malaria¹²:

- HIV-associated immunosuppression increases the severity of malaria cases and the resulting consequences in adults, pregnant women, and children.
- Malarial infection stimulates HIV replication and possibly contributes to HIV disease progression, transmission in adults, and MTCT.
- Malaria and HIV co-infection in pregnant women contributes to anemia, low birth weight, and infant mortality.
- Treatment of malarial anemia in children with blood transfusions may lead to HIV transmission.

Populations of interest for both malaria and HIV interventions include children under 5, pregnant women and adults with elevated CD4 counts. Both diseases share some common challenges to effective interventions: the need for diagnostics, complexity and cost of treatment options, and drug resistance. At the health system level, malaria and HIV may share the same service delivery points including antenatal clinics, MCH clinics, CT sites and ARV clinics. At the national and international levels, funding for both HIV and malaria flows through common or parallel structures, including the Global Fund for AIDS, Tuberculosis and Malaria and its Country Coordinating Mechanisms (CCMs) as well as USAID programs implemented with PEPFAR and the Presidential Malaria Initiative (PMI) funding. The TO I contractor(s) may be required to provide services to mission programs that include both HIV and malaria components, or attempt to reach common target groups with both types of interventions. These interventions must take into account the program implementation guidance provided by both OGAC and PMI, and any forthcoming joint guidance on program integration.

IV. C. 3. Multi-sectoral Linkages

The advent of broader access to treatment in developing countries has brought with it a range of related concerns for those infected and affected by HIV/AIDS that reach beyond the confines of clinical care or what is traditionally considered part of the health sector. HIV-infected individuals on ART, and their families, now face questions with regard to

¹² “Interaction of HIV and Malaria”, Malaria Branch, Division of Parasitic Diseases, National Center for Infectious Diseases, Powerpoint Presentation available at: http://www.cdc.gov/malaria/ppt/Malaria_HIV_Rick_website.ppt#405.

livelihoods, employment, access to credit, housing, community participation and advocacy, and educational opportunities. According to one definition, multisectoral approaches to HIV/AIDS are those “which seek to reduce HIV prevalence, provide care and treatment to people living with HIV/AIDS (PLWHA), and mitigate the impacts of the epidemic on affected populations by employing an appropriate mix of health- and non-health-based interventions and involving a broad array of stakeholders in their design and implementation”¹³.

PEPFAR programs include linkages to these areas under the umbrella term “wrap arounds”, which are defined as activities that “leverage resources, both human and financial from entities with different funding sources in order to complement Emergency Plan 2-7-10 goals and maximize the effectiveness of programs to improve quality of life for people affected by HIV/AIDS and their families”¹⁴. PEPFAR resources can be used to provide wrap-around services to priority populations, and to link individuals to wrap around services provided with other sources of funding. For example, due to the increased nutritional requirements of PLWHA on treatment, and the increased susceptibility to diseases that contribute to malnutrition, PEPFAR places particular emphasis on wrap around programs focusing on food and nutrition support for families affected by HIV/AIDS.

More work needs to be done to examine the linkages between economic development, livelihoods programs for youth and OVC, microfinance programs, small and medium enterprise (SME) development support, and long-term outcomes for those infected and affected by HIV/AIDS. Interventions to improve OVC referral systems, both between essential service areas (e.g. health and education), for comprehensive OVC service delivery, and between other HIV/AIDS program areas (palliative care, CT, treatment) are also needed. A special emphasis exists within PEPFAR on education wrap-arounds, i.e. linking youth affected by HIV to programs which support literacy and staying in school.

In many contexts, girls and young women are at risk of HIV infection through cross-generational or transactional sexual relationships, early sexual debut, and multiple and concurrent partnerships, but the effect of economic and educational interventions on mitigating these risky behaviors and their outcomes remains uncertain. Recent studies document some pilot programs that attempted to address the economic bases of risky behaviors by young women, but their findings are not conclusive¹⁵.

IV. D. Priority Technical Areas

IV. D. 1. Prevention

¹³ Sarah Gavian, David Galaty and Gilbert Kombe. Multisectoral HIV/AIDS Approaches in Africa: How Are They Evolving? Available at: <http://www.ifpri.org/pubs/books/oc50/oc50ch12.pdf>.

¹⁴ Office of the Global AIDS Coordinators, PEPFAR Country Operational Plan Guidance, 2008.

¹⁵ Urdang, Stephanie. Change, Choice and Power: Young Women, Livelihoods and HIV Prevention Literature Review and Case Study Analysis, New York: IPPF/UNFPA/YOUNG POSITIVES, 2007. Also see Hall, Joan. Tap and Reposition Youth (TRY) Program: Providing Social Support, Savings and Micro-credit Opportunities to Adolescent Girls at Risk for HIV/AIDS in Kenya. The Population Council, 2006.

PEPFAR's five-year goal is to prevent 7 million new cases of HIV/AIDS by 2010. Prevention has long been a cornerstone of a comprehensive approach to the HIV/AIDS epidemic. Although some success has been achieved in containing HIV transmission in epidemics where HIV is concentrated among high-risk populations, prevention efforts have lagged behind treatment successes in the generalized epidemics in PEPFAR focus countries, where roughly half of all people living with HIV reside. According to UNAIDS in 2006, for every patient who started antiretroviral therapy in 2006, six other individuals became infected with HIV. If this trend continues, it is projected that 60 million more HIV infections will occur by 2015, and the annual number of new HIV infections will increase by 20% or more by 2012¹⁶.

Great strides have been made in the field to demonstrate effective programs in prevention, however, many of these projects have happened at a small scale with little reach; in addition new innovations in prevention techniques are being discovered and piloted at a rapid pace. There is a need to scale up these programs to reach those most vulnerable to HIV and make access to prevention methods a priority. TO 1 will contribute to advancing HIV prevention programming in the following ways:

- Providing technical assistance to USG country teams to analyze the epidemiological context of the HIV epidemic and strategically plan the appropriate mix of prevention approaches to align with this context.
- Developing and testing interventions to change high risk behavioral norms in high prevalence regions where most new infections result from chains of concurrent sexual partnerships in the general population, with particular attention to multiple, concurrent, cross-generational and transactional partnerships.
- Providing technical assistance to support the adoption of evidence-based, best practice intervention models for HIV prevention, that incorporate sufficient dose, intensity, coverage and quality assurance to ensure behavioral change at the population level.
- Identifying, piloting and documenting new intervention models to promote partner reduction and mutual fidelity, adoption of preventive behaviors among individuals who test HIV-negative, and to reach groups at elevated risk of HIV and those who may be hard to reach, such as sero-discordant couples, migrant workers and young women in their twenties.
- Identifying strategies for and supporting scale-up of best-practice, comprehensive prevention programs for most at risk groups, including sex workers, injecting drug users, and men who have sex with men, with an emphasis on strengthening referrals to STI management, HIV counseling and testing, and care and treatment services.
- Identifying successful prevention models for scale-up and adaptation across similar epidemiological settings.
- Developing, testing and scaling up models for integrating prevention into care and treatment programs, across facility, community and home-based settings.

TO1 may also host a special initiative that addresses critical programmatic gaps facing two interrelated behavioral drivers of the most severe HIV epidemics: multiple and/or concurrent sexual partnerships, and cross-generational sex. The objectives of this initiative are to:

¹⁶ Global HIV Prevention Working Group, 2007.

- provide essential global technical leadership and knowledge management to support the identify, develop, implement and disseminate evidence based approaches to address the risks associated with multiple/concurrent sexual partnerships and cross-generational sex, and
- provide local in-country technical assistance to design, implement, and evaluate promising models, approaches, and activities that address the risks associated with multiple/concurrent partnerships and cross-generational sex.

IV. D. 2. Counseling and Testing

Approximately 90 percent of the estimated 40 million people infected with HIV are unaware that they are infected. Increasing access to and uptake of counseling and testing services, therefore, represents a key step toward achieving corresponding increases in delivery of prevention, care and treatment services. Lessons learned from the initial phase of PEPFAR include that counseling and testing services (CT) delivered through mobile sites have a higher uptake than services offered through clinic and hospital-based sites, and that provider initiated and diagnostic counseling and testing also has a high uptake rate, and identifies a high percentage of HIV-positive individuals. Experience has also shown that capacity issues exist related to the availability of providers to conduct pre-test education and counseling and post-test counseling, and that lack of access to the services, fear of stigma and discrimination, human capacity shortages (including of laboratory personnel), lack of physical access to testing due to distance from sites, and lack of availability of rapid test kits all constitute barriers to uptake of CT services.¹⁷ From the health system perspective, inadequate referral linkages from counseling and testing to treatment, care, support and other services exist, and there continues to be a need for training of providers of counseling and testing services, improvement of supervision systems and better monitored referral linkages to care and treatment programs for those testing positive.

TO1 will address technical leadership needs in the area of counseling and testing by exploring the following types of issues:

- Develop and test strategies to build local capacity to establish and manage CT services that maximize the potential for sustainability, local ownership and rapid expansion of services.
- Test methods of integrating mobile, fixed, provider-initiated (PITC) and integrated CT/PITC within a single national system.
- Analyze the effectiveness of particular modes of delivering CT services on specific populations.
- Develop specific to reach individuals with prevention messages who test negative for HIV but are continuing to engage in high risk behaviors.
- Develop improved models for referring and managing positive clients into care and ART education programs.

IV. D. 3. Care and Treatment

¹⁷ Institute of Medicine of the National Academy of Sciences, PEPFAR Implementation: Promise and Progress. Washington, D.C.: National Academies Press, 2007, p. 163.

IV. D. 3. (a) Palliative Care

Palliative care, as stated in the U.S. Five-Year Global HIV/AIDS Strategy, aims to achieve optimal quality of life for PLWHA and their families and minimize suffering through mobilizing clinical, psychological, spiritual, social and preventative care throughout the course of HIV infection. It also provides routine monitoring that is essential to determining the optimal time to initiate antiretroviral therapy (ART), and it continues during and after the initiation of treatment. Palliative care includes and goes beyond the medical management of infectious, neurological or oncological complications of HIV/AIDS to comprehensively address symptoms and physical as well as psychological and spiritual suffering throughout the continuum of HIV disease. Routine, confidential counseling and testing is an essential linkage with palliative care to identify those who need or will need palliative care, family members who could also be infected and in need of care and, family members and partners not infected and in need of prevention.

Under PEPFAR, HIV/AIDS care programs:

- Respect patient autonomy and choice and provide adequate access to information.
- Support respectful and trusting relationships between the HIV-positive person and the caregivers.
- Support the family, child, and community caregivers in delivering palliative care.
- Integrate and respect cultural values, beliefs and customs.
- Enhance quality of life throughout the continuum of disease.

Palliative care for PLWHA requires a well organized system that recognizes the multiple layers and entry points required to provide quality comprehensive HIV and AIDS care. The introduction of ART has changed the care needs of patients and created a broader dependency on linking and integrating various services included in the care design. One palliative care program or intervention cannot meet all the needs of a patient and his/her family in coping with HIV/AIDS. Therefore, it is critical to establish relationships within and outside the health care system to deliver services under the components of clinical, psychological, social, spiritual and preventive care.¹⁸

The Emergency Plan can support all areas of comprehensive palliative care offered throughout the course of HIV disease. Individual country programs will vary in type, scope, and intensity based on the progression of the disease, availability of anti-retroviral therapy (ARVs), human capacity, and the needs of the individual and family. Pediatric palliative care programming faces even greater challenges than similar programs for adults in most countries. The TO 1 contractor(s) will be expected to support palliative care programming through such activities as:

- Establishing referral systems for home-based care programs to ensure PLWHA are receiving needed care services.
- Documenting good models of integrating clinical, community-based and home-based palliative care.
- Linking drug and commodity systems for OI and pain management pharmaceuticals.

¹⁸ See the USG Palliative Care Guidance Document at <http://www.pepfar.gov/pepfar/guidance/75827.htm>.

- Linking palliative care programs with wrap around interventions such as nutrition, safe water, hygiene and sanitation.
- Strengthening pediatric palliative care programming, and ensuring that HIV positive children have access to prophylaxis for OIs, pain management, nutrition and other interventions.
- Developing policies and standards on pediatric palliative care for host governments.
- Identifying positive models of pain management for PLWHA and disseminating findings.

IV. D. 3. (b) Nutrition Support¹⁹

In many high HIV prevalence regions, inadequate caloric intake is a concurrent health problem and ultimately impacts on the effectiveness of ARV treatment. PEPFAR prioritizes the following groups for nutritional interventions: OVCs, particularly young children born to HIV-positive mothers, HIV-positive pregnant and lactating women, PLWHA on ART or ART-eligible w/ clinical evidence of malnutrition, and PLWHA in care programs with clinical evidence of malnutrition. PEPFAR programs can support the development and adaptation of nutrition policies and guidelines, nutritional assessment and counseling services, therapeutic and supplementary feeding of malnourished PLWHA and OVC, micronutrient supplementation where dietary intake is inadequate, infant feeding support in context of WHO and national PMTCT guidelines, and linkage of Emergency Plan programs to food assistance, food security and livelihood assistance programs. Many gaps in knowledge exist related to the interaction between food, nutrition, and HIV, and related to effective programmatic models to address these issues. As additional research findings emerge, the TO1 contractor(s) may be required to:

- Design and implement therapeutic feeding programs that also promote treatment adherence;
- Develop programmatic approaches to transition clients from food aid to food security and livelihood assistance programs;
- Adapt food and nutrition interventions to better serve HIV-infected and affected clients;
- Document programmatic lessons from cross-sectoral interventions to support nutrition, such as school feeding programs that benefit HIV-affected children.

IV. D. 4. Treatment

A central pillar of PEPFAR is the commitment to provide antiretroviral treatment to 2 million HIV-infected people, over its initial 5 year term. USG-funded treatment programs follow the PEPFAR mandate that ART should be offered in a manner that is safe, effective, of high quality and sustainable. By 2006, PEPFAR reported that 822,000 people were receiving ART as a result of PEPFAR support. Independent observational studies have concluded that adherence rates are high and many USG programs continue to utilize a “buddy” system where the patient enlists the support of a friend or family member to participate in adherence

¹⁹ Guidance on the use of PEPFAR funds for food and nutrition related programming is available at: <http://www.pepfar.gov/pepfar/guidance/77980.htm>

training and follow-up. The availability of ART has also had the effect of reducing the stigma associated with and has correspondingly led to an increase in demand for HIV testing services²⁰.

A significant barrier to the roll-out of ART, particularly in rural areas, is the weak capacity of local health systems. There is a pressing need for more and better trained health care personnel, laboratory capacity, and functioning supply chains for drugs. There is a continued need to improve referral systems, particularly from counseling and testing to care and treatment, and to integrate prevention messages and strategies into counseling and educational programs for HIV positive individuals. Pediatric treatment remains a challenge, and there is continued need to strengthen referral systems between PMTCT and treatment programs, and integrate AIDS guidance within IMCI protocols. The TO 1 contractor(s) will advance the adoption of best practices in HIV treatment by engaging in such activities as:

- Developing systems for referral and improved integration between ART and STI treatment, tuberculosis, malaria, family planning, home based care and community-based programs.
- Synthesizing programmatic best practices related to maximizing children's access to treatment, including increasing identification of HIV positive children, and improving treatment adherence.
- Expanding state of the art treatment programs to meet the needs of high risk, marginalized populations.

IV. D. 5. Gender

PEPFAR supports the integration of gender issues into all its program areas and to date has supported a broad range of gender-related activities. Additionally, the authorizing legislation for PEPFAR (Public Law 108-25 – May 27, 2003) specifies PEPFAR will support five priority gender strategies. They are:

- Increasing gender equity in HIV/AIDS activities and services
- Reducing violence and coercion
- Addressing male norms and behaviors
- Increasing women's legal protection, and
- Increasing women's access to income and productive resources.

In FY2006, a total of \$442 million supported more than 830 interventions that included one or more of these legislated strategies. Challenges to addressing gender and HIV/AIDS include the need to: conduct gender situation analyses in countries to identify priority areas for gender-related intervention; identify, evaluate and scale-up evidence-based practices; collect and analyze sex-disaggregated data to better inform programming; and foster partnerships with a wide range of stakeholders. Technical assistance will be required by USAID missions and in-country partners to implement the following types of interventions that incorporate gender as a major theme:

²⁰ Institute of Medicine of the National Academy of Sciences, PEPFAR Implementation: Promise and Progress. Washington, D.C.: National Academies Press, 2007, p. 123.

- Prevention programs which reduce girls' vulnerability, target male norms and behaviors, reduce cross-generational and transactional sex, expand couples counseling and address barriers to women's access to quality PMTCT services.
- Care and treatment programs which ensure equitable access to services for women and men, address the disproportionate burden of care falling on women and girls by providing resources and support to enable them to fulfill their roles, and increase women's access to productive resources and legal and inheritance rights.
- Strategic Information activities which collect sex disaggregated data, build capacity of data systems to collect sex disaggregated data, and assess gender differentials in access to services, health-seeking behaviors, and adherence to treatment.
- Wrap-around programs and innovative partnerships which focus on providing women and girls with access to education and economic opportunities as well as linkages (as appropriate) with family planning.
- Overall strategic planning in mainstreaming and analyzing gender in USG portfolios.
- Collection and dissemination of best practices and evidenced-based approaches in gender programming.

IV. E. Description of Tasks Required under the Task Order

The TO 1 contractor(s) will provide technical assistance services to USAID's Office of HIV/AIDS and USAID missions in the following three task areas. Illustrative activities under each task are provided below. These tasks represent the kinds of activities that will be required by USAID, refined in workplans developed by the contractor(s) on an annual basis, and approved by the Cognizant Technical Officer (CTO). Activities funded by field support will be demand driven and defined by missions based on their priorities, but will fall within the general framework of each task area description and the broader statement of work. The program should be flexible enough to include international and local partners if and where appropriate through the use of grants (see VII.C.10 below).

IV. E. 1. Task Area One: Global Technical Leadership & Knowledge Management (KM)

Result: A knowledge base of effective program approaches in HIV prevention, care and treatment synthesized and expanded, and utilization of good and promising programmatic practices increased among implementers.

Sub-Tasks:

1. Develop a global knowledge base of promising programmatic approaches to prevention, care and treatment from PEPFAR and other countries.
2. Disseminate key findings on effective programmatic approaches, and facilitate their adoption.
3. Pilot interventions that translate new scientific findings into programmatic approaches that address HIV acquisition, treatment and care, as appropriate.

Illustrative Activities²¹:

- Develop or adapt a website to include a searchable document database of evidence based programmatic practices in HIV prevention, care and treatment.
- Conduct 3-5 dissemination activities or events to share information on effective program approaches, with specific attention to USG country teams, PEPFAR implementing partners and government counterparts as primary audiences.
- Identify 2-3 promising new scientific findings with implications for HIV programming, develop proposals to pilot test programmatic innovations based on these findings.
- Identify a set of best practices in OVC programming for low-prevalence countries.

IV. E. 2. Task Area Two: Quality and Sustainability

Result: The quality and sustainability of USG-supported HIV prevention, care and treatment programs is improved.

Sub Tasks:

1. Implement or scale up existing quality assurance systems within HIV prevention, care or treatment programs in 5 or more countries.
2. Strengthen private sector (NGO and commercial) delivery of HIV prevention, care and treatment services in 3 or more countries.
3. Strengthen country-level policies and guidelines that support HIV-related service delivery and access to care in 5 or more countries.
4. Develop and strengthen viable integrated models of HIV service delivery, including with other types of health services (MCH, FP) as well as with broader civil-society programs (employment, education, microfinance) in 5 or more countries.

Illustrative Activities:

- Conduct a global survey of existing quality improvement/quality assurance systems currently in use for HIV-related prevention, care and treatment, including assessment of strengths and weaknesses.
- Identify and document cases where reform of policies and service delivery guidelines enhanced or facilitated HIV-related outcomes (prevention, testing, treatment, pain assessment and management) for the purpose of dissemination and replication in other contexts.
- Develop a conceptual framework that illustrates the pathways through which multisectoral interventions achieve HIV/AIDS related outcomes (prevention, care and treatment and mitigation); develop indicators that will facilitate a cost-benefit analysis of various multisectoral interventions.
- Identify existing OVC database systems and assess whether such systems are facilitating OVC identification, tracking and service delivery.
- Analyze the extent to which private/commercial providers are providing HIV-related services in three countries (e.g. Ethiopia, South Africa, Nigeria), including

²¹ Numerical targets included under the “Illustrative Activities” section of each task area indicate illustrative outputs for a one-year annual work plan period.

assessment of the quality of different types of services, the socio-demographic profile of the clients, the types of providers delivering services and the extent to which there is public/private collaboration and coordination.

- Identify and document successful models of integrated HIV and other health service delivery (with MCH services, including ante-natal care, TB, malaria or other health service), pilot test an integrated model of services in at least one country.
- Identify and document successful models of integrated HIV service delivery and civil society programming (education, employment, micro-finance, and governance); pilot test an integrated model of service delivery in at least one country.

IV. E. 3. Task Area Three: Strategic Planning & Implementation

Result: Strategic, evidence-based programmatic approaches to HIV prevention, treatment and care developed and implemented in other bilateral countries.

Sub-Tasks:

1. Provide strategic planning technical assistance to PEPFAR partners in 10 or more countries to develop and refine prevention, care and treatment approaches that are tailored to particular epidemic contexts, state-of-the-art, evidence-based and country specific.
2. Develop and implement evidence-based interventions in 10 or more countries which are tailored to specific epidemiologic contexts and that:
 - a. Deliver HIV prevention messages, products or services, or change behavioral norms that facilitate HIV transmission.
 - b. Expand the availability and uptake of HIV treatment services.
 - c. Expand care and support programs that deliver clinical, psychological, spiritual, and social services to those infected and affected by HIV/AIDS, including OVCs.

Illustrative Activities:

- Conduct at least 5 technical assistance visits to countries receiving PEPFAR funding to provide strategic planning advice to USG country teams on context-specific programming for prevention, care or treatment.
- Implement field-support funded interventions in at least 5 other bilateral countries to support and advance achievement of PEPFAR targets in prevention, care and treatment.

IV. F. Task Order Deliverables

The following deliverable are specified as part of the statement of work, and will be inspected and accepted by the designated CTO for the task order. Additional deliverables may be specified in the annual workplans and which will be reviewed and approved by the CTO on an annual basis.

1. An on-line, searchable library of documentation and evaluation reports on a range of good and promising programmatic practices related to HIV/AIDS prevention, care and treatment.

2. Work plans for obligated funds within 45 days of initial award; for subsequent fiscal years or funding obligations, work plans are to be submitted by September first of each year. Work plans must include activities, benchmarks, indicators, targets, timelines and budgets.
3. A monitoring and evaluation plan within 90 days of the initial award.
4. A branding and marking plan submitted for USAID approval within 60 days of award.
5. An annual mid-year report by March 30 and an annual report by October 30 of each year.
6. Periodic submission of data for USAID portfolio reviews annually including results, challenges/issues and pipeline information at a date to be determined by USAID (usually during the first two months of each fiscal year).
7. Submission of consultant reports within 30 days after the completion of each TA visit.
8. Final documents or reports for all special studies or analyses. Deadlines for submission to be determined in the workplan for these activities.

C.2 COUNTRIES

USAID anticipates that the Tasks outlined above will be implemented in all geographic regions, including Africa, Asia/Near East, Europe and Eurasia, and Latin America and the Caribbean. However, the actual location of work will depend mainly on mission demand and the level of Mission funding. It is anticipated that the majority of the work will be implemented in non-focus (other bi-lateral) countries. It is expected that the scope of activities implemented in individual countries will fall within any combination of one or more of the objectives of this TO.

C.3 TRAVEL

International and in-country travel will be allowed under this Task Order.

C.4 PROJECT NAME

Offerors are encouraged to propose a project name for this task order as part of their submission. The project name should be distinct from the AIDSTAR IQC name, and reflect the broad scope and purpose of the task order SOW. The final project name will be determined in conjunction with USAID following award of the task order.

C.5 GEOGRAPHIC CODE:

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

C.6 REPORTING REQUIREMENTS:

The following contract reports will be delivered:

- Mid year, annual and final reports (see deliverables above)
- Trip reports for core-funded short term TA (see deliverables above)
- Baseline and results reports for annual USAID portfolio reviews (see deliverables above)

- Quarterly financial reports are to be submitted if so requested by the operating unit that obligates the funds.

C.7 PERIOD OF PERFORMANCE:

The period of performance of this task order is three (3) years from the date of award plus one two-year option, exercised at the discretion of USAID. Therefore, the core period of performance is from the date of award to September 30, 2010, and the option period is from October 1, 2010 to September 30, 2012.

C.8 RELATIONSHIPS & RESPONSIBILITIES

The CTO authority for this Task Order shall be specified by the USAID Contracting Officer in the CTO designation letter, a copy of which will be provided to the contractor. This activity will be managed by the USAID/GH/OHA. USAID may conduct a mid term or final evaluation or management review of this Task Order if necessary.

C.9 METHOD OF AWARD AND INSTRUCTIONS FOR PROPOSAL PREPARATION

USAID may, without discussion or negotiations, award a task order resulting from this RFTOP to a responsible contractor(s) whose proposal(s) conforms to the SOW and offers the best value. “Best value” is defined as the offer that results in the most advantageous solution for the Government, in consideration of technical, cost, and other factors. Therefore, the initial proposal should contain the contractor’s best terms from a cost and technical standpoint. USAID may reject any or all proposals, accept other than the lowest cost proposal, and waive informalities and minor irregularities in proposals received. .

USAID will award the contractor(s) whose proposal best addresses the SOW and represents the best value to the Government, all factors being considered. Proposals for each activity will be evaluated based on adjectival ranking for each evaluation criteria. Sub-criteria are assigned individual weights (see below). The following adjectives will be used in assessing the criteria set forth: outstanding, very good, good, marginal, and unsatisfactory.

C.10 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 1/2” 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.

1. Technical Approach

Written component (recommended length 20 pages): Describe the approach to achieving the results in each Task Area (1-3) outlined in the statement of work, and how sub-tasks will be carried out to achieve desired results. The technical approach should also include a workplan (activity description, schedule, level of effort) for years one through three (1-3) that includes the illustrative activities specified in the SOW, and any additional activities that the offeror wishes to include as part of the technical approach. The approach for monitoring and evaluating execution of the tasks should be described, including proposed indicators.

2. Personnel (Written, recommended length 3 pages)

The four positions listed below are designated as key personnel. USAID has identified the need for additional technical assistance in particular areas highlighted under the “Other Personnel” category below. These positions reflect technical areas that are of high importance to PEPFAR country programs, but which may not require full-time positions on the Task Order, particularly at the initiation of the contract. Proposals should include at least one resume for each technical area highlighted under “Other Personnel”, in addition to the key personnel positions.

Offerors may propose other key personnel positions if they choose. For each additional "key" personnel proposed, the offeror should provide a proposed short job description. Job descriptions may be included in the annex and do not count toward to technical proposal page limit.

Project Director

The Project Director will provide technical leadership and managerial oversight for the task order, and ensure timely implementation and reporting of activities. The Project Director will liaise with other organizations in order to ensure coordination of this task order with activities being undertaken by other partners. The CV of the proposed project director and any other proposed key personnel should be included as an Annex. At a minimum, the Project Director shall have:

- A masters’ degree in public health, or a related advanced degree;
- Extensive experience implementing HIV-related programs, including at least 3 years of experience working with HIV programs in developing countries;
- At least 7 years of experience working with public health programs in developing and transitioning countries;
- Demonstrated skills and experience managing a program of similar magnitude and complexity;
- Excellent communication skills, demonstrated leadership, and the ability to work collaboratively across technical disciplines.

Prevention Advisor

The Prevention Advisor should have the following qualifications and demonstrated experience related to the management and implementation of successful behavior change programming in developing countries:

- Professional advanced degree, MPH, MSH, or PhD in health, public health, epidemiology, sociology or related field.
- At least 5 years of experience in public health programs in developing countries with demonstrated broad technical knowledge and experience in planning and management of programs in developing countries.
- Minimum three years of demonstrated ability in strategic planning, program management and implementation, preferably within a developing country or resource-poor context.
- Proven ability to apply sociological, anthropological or related cultural knowledge in addressing issues in the design, implementation and/or evaluation of HIV/AIDS prevention programs.
- Experience working in both concentrated and generalized HIV epidemic contexts is desirable.

Care and Treatment Advisor

The Care and Treatment Advisor should have the following qualifications and demonstrated experience related to the management and implementation of HIV care and treatment programs, preferably in developing countries:

- A clinical degree in medicine or nursing.
- At least 10 years of experience working in health programs, with at least three years of experience with antiretroviral therapy for HIV and palliative care and support.
- Demonstrated experience with pediatric AIDS care and treatment, treatment programs working with marginalized, high-risk populations.
- Experience with start-up and implementation of ART in developing countries.

Research/Monitoring and Evaluation Advisor

The Research/Monitoring and Evaluation Advisor should have the required academic qualifications and demonstrated experience in research, monitoring and evaluation of public health programs to provide technical leadership to these activities under TO One. These qualifications should include:

- A PhD or DrPH 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 in HIV-related programming.
- Demonstrated experience and familiarity with behavioral surveillance surveys, research methodologies, qualitative and quantitative research methods, sampling techniques and establishing M&E systems in developing countries.

Other Personnel

USAID has identified the following technical areas as of particular importance to implementing the Statement of Work under this Task Order:

- Orphans and Vulnerable Children (OVC) programming
- Knowledge Management
- Prevention of Mother to Child Transmission (PMTCT)
- Social and Behavior Change

The Offeror should propose other long and short-term staff and consultants as appropriate to carry out the SOW and based on the offerors proposed approach. The Offeror should propose a combination of local, regional and/or international staff and consultants. The Offeror should provide a matrix (included in the annex) of proposed staff and consultants. The matrix should provide the following information: Name, Functional Labor Category, Task Area of expertise, estimated Level of Effort, education, language skills, and developing country experience.

3. Management (Written, recommended length 2 pages)

The Offeror should propose a management structure to address the breadth, depth, and technical areas required to successfully undertake this Task Order. The Offeror should describe how the tasks will be organized and managed to minimize non-productive costs to the government such as multiple overheads and how the contractor will utilize the complementary capabilities of any proposed sub-contractors most effectively and efficiently. Applicants should describe how lines of authority will be managed within their own organization and between the Offeror and any sub-contractors. The management plan should demonstrate the Offerors' understanding of efficient management practices, including approaches to cost containment, avoidance of duplication of effort, and use of technology. The plan should also demonstrate how the Offeror will use developing country partners and in-country technical resources to build capacity and reduce costs. This plan should describe lines of communication and reporting, and how the Project Director will liaise with the USAID CTO, USAID Missions, in-country staff. Offerors are encouraged to include an organizational chart in the Personnel Annex to the technical proposal.

C.11 Cost Proposal

Offerors shall submit their cost proposal(s) in excel format with full access to all formulas and in the following Contract Line Item Number (CLIN) format, by country and by operating period as well as a summary for all countries and for the overall period of performance. Please use “Rwanda” as an illustrative country then multiply the total country budget by a factor of 8 for cost realism. Please note that the numbers of rows in the table below, or the illustrative CLINs, are not intended to reflect USAID’s expectations regarding the final identity and/or number of CLINS that may result in the Task Order issued, but are intended for illustrative purposes only (except where plug figures are provided). 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. For example, CLIN 1 (Salaries) should have an LOE chart for the 20% central component and an LOE chart for the

80% mission component. USAID will set the standard of Full Time Equivalent (FTE) of 260 working days/year. USAID anticipates ordering 20 FTEs/year for central funding and 106 FTEs/year for mission funding. Please adjust proposed budgets accordingly.

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 Tables 1-2. 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 of performing under this Task Order.
- b) Detailed level of effort and labor cost estimates must be submitted to support the proposed implementation of the Statement of Work. Please provide a separate line item for each proposed individual and identify each by name, labor category, daily rate in accordance with the basic contract, and the level of effort for that individual. For “key” individuals and professional staff 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 of salary for all proposed CCN Direct Labor;
- e) A certification that no USAID employee has recommended the use of an individual or subcontractor under the proposed Task Order who was not initially located and identified by your organization;

It is anticipated that there will be a central funding and mission funding components to this Task Order. The anticipated break down of the TO Total Estimated Cost is as follows:

Central funding: 20%
Mission funding: 80%

Table 1: Base Period Award (Year 1-3) Task Order Budget

Cost Element	Y1	Y2	Y3	Total
Total Direct Labor				
Salary				\$ _____
Fringe Benefits				\$ _____
Consultants				\$ _____
Subcontracts A (Staff & Consultants), FB & OH)				\$ _____
Subcontracts B (All Costs except Subcontracts A)				\$ _____
Grants under Contracts (mission funding)				\$10.00 mil.

Local Professional Staff	\$ _____
Allowances	\$ 2.00 mil.
Travel, Transportation, and Per Diem	\$ 2.20 mil.
Other Direct Costs	\$ _____
Indirect Costs	\$ _____
Subtotal Estimated Cost	\$ _____
Fixed Fee	\$ _____
Total Estimated Cost	\$ _____

Table 2: Two year option (Yr 4-5) Task Order Budget

Cost Element	Option Years 4 & 5
Total Direct Labor	
Salary	\$ _____
Fringe Benefits	\$ _____
Consultants	\$ _____
Subcontracts A (Staff & Consultants), FB & OH)	\$ _____
Subcontracts B (All Costs except Subcontracts A)	\$ _____
Grants under Contracts (mission funding)	\$ 7.00 mil.
Local Professional Staff	\$ _____
Allowances	\$ 1.50 mil
Travel, Transportation, and Per Diem	\$ 1.60 mil
Other Direct Costs	\$ _____
Indirect Costs	\$ _____
Subtotal Estimated Cost	\$ _____
Fixed Fee	\$ _____
Total Estimated Cost	\$ _____

The above budget shall be supported by a detailed budget narrative in sufficient detail to allow a complete cost analysis & realism. Use the **plug figures provided** for Allowances, Travel & grants under Contracts as stated. Offerors must propose costs that they believe are realistic and reasonable for the work in accordance with their respective Task Order Technical Proposals. **Offers proposed budgets must identify central cost components and mission cost components in the 3 year basic contract and the two year option.**

C.12 Evaluation Criteria for Award (% weights as indicated)

Each proposal will be evaluated in relation to the evaluation criteria set forth in this RFTOP. These factors have been tailored to the requirements of this Task Order to allow USAID to choose the highest quality proposal. These criteria identify the significant areas that Offerors should address in their proposals and serve as the standard against which all proposals will be evaluated. Sub-criteria have been assigned specific weights.

The Government may award a Task Order(s) without discussions with applicants. However, the Government reserves the right to conduct discussions if later determined by the Contracting Officer as necessary. Therefore, each initial proposal (written and oral) should contain the Offeror's best terms from a cost or price and technical standpoint.

1. Cost (40%):

The cost evaluation criteria will have a 40% weight of the total score for the proposal. Contractor should offer a cost proposal that represents the best value to the Government as determined by the Contracting Officer.

2. Technical Approach (30%):

- a. The proposal demonstrates an understanding of key HIV-related technical areas in both generalized and concentrated epidemic contexts including: prevention, counseling and testing, OVC programming, palliative care, nutrition support, ART, and gender awareness in program design and implementation. **10%**
- b. The proposed knowledge management strategy defines criteria and strategies for identifying, documenting and synthesizing good programmatic practices, and includes a feasible and cost-effective plan for collaboration and dissemination. **10%**
- c. The proposed approach to HIV program sustainability addresses challenges and opportunities, and presents a strategic approach to advancing quality assurance, sustainability, private sector involvement and policy and guideline development. **6%**
- d. The proposal articulates how the contractor will work to implement integrated services within country programs, including within HIV services, between HIV and other key public health services, and between HIV and other types of social and economic support services. **4%**

3. Personnel (15%):

- a. The proposed Project Director meets or exceeds the minimum requirements set forth in Section C.10.2. **5%**
- b. The other proposed key personnel meet or exceed the minimum requirements set forth in Section C.10.2. **5%**
- c. The proposed staff and consultants possess the demonstrated expertise, skills and experience required to implement the full range of technical and management tasks described in the SOW. **5%**

4. Management Approach (15%):

- a. The management plan demonstrates a clear strategy for supporting in-country capacity building through substantive use of in-country and third country partners. **5%**

- b. The proposal includes a plan for monitoring and reporting on subcontractor participation in terms of both Level of Effort (LOE) and expenditures. **5%**
- c. The proposed organizational chart is clear, logical, and cost-effective and shows appropriate lines of authority for managing all staff, including consultants and sub-contractors. **5%**

C. 13 BRANDING STRATEGY

The Contractor is expected to follow USAID guidelines on USAID branding which is outlined in the USAID “Graphic Standards Manual” and available on the USAID website at: www.usaid.gov/branding and revised and expanded ADS chapter on Branding and Marking issued (see both sections D.1 & D.2).

C. 14 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 Cognizant Technical Officer (CTO).

C.15 SUBCONTRACTS AND GRANTS

Sub-contracts are allowed and encouraged in order to complete the proposed in-country work. USAID anticipates obtaining the authority to authorize grants under contract for this task in accordance with C.6 of the basic IQC. In conjunction with this requirement, the contractor must submit a small grants management plan within 30 days of the task order award date.

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

Markings under any awarded contract under this TO shall comply with the USAID “Graphic Standards Manual” available at <http://www.usaid.gov/branding>, the policies found at Automated Directives System (ADS) Chapter 320 (dated January 8, 2007), or any successor branding policy.

END OF SECTION D

SECTION E - INSPECTION AND ACCEPTANCE

E.1 TASK ORDER PERFORMANCE EVALUATION

Task order performance evaluation shall be performed in accordance with AIDSTAR Sector I IQC.

END OF SECTION E

SECTION F – DELIVERIES OR PERFORMANCE

F.1 AIDAR 752.7005 SUBMISSION REQUIREMENTS FOR DEVELOPMENT EXPERIENCE DOCUMENTS (JAN 2004) (AAPD 04-06)

(a) Contract Reports and Information/Intellectual Products.

(1) The Contractor shall submit to USAID's Development Experience Clearinghouse (DEC) copies of reports and information products which describe, communicate or organize program/project development assistance activities, methods, technologies, management, research, results and experience as outlined in the Agency's ADS Chapter 540. Information may be obtained from the Cognizant Technical Officer (CTO). These reports include: assessments, evaluations, studies, development experience documents, technical reports and annual reports. The Contractor shall also submit to copies of information products including training materials, publications, databases, computer software programs, videos and other intellectual deliverable materials required under the Contract Schedule. Time-sensitive materials such as newsletters, brochures, bulletins or periodic reports covering periods of less than a year are not to be submitted.

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

(b) Submission requirements.

(1) Distribution.

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

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

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

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

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

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

(2) Format.

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

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

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

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

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

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

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

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

END OF SECTION F

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1 CONTRACTING OFFICER'S AUTHORITY

The Contracting Officer is the only person authorized to make or approve any changes in the requirements of this Task Order and notwithstanding any provisions contained elsewhere in this Task Order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other 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/GH/OHA shall provide technical oversight to the Contractor through the designated CTO. The contracting officer shall issue a letter appointing the CTO for the Task Order and provide a copy of the designation letter to the contractor.

G.3 ACCEPTANCE AND APPROVAL

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

G.4 INVOICES

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to... (See Section G.5 of subject IQC). One copy of the voucher and the invoice shall also be submitted to the Contracting Officer and the CTO.

Electronic submission of invoices is encouraged. Submit invoices to the Office of Chief Financial Officer to this address if a core/central funded activity: EI@USAID.GOV. For mission/field funded activity, billing instructions will be provided by the CTO.

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

Paper Invoices shall be sent to the following address:

See Section G.5 of the subject IQC.

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 contractor shall provide key personnel for the performance of this Task Order pursuant to the Statement of Work.

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. Ability to hire local language expertise is required when necessary for the completion of field support tasks.

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 CTO.

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.

H.6 PERIODIC PROGRESS REPORTS (July 1998) (CIB 98-21)

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

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

END OF SECTION