

**POPULATION, HEALTH AND NUTRITION TECHNICAL ASSISTANCE AND SUPPORT 3 (TASC3) IQC  
SECTION A –REQUEST FOR TASK ORDER PROPOSAL (RFTOP)**

***HIV Prevention Project***

1	RFTOP Number	114-09-012
2	Date RFTOP Issued	June 22, 2009
3	Issuing Office	USAID/Caucasus/Georgia
4	Contracting Officer	Camille Garcia
5	Proposals to be Submitted to	Yana Adelberg, Acquisition Specialist, Regional Contracting Office, USAID/Caucasus <a href="mailto:yadelberg@usaid.gov">yadelberg@usaid.gov</a> or <a href="mailto:rcocaucasus@usaid.gov">rcocaucasus@usaid.gov</a>
6	Proposals Due	August 5, 2009
7	Payment Office	* See Section G.4 Invoices
8	Name of Firm	
9	IQC Task Order Number	
10	DUNS number	
11	Tax Identification Number	
12	Address of Firm	
13	RFTOP Point of Contact (POC)	
	Secondary POC	
14	Person Authorized to Sign RFTOP	
15	Signature	
16	Date	

## TABLE OF CONTENTS

<b>SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS .....</b>	<b>1</b>
B.1 PURPOSE .....	1
B.2 CONTRACT TYPE .....	1
B.3 BUDGET AND CEILING PRICE .....	1
B.4 PAYMENT .....	1
<b>SECTION C - PERFORMANCE WORK STATEMENT .....</b>	<b>2</b>
C.1 BACKGROUND .....	2
C.1.1 Context for USAID Assistance .....	2
C.1.2 International Donor Support .....	5
C.1.3 Relations to Country and Mission Strategy .....	7
C.2 TITLE: HIV PREVENTION PROJECT .....	10
C.3 STATEMENT OF NEED .....	10
C.4 OBJECTIVE .....	10
C.5 SCOPE OF WORK .....	11
C.6 IMPLEMENTATION AND MANAGEMENT PLAN .....	16
C.7 PERFORMANCE MONITORING PLAN .....	16
<b>SECTION D – PACKAGING AND MARKING .....</b>	<b>17</b>
D.1 AIDAR 752.7009 MARKING (JAN 1993) .....	17
D.2 BRANDING STRATEGY .....	17
D.3 BRANDING IMPLEMENTATION PLAN AND MARKING PLAN .....	18
<b>SECTION E - INSPECTION AND ACCEPTANCE .....</b>	<b>19</b>
E.1 TASK ORDER PERFORMANCE EVALUATION .....	19
<b>SECTION F – DELIVERIES OR PERFORMANCE .....</b>	<b>20</b>
F.1 PERIOD OF PERFORMANCE .....	20
F.2 DELIVERABLES SCHEDULE AND REPORTING REQUIREMENTS .....	20
F.3 TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS .....	22
F.4 PLACE OF PERFORMANCE .....	22
F.5 AUTHORIZED WORK DAY / WEEK .....	22
<b>SECTION G – TASK ORDER ADMINISTRATION DATA .....</b>	<b>23</b>
G.1 CONTRACTING OFFICER'S AUTHORITY .....	23
G.2 TECHNICAL DIRECTION .....	23
G.3 ACCEPTANCE AND APPROVAL .....	23
G.4 INVOICES .....	23
<b>SECTION H – SPECIAL TASK ORDER REQUIREMENTS .....</b>	<b>24</b>
H.1 KEY PERSONNEL .....	24
H.2 AUTHORIZED GEOGRAPHIC CODE .....	24
H.3 LANGUAGE REQUIREMENTS .....	24
H.4 GOVERNMENT FURNISHED FACILITIES OR PROPERTY .....	24
H.5 CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY .....	24

*HIV Prevention Project  
RFTOP No. 114-09-012  
Table of Contents*

H.6 CONTRACTOR'S STAFF SUPPORT, AND ADMINISTRATIVE AND LOGISTICS ARRANGEMENTS .....	25
H.7 PERIODIC PROGRESS REPORTS (JULY 1998) (CIB 98- 21) .....	25
H.8 EXECUTIVE ORDER ON TERRORISM FINANCING.....	25
H.9 REPORTING ON TAXATION OF U.S. FOREIGN ASSISTANCE.....	25
H.10 USAID DISABILITY POLICY - ACQUISITION (DECEMBER 2004).....	26
H.11 GRANTS UNDER CONTRACTS.....	27
<b>SECTION I – CONTRACT CLAUSES .....</b>	<b>28</b>
I.1 REFERENCE: TECHNICAL ASSISTANCE AND SUPPORT CONTRACT (TASC3) INDEFINITE QUANTITY CONTRACT (IQC).....	28
I.2 AIDAR 752.7028 DIFFERENTIALS AND ALLOWANCES (JULY 1996).....	28
<b>SECTION J – ATTACHMENTS .....</b>	<b>31</b>
<b>SECTION K – Certifications and Representations .....</b>	<b>32</b>
<b>SECTION L – INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS .....</b>	<b>33</b>
L.1 GENERAL .....	33
L.2 GENERAL INSTRUCTIONS TO OFFERORS .....	33
L.3 RECEIPT OF PROPOSALS AND DELIVERY INSTRUCTIONS .....	33
L.4 INSTRUCTIONS FOR PREPARATION OF THE TECHNICAL PROPOSAL.....	35
L.5 COST PROPOSALS .....	38
L.5(a) COST-PLUS-FIXED-FEE BUDGET .....	38
L.5(b) Budget Estimate .....	39
L.5(c) Personnel.....	39
L.5(d) Detailed Cost Proposal Instructions and Additional Information .....	39
<b>SECTION M - EVALUATION FACTORS FOR AWARD.....</b>	<b>43</b>
M.1 GENERAL INFORMATION.....	43
M.2 TECHNICAL PROPOSAL EVALUATION CRITERIA.....	43
M.3 COST PROPOSAL EVALUATION.....	45

*HIV Prevention Project  
RFTOP No. 114-09-012  
Table of Contents*

**ACRONYMS:**

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral treatment
BCC	Behavior Change Communication
BSS	Behavioral surveillance survey
CCM	Country Coordinating Mechanism
CLI	Community-level intervention
CSWs	Commercial sex workers
FSWs	Female sex workers
FY	Fiscal Year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoG	Government of Georgia
HIV	Human Immunodeficiency Virus
HWG	Healthy Women in Georgia Project
IDUs	Injecting drug users
IEC	Information, Education, Communication Campaign
MARP	Most at Risk Persons
MES	Ministry of Education and Science
MoLHSA	Ministry of Labor, Health, and Social Affairs
MSM	Men who have sex with men
OST	Opiate Substitution Therapy
PLWH	People living with HIV
RCC	Rolling Continuation Channel
SHIP	STI/HIV Prevention Project
STIs	Sexually transmitted infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Family Planning Association
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization

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

### **B.1 PURPOSE**

The United States Agency for International Development (USAID) Georgia's Office of Health and Social Development (HSD) requires technical assistance to implement the HIV Protection project, which is to support HIV prevention among high risk groups in Georgia in order to avert the spread of HIV to the general population as detailed in Section C. The work to be performed under this task order derives from the USAID Mission Strategic Plan. Implementation of this project supports achievement of the Strategic Assistance Objective for Investing in People and the Assistance Goal of Improving the Delivery of Social Services by promoting HIV prevention practices. The project builds on successes of other USAID projects supporting HIV prevention and reinforces education priorities of the Government of Georgia (GoG). The resulting task order may result in logical follow-on task orders.

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

This is a cost plus fixed fee, if any, term form task order. For the consideration set forth in the contract, the Contractor shall provide the deliverables or outputs described in Section C and comply with all contract requirements.

### **B.3 BUDGET AND CEILING PRICE**

The Total Estimated Cost of this acquisition is \$ TBD.

For Workdays (LOE) Ordered	\$ _____
For Other Direct Costs	\$ _____
Indirect Costs (includes overhead, G&A, and MHO)	\$ _____
Fixed Fee	\$ _____
Cost Plus Fixed Fee Ceiling Price	\$ <u>TBD</u> .

The contractor will not be paid any sum in excess of the ceiling price.

### **B.4 PAYMENT**

The paying office is:  
Financial Management Office  
USAID/Caucasus  
11 George Balanchine Street  
Tbilisi 0131, Georgia

**END OF SECTION B**

## **SECTION C - PERFORMANCE WORK STATEMENT**

### **C.1 BACKGROUND**

#### **C.1.1 Context for USAID Assistance**

Prior to August 2008, Georgia enjoyed nine percent annual economic growth and exhibited promising movement on the slate of reforms. Nonetheless, in the aftermath of the current crisis, Georgia faces significant and newly emerging tests ahead. The need to improve the country's health outcomes becomes especially critical. Like many of its neighbors, Georgia faces the possibility of large HIV/AIDS epidemic, which in addition to steady out-migration and low fertility may eventually contribute to overall population decline. The FY 2009 U.S. "Mission Strategic Plan" for Georgia recognizes the importance of an improved public health system to Georgia's continued success as a young democracy, dedicating U.S. agencies to help "increase access to affordable health services, while addressing infectious diseases."<sup>1</sup>

#### **HIV/AIDS in Georgia**

Over the last ten year period, Georgia has officially registered 1,977 cases of HIV, which have included 1,020 AIDS cases and 427 deaths. The overall prevalence has remained low at 0.1%. The number of patients currently on antiretroviral treatment (ART) is 495. Annual reported new cases of HIV have more than tripled over the last five years, from 100 cases in 2003 to 351 cases in 2008. The National AIDS Center estimates that there are 4,000 people living with HIV in Georgia. Seventy-five percent (1,485) of all registered HIV cases are among men and the epidemic in Georgia remains largely concentrated among injecting drug users (IDUs), men who have sex with men (MSM), female sex workers (FSWs), and the sexual partners of these groups. Injection drug use itself accounts for 60% of reported HIV cases, and one-third of heterosexual transmissions involved sex with a partner who injected drugs. As a result, injection drug use is at the root of approximately 70% of HIV infections in Georgia.

Estimated HIV prevalence rates among high risk groups are currently below the concentrated epidemic stage (5% or greater within a risk group) but these rates are increasing rapidly. Prevalence rates range from 0.4% to 3.0% among IDUs, 3.7% among MSM, and 0.6% to 1.3% among FSWs (ranges reflect variances in regional prevalence and surveillance). Most young people do not have accurate knowledge about HIV and some indicators suggest they are initiating illicit drug use and injection at an earlier age than before<sup>2</sup>. Of the 1,940 TB patients who were tested in 2008, 1.3% were HIV-positive. Conversely, approximately 20% to 26% of registered HIV patients also have active TB (i.e. in the contagious phase). Georgia's HIV epidemic is in some part influenced by migration of Georgian citizens to and from Ukraine and Russia, where HIV prevalence among IDUs ranges from 10% to 66% across cities in Ukraine and from 3% to 70% across cities in Russia. HIV prevalence in Georgia's breakaway region of Abkhazia is almost four times higher than the rest of the country.

Several contextual issues influence Georgia's epidemic. HIV stigma is high and people living with HIV frequently report being rejected by family and friends and even being refused healthcare by health providers (although rare, but still an unacceptable practice). Georgia is in the midst of sweeping changes in its healthcare delivery and financing systems. The state is

---

<sup>1</sup> "FY 2009 Mission Strategic Plan." U.S. Mission to Georgia, March 30, 2007

<sup>2</sup> Behavior Surveillance Survey (BSS 2008) results

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

replacing its vertically aligned specialty care system with a family-medicine-oriented primary care model, privatizing almost all hospitals, and replacing full government funding of healthcare with a new financing system of patient fees, private insurance, and social insurance. These reforms are likely to greatly influence future GoG decisions on HIV prevention and treatment financing and service delivery for people living with HIV.

**Government of Georgia Institutional Structure for Combating HIV**

The National AIDS Centre (Infectious Diseases AIDS and Clinical Immunology Research Center) is located in Tbilisi and heads a network of nine counseling and testing units and 64 HIV diagnostic laboratories operating throughout the country, including a central reference laboratory in Tbilisi. In 2003-2005, two regional AIDS Treatment Centers in Batumi (Adjara) and Zugdidi (Samegrelo region) became operational as part of the National AIDS control system, thereby improving access to HIV/AIDS treatment and care services at sub-national levels. In 2009, a third regional center in Kutaisi (Imereti region) was added to the National AIDS control network.

During the period from 1994 to 2007, funding for HIV/AIDS Prevention and Control interventions in Georgia was mainstreamed through four national programs: 1. National AIDS Prevention Program; 2. National Safe Blood Program, 3. National AIDS Treatment Program, and 4. VCT for the most-at-risk groups. An additional 5<sup>th</sup> national program for Prevention of Mother to Child Transmission became operational in 2005 which includes HIV testing for all pregnant women in Georgia.

The National AIDS Prevention Program was implemented by the Public Health Department of the Ministry of Labor, Health, and Social Affairs. In 2007, the National AIDS Prevention Program was closed as part of the ongoing reforms of the health care sector. The GoG stopped funding two key prevention programs, a national hotline service and training of health care providers and youth on HIV/AIDS prevention. However, the National Prevention Program's testing services were incorporated in the National AIDS Treatment program administered by the State Health and Social Insurance Fund which is implemented by the National AIDS Center network.

Before 2007, the National AIDS Center was the main entity responsible for HIV testing confirmation, antiretroviral treatment, and surveillance and data collection. HIV/AIDS surveillance was implemented under the National HIV/AIDS Prevention Program by the National AIDS Center at the central level; regional and district HIV diagnostic laboratories at the sub-national level and other HIV/AIDS/STI service providers at all levels. The surveillance data included results of HIV testing of most at risk population groups.

Starting in 2007, HIV/AIDS surveillance became a part of the united National Surveillance Program for all reportable diseases in Georgia administered by the National Center for Disease Control (NCDC), and it is linked with STI and Hepatitis B and C surveillance countrywide. Data is collected and analyzed at the NCDC on monthly basis and reported to the Ministry of Labor, Health, and Social Affairs. However, there is no behavioral surveillance capacity developed at any level of the country's surveillance system.

The National AIDS center remains responsible for HIV testing through its laboratories, confirmation of all HIV positive cases detected within or outside of its system in its reference laboratory, and providing antiretroviral treatment. The National AIDS center maintains 12 in-patient beds in Tbilisi and 2 to 3 beds at each of its regional centers in Zugdidi, Batumi, and

Kutaisi for the treatment of patients with full-blown AIDS symptoms. This capacity is sufficient for current needs but would require expansion if Georgia's HIV epidemic begins to worsen.

### **Antiretroviral treatment (ART)**

Antiretroviral treatment prevents development of the actual disease – AIDS – in the people who live with the HIV virus. In Georgia, antiretroviral drug treatment (ART) is prescribed for those patients who meet the treatment criteria developed by the World Health Organization (WHO). Currently there are 495 patients receiving ART that is provided exclusively in the National AIDS center located in Tbilisi and its branches in Batumi, Zugdidi, and Kutaisi. All patients from across the country that need ART are referred to these four government operated facilities. The costs for ART drugs are currently funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM or Global Fund). The cost of first line antiretroviral drugs is about \$1,000 per patient per year while treatment that requires second line drugs costs up to \$3,000 per year. Currently the cost of antiretroviral drugs for AIDS patients in Georgia is approximately \$900,000 per year.

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the GoG currently contributes 11% of total costs for ART treatment by covering the salary costs of medical staff who operate the National AIDS Center and its regional branches. The top priorities of the government are to maintain current patients on ART and to plan for future treatment capacity.

### **HIV Prevention**

Currently the GoG provides no funding for HIV prevention, relying entirely on international donors and NGOs to fund activities designed to reduce the rate of transmission of HIV in Georgia. The global experience shows that in the area of HIV prevention the role of NGOs is crucial. Prevention outreach is mainly aimed at hard to reach groups at high risk of contracting HIV. These individuals, whose behaviors are commonly criminalized, often deliberately avoid interaction with any official governmental entities, out of fear of being reported to authorities for prosecution. Historically, NGOs have been perceived as neutral and non-judgmental and have had more success in establishing trust with high-risk groups. Thus, the role of NGOs in communicating prevention messages and providing counseling and outreach services is vital.

### **Health Reform**

The Government of Georgia (GoG) has shown a willingness to make dramatic structural changes in the health sector. Back in 1997, Georgian parliament approved the law initiating the steady privatization of state health facilities to improve the quality of health care through putting facilities under private sector management. In 2007, the GoG initiated a plan for massive privatization of health facilities. The GoG transferred ownership of 200 public hospitals last year to private investors with the requirement that these investors build 70 new hospitals to replace the old, deteriorated facilities. The GoG also has plans to privatize most primary health clinics. However, the global economic crisis has placed great strain on the health care privatization process. Many of the new hospital owners report difficulty obtaining the capital needed to either build the required new hospitals or renovate and operate the old ones.

### **Private Health Insurance**

Currently no health insurance policies available in Georgia cover HIV treatment. So far, treatment of HIV remains fully subsidized by the government and the Global Fund through public health programs. All pregnant women are tested for HIV as part of their maternity care, regardless of whether they have health insurance or not. These diagnostic costs are currently

covered by the Prevention of Mother to Child Transmission Program, a public health program launched by the GoG in 2005.

### **Stigma**

High-level stigma among the general population is stifling prevention efforts as it discourages open discussion about risks, desire to know one's status, and willingness to reveal one's status to prevent further transmission. Because Georgia is a low prevalence country, HIV is not a priority for most people, and it is easy to ignore both the disease and the people who have it. There is little public dialogue about HIV and no demands from civil society that the government address the issue. Therefore, ungrounded fear and misconceptions about HIV continue to linger at the expense of those affected by the disease.

### **Medical Education, Training, and Institutional Limitations**

It is unclear whether the government will decentralize the treatment and health monitoring of HIV patients from specialized facilities into primary care settings. Given the complex nature of HIV treatment and the absence of standard HIV clinical training for general practitioners in medical schools, primary care providers are not likely to have the clinical expertise to treat HIV patients adequately. Furthermore, until general practitioners become more accepting of HIV patients and sensitized to their needs, HIV patients are likely to avoid seeking care within primary care settings.

## **C.1.2 International Donor Support**

Georgia is still highly dependent on donor support for both HIV prevention and treatment. Georgia receives significant financial support from the Global Fund where the majority of the funding is earmarked for antiretroviral treatment, clinical supplies (including HIV test kits and methadone), and development of surveillance and monitoring systems. About 10% of the Global Fund supports behavioral interventions for risk groups, primarily in Western Georgia. USAID currently funds HIV prevention activities in Tbilisi and large population centers in eastern Georgia. In addition to the Global Fund and USAID, who are the key donors in the area of HIV prevention, smaller scale funding periodically comes from other international donors, including European Union, the United Nations AIDS Theme Group, other bilateral, and private foundations

### **Global Fund**

Current Global Fund awards relevant to HIV include:

Round 2: Although this funding officially ended in February 2009, bridge funding was awarded to extend activities until the start of 2010. The bulk of Round 2 funding supports Prevention of Mother to Child Transmission (PMTCT) (VCT and treatment), blood safety measures, ART for approximately 500 patients, six opiate substitution treatment programs, and policy advocacy. Approximately 14% of the \$12.1 million award funds six needle exchanges throughout Georgia and limited VCT and outreach targeting IDUs, FSWs, and MSM in regions where SHIP is not currently working. The scope of these programs is very limited, however, and the implementing NGOs predict they will not reach their 2009 coverage targets due to difficulties in accessing high-risk groups. The original Round 2 funding also included support for school-based HIV education for youth and a youth VCT center, although all of this funding was withdrawn from the Rolling Continuation Channel (RCC) proposal that was recently submitted to the Global Fund to continue Round 2 funding. If approved, the new RCC/Round 2 funding will continue existing

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

activities (with the exception of those targeting youth) and scale-up ART access through at least 2015.

Round 6: Current funding (\$11.5 million) is approved through the end of 2010. The government plans to apply for continuation funding in 2010 through the Global Fund's revised strategic planning funding system. The Round 6 award supports build-up of national surveillance, supplemental ART, two additional OST centers, VCT services in a small number of prisons, and limited needle exchange and VCT for IDUs in Eastern Georgia.

**USAID Activities**

USAID programs support Global Fund and GoG programs by helping to cover unmet needs of most at risk persons (MARPs).

To date USAID has been the only donor in the country to prioritize organizational capacity building among NGOs in its HIV prevention programming. USAID believes that NGO capacity building is essential to ensuring sustainability of HIV prevention programs in Georgia. In addition to funding direct service to MARPS, USAID has also provided training for NGO managers on proposal writing, fiscal management, and strategic planning. The result of USAID support to NGO capacity building is a promising network of local NGOs including several that have shown particular skill not only in HIV prevention fieldwork but in managing the expansion of their activities across regions. USAID's implementing partners have also created mechanisms to disseminate expertise among NGOs, promoting managerial competence and organizational stability throughout Georgia's nascent nonprofit sector.

Another byproduct of this capacity building has been a positive change in government mindset toward civil society. Because of the success NGOs have had in implementing HIV prevention programs, the government is beginning to recognize the value of NGOs in public health efforts, and is much more willing to work collaboratively with the local NGO sector.

USAID activities in HIV prevention are implemented through the following projects:

SHIP Project

Since 2002, USAID has funded the Sexually Transmitted Infections (STI) and HIV Prevention Project (SHIP), implemented by Save the Children International, which reaches out to the most-at risk groups (IDUs, CSWs, MSM and high-risk youth within these MARPs) in Tbilisi, Kutaisi, Batumi and originally in Sukhumi, Abkhazia. The SHIP project had to suspend its activities in Abkhazia due to the August 2008 conflict. Save the Children and its partner organizations PATH, Tanadgoma and Bemoni Public Union work in the areas of behavioral interventions, clinical services for STIs, behavioral surveillance and public advocacy. The SHIP project will end in September 2009. SHIP activities include:

- Working with stakeholders and decision makers at the policy level to strengthen STI/HIV surveillance;
- Working with beneficiaries to change risk behavior through implementation of tailored Behavior Change Communication (BCC) strategies;
- Providing training in prevention counseling to health care providers involved in outreach to MARPS;
- Supporting 2 Medical Mobile Laboratories operated by the NGO Tanadgoma to improve access to quality voluntary counseling and testing (VCT) services;
- Supporting capacity building of local NGOs and government partners to sustain effective response to HIV prevention; and

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

- Increasing public awareness of STI/HIV prevention through public campaigns on World AIDS Day and International AIDS Candlelight Memorial Day.

Healthy Women in Georgia Project.

The Healthy Women in Georgia (HWG) Project, implemented by John Snow Inc., and its sub-contractors Save the Children, Hera, and Curatio, since 2003, has three main program components: modernizing maternity care, increasing access to and utilization of family planning, and creating informed consumers. Under the creating informed consumers component, HWG works in Imereti and Kvemo Kartli on integrating Healthy Lifestyle curricula in the schools for 8-12th graders (aged 14-18 years old). Starting from 2009, Samegrelo region also became a pilot for this component. The Healthy Lifestyle course curriculum includes modules on: Smoking, Alcohol, Drugs, Early Marriage, Puberty, STI, HIV/AIDS, and Adolescents Reproductive Health. This course is more oriented on behavior change rather than the provision of health information.

Fostering Healthy Lifestyles among Georgian Youth

The Fostering Healthy Lifestyles among Georgian Youth grant to International Orthodox Christian Charities (IOCC) was awarded in September 2007 to implement activities in Tbilisi where there are the greatest number of drug users and most at-risk populations of youth. The project ended in January 2009. A main goal of this activity was to empower youth between 11-21 years old to reject illicit drug use and risky behaviors that perpetuate the transmission of HIV/AIDS by enhancing social support networks through the training of clergy, teachers and youth coordinators, and by carrying out an age-appropriate drug abuse and HIV/AIDS prevention national media campaign. The Georgian Orthodox Church plays an important and influential role in the lives of the Georgian people. IOCC's implemented program developed a unique working relationship with the church and was able to work successfully towards prevention efforts on the topics of drug abuse and HIV prevention.

The initiative targeted seven secondary schools located in Tbilisi for youth initiative clubs with support from youth coordinators and teachers. Activities included writing and performing plays, essay competitions and art competitions devoted to HIV and narcotic drug use prevention. In addition to activities in the pilot schools, brochures aimed at increasing awareness on drugs and illicit drug use were developed, printed and distributed to 2,100 schools throughout Georgia through the help of the Ministry of Education.

Mass media campaigns carried out by national television and radio stations were used to convey project messages to the targeted beneficiaries. TV programs dedicated to the drug abuse prevention campaign were broadcast through local media outlets (Georgian Public Broadcasting, Mze and TV/Radio station Iveria). These programs provided the target audiences with information that will empower them to address issues of drug abuse in their families and communities. Five animations and eight feature public service announcements were produced and broadcast through five major national TV channels.

### **C.1.3 Relations to Country and Mission Strategy**

Relationship to the US Mission Strategic Plan

Implementation of the activity will support achievement of the Strategic Assistance Objective for Investing in People and the Assistance Goal of Improving the Delivery of Social Services by promoting HIV prevention practices that will save lives.

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

The HIV Prevention project falls under *Approach One*, of the Investing in People Objective under the Development Planning Framework for Georgia FY 2009 – 2011: “Build GoG’s management capacity to ensure provision of quality social services. The Ministry of Labor, Health, and Social Affairs (MoLHSA) and the Ministry of Education and Science (MES) need substantial management training and capacity building to manage and monitor the provision of both privatized and non-privatized public health services as well as education and vocational training services. The current activity portfolio in health and social development supports management capacity building in the health sector through its policy reform, Master’s of Business Administration and Health Administration, reproductive health, TB, and HIV/AIDS programs.”

**Host Country Commitment**

The GoG identified HIV/AIDS among the top national priorities in the early 1990s, becoming among the first Former Soviet Union countries to develop a national HIV/AIDS program in 1994. A National AIDS Registry was launched in 1989 and the Georgian National AIDS Program was elaborated in 1993. The Law on HIV/AIDS was adopted in 1995 with amendments following in the year 2000.

The National Program priorities include: HIV/STI surveillance and mandatory testing of all blood and organ donors for HIV, HBV and HCV infections; free syphilis HIV testing for high risk groups (IDUs, Commercial Sex Workers (CSWs), MSM, STI patients, sexual and medical contacts of HIV positive persons, and patients with Hepatitis B and C and/or TB; diagnostics, care and symptomatic treatment for people living with HIV/AIDS; and free PMTCT services for all pregnant women and their families. Annually 18,000-20,000 people are tested for HIV/AIDS in Georgia within the framework of the national program.

The National AIDS Control service includes nine voluntary counseling and testing (VCT) units and 64 HIV diagnostic labs operating throughout the country and the National AIDS Centre in Tbilisi. In 2003-2005, two regional AIDS Treatment Centers in Batumi (Adjara region) and Zugdidi (Samegrelo region) became operational, thereby, improving access to HIV/AIDS treatment and care services at sub-national levels.

In 2001 and 2002 the Georgian Government through UN Theme Group support and leadership from UNICEF carried out the first comprehensive Situation and Response Analysis on HIV/AIDS. Based on findings and recommendations of the two studies, the 2003-2007 National Strategic Plan of Action was elaborated outlining the policy and strategic framework for Georgia’s response to HIV/AIDS.

In 2004, Georgia became first among the FSU countries to attain universal access to free-of-charge comprehensive treatment, including ART for all people living with HIV (PLHA). Effective selection algorithms, monitoring of adherence and evaluation of treatment outcomes are in place for all registered AIDS patients. In 2005, the first Methadone Substitution Treatment Center was opened at the Institute on Drug Addiction to provide services to about 200 IDUs. Currently, there are three centers open, with approximately 300 IDUs on substitution therapy (ST). Under current and proposed GF activities and in collaboration with the GoG there are plans to open up eight new sites, serving a total of over 1,000 patients.

The Minister of Labor, Health and Social Affairs, together with the First Lady of Georgia, co-chairs the Country Coordination Mechanism (CCM) – a National Coordination Body for all HIV/AIDS, TB and Malaria related projects. The Minister has repeatedly stated his strong support for ongoing and planned USAID supported activities in this area.

**Crosscutting Linkages**

The project significantly supports and reinforces other key USG strategic foreign policy objectives including:

- Contributing to a positive long term impact on the domestic demographic situation and the health status of the workforce;
- Reinforcing the USG Economic Growth Strategy by strengthening corporate social responsibility, building the market for commercial contraceptives and meeting unmet need by educating pharmacists and retailers and focusing on consumers;
- Connecting government and governed by encouraging connections with NGOs working on HIV prevention;
- Improving media capacity to cover HIV prevention issues, including stigma reduction;
- Reducing the burden to the society of costly ART treatment through averting growth of HIV prevalence; and
- Strengthening the efficiency MOH health insurance voucher system by stretching scarce resources through reductions in mortality and morbidity.

**Strategic Objective**

Implementation of the HIV prevention project in Georgia will significantly contribute to IR 3.4.2. “Increased knowledge of health-promoting practices”, IR 3.4.5 “Improved quality of health services” which support USAID/Caucasus’ Strategic Objective 3.4 “Increased use of social and health services and changed behavior.”

**Results Framework**

Proposed activities will support USAID Operational Plan (OP) Area - Health

**Program Element 3.1.1: HIV/AIDS**

Sub-Element 3.1.1.5: Condoms and Other Prevention Activities

Sub-Element 3.1.1.9: Counseling and Testing

Sub-Element 3.1.1.13: Other/Policy Analysis and System Strengthening

Sub-Element 3.1.1.14: Host Country Strategic Information

**Proposed “F” structure indicators:**

- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
- Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
- Number of service outlets providing counseling and testing according to national and international standards
- Number of individuals who received counseling and testing for HIV and received their test results
- Number of individuals trained in counseling and testing according to national and international standards

*HIV Prevention Project*  
*RFTOP No. 114-09-012*  
*Section C*

- Number of local organizations provided with technical assistance in strategic information (includes M&E, Surveillance, and/or HIMS)
- Number of individuals trained in strategic information
- Number of local organizations provided with technical assistance for HIV –related policy development
- Number of local organizations provided with technical assistance for HIV-related institutional capacity building
- Number of individuals trained in stigma and discrimination reduction
- % of (most-at-risk populations) reached by prevention programs (Program monitoring/special surveys)
- % of (most-at-risk populations) who both correctly identify ways of preventing the transmission of HIV and who reject major misconceptions about HIV transmission (Behavior surveillance surveys)
- % of men reporting the use of a condom the last time they had anal sex with a male partner (Behavior surveillance surveys)
- % of sexually active injecting drug users who report use of a condom at last sex (Behavior surveillance surveys)
- % of injecting drug users who avoid sharing injecting equipment (Behavior surveillance surveys)
- % of (most-at-risk populations) who are HIV infected (HIV surveillance)

**C.2 TITLE:           HIV PREVENTION PROJECT**

**C.3 STATEMENT OF NEED**

While the overall HIV prevalence rate in the general population has remained low (0.1%), there are clear indications that prevalence rates in some high risk groups are beginning to increase rapidly and may soon reach the concentrated epidemic stage. A concentrated or more wide-spread HIV epidemic could seriously impede the momentum of Georgia’s civil and economic development. Georgia has a rare opportunity, provided to only countries with low prevalence of HIV and at the earliest stages of a potential epidemic, to alter dramatically the future course of HIV transmission by conducting a concerted HIV prevention and education effort now. Without more comprehensive prevention outreach efforts, HIV transmission could quickly shift to the general population through heterosexual contact. Global Fund resources currently cushion the economic impact of HIV/AIDS treatment in Georgia but as these resources diminish in coming years, Georgia will have a greater chance of successfully financing appropriate HIV/AIDS treatment for its citizens if the overall numbers of persons requiring expensive ART treatment remains low.

**C.4 OBJECTIVE**

At this time, Georgia has an excellent opportunity to contain its HIV epidemic so long as it sustains sufficient focus on prevention. At the same time, HIV could easily get lost or ignored among other pressing issues such as healthcare reform, economic development, and regional conflict. The government does not have the ability to reach hard-to-reach high risk groups or the technical expertise to prevent HIV from becoming a much larger crisis without external support of non-governmental organizations able to conduct successful outreach and education campaigns.

There is general agreement among international experts in HIV prevention that the best practice strategy for low-prevalence countries is three-fold: concentrating prevention on primary risk groups, paying attention to groups likely to get infected next, and reducing stigma in the general population. This approach provides a logical framework for strategic planning in Georgia where 70% of HIV cases are among IDUs and their sexual partners and stigma levels are quite high in the general population. Based on the above, the objectives of this project are as follows:

Objective 1: Prevention in primary risk groups

- Develop and implement a community-level intervention (CLI) targeting IDUs;
- Increase prevention and VCT efforts targeting IDUs, MSM, FSW;

Objective 2: Intervention in groups likely to be infected next (youth)

- Expand outreach and education through the Healthy Lifestyles curriculum as well as other activities in order to educate youth about HIV;
- Build NCDC capacity for BSS surveillance, monitoring, and trend analysis;

Objective 3: Stigma Reduction

- Lead efforts to develop a National HIV Prevention Communication Strategy; and
- Engage in national policy dialogue to reform laws which impede effectiveness of prevention activities.

## **C.5 SCOPE OF WORK**

The goal of the HIV Prevention Project is to support HIV prevention among high risk groups in Georgia in order to avert the spread of HIV to the general population. The project activities and interventions in support of objectives listed in Section C.4 are described below.

### **Objective 1: Prevention in primary risk groups**

#### **Activity 1.1: Develop and implement community-level intervention (CLI) targeting injection drug users (IDUs).**

Because injection drug use accounts for more cases of HIV than any other risk behavior, funding a comprehensive HIV prevention intervention for IDUs is a top priority. Changing this trend will require an intensified, concentrated effort that must target not only IDUs, but the social environment surrounding them. It must also address injection use at all points along the drug-use continuum, from initiation of drug use to recovery from addiction. Behavior Change Communication (BCC) interventions for IDUs and their partners may fail if the surrounding environment is not supportive.

A crucial component of this CLI is a comprehensive stigma-reduction campaign for general communities and for healthcare workers in particular. It is important to distinguish between true stigma reduction and general awareness-raising. The assumption behind many HIV awareness campaigns is that if people just knew the facts about HIV they would be less scared of it and less judgmental of the people who have it. While this makes sense theoretically, it has not been proven true in practice or by evaluation research. While fact-based education does play a part, stigma reduction requires precise and well-tested messaging about acceptance. Stigma reduction, therefore, targets a general audience, but results in a more supportive environment for HIV prevention among targeted risk groups and plays an essential role in the long-term mitigation of HIV.

**Interventions:**

- Use a social networking model to reach out to IDUs and their partners in order to provide VCT, risk reduction counseling, and services.
- Research underlying motivators and barriers to behavior change and utilize this in the development of an appropriate behavior change model that will guide interventions at multiple levels described in the socio-ecological model, in particular the individual and interpersonal levels.
- Implement community-level interventions for IDUs that include components focusing initially on the individual and then extending outward, targeting surrounding people and communities that can influence IDUs' norms.
- Development of Information Education Communication materials, in which messages not only give facts about transmission but also address attitudes and motivations underlying behaviors.
- Support access to risk reduction tools, and provide condom distribution that includes skills building on negotiation communication. Use peer-based education, which is most effective when focused on skills building and positive role modeling and not just information diffusion.
- Design Behavior Change Communication (BCC) targeting partners and family members of IDUs. A BCC campaign could include peer education among female partners of IDUs, media promoting a support and testing referral hotline for female partners, or a mass media campaign encouraging families to help a loved one who injects drugs to get an HIV test.
- Carry out a comprehensive stigma reduction campaign for general communities and for healthcare workers in particular.
- Support pharmacy-based education. Pharmacists could be trained to provide risk reduction counseling. Pharmacies can be points of IEC distribution or creative social marketing.
- Enhance drug treatment support. IDUs that are trying to stop using drugs or maintain their recovery from addiction also need support to prevent relapse into old risk behaviors. While funding will be too limited to provide actual treatment, there are many low-cost ways to support addiction recovery such as community support groups and peer-to-peer recovery mentorships.
- Involve IDUs in a participatory approach where they are involved in the process of determining the direction of the prevention efforts.
- Provide technical assistance and training to local NGOs engaged in HIV prevention activities to improve their long-term financial sustainability by increasing their ability to raise funds through donations or the provision of services.

**Activity 1.2: Increase prevention and VCT efforts targeting IDUs, MSM, FSW**

MSM have the highest prevalence of HIV of all risk groups and should receive second priority behind IDUs. BSS results also show that MSM also have very high levels of risk behavior with a high number of partners, a combination of factors that can fuel the rapid spread of HIV. MSM are a very heterogeneous population that remains somewhat hidden from the general population. The SHIP project has generated promising momentum with this population after several years of building relationships and trust, and the expanded interventions should capitalize on these efforts and develop more comprehensive programming.

Research has shown that individuals do reduce risk behavior after they find out they are HIV-positive. This is a persuasive argument for using VCT as an HIV prevention strategy, especially with high-risk groups. Resources should be used to expand more mobile lab services or in support of another innovative model that will increase access to VCT by all risk groups, including IDUs, MSMs, and FSWs.

**Interventions:**

- Introduce prevention efforts beyond basic dissemination of information.
- Use peer-driven interventions and network-based approaches.
- Use mobile labs to attract high-risk clients to VCT and expand geographic availability of VCT to eastern Georgia.
- Use VCT as a point of recruitment for peer based interventions.
- Provide counseling to those with negative HIV tests on HIV behavioral risks, the need for follow-up testing, and referral to HIV risk-reduction and other appropriate services.
- Institute motivational interviewing as a counseling tool to change high risk behaviors.
- Provide counseling on negotiating condom use with partners.
- When appropriate, encourage high risk groups to engage their partners and refer them to the VCT centers/mobile labs.

**Objective 2: Intervention in groups likely to be infected next (youth)**

**Activity 2.1: Expand outreach and education through the Healthy Lifestyles curriculum as well as other activities in order to educate youth about HIV;**

Prevention targeting youth is strongly recommended for low-prevalence countries. Youth are easy to access in large numbers, and changing attitudes and behaviors is easier if started before patterns develop. Youth in Georgia are using drugs and having sex earlier, and their knowledge about HIV transmission is low. Behavior linked with drug abuse is the most significant factor in the spread of HIV infection among adolescents. USAID's Healthy Women in Georgia Project has already developed, implemented, and evaluated a comprehensive life-skills-based education (LSBE) curriculum known as a "Healthy Lifestyle Course," which has been endorsed by the Ministry of Health and approved by the Ministry of Education (MOE). However, absence of legislative or ministerial policy mandating HIV education in schools is one of the most significant gaps in Georgia's HIV response.

Another USAID supported program, implemented by IOCC, has focused on empowering youth between 11- 21 years old to identify risky behaviors and reject illicit drug use by enhancing social support networks through the training of clergy, teachers, youth leaders and parents, and by carrying out an age-appropriate drug abuse prevention national media campaign. The new HIV prevention project is expected to continue and expand this approach. Please note that offerors may not form exclusive partnerships with targeted beneficiaries.

**Interventions:**

- Support school-based education programs, particularly those in which HIV education is integrated into wider LSBE.
- Actively promote and implement existing curriculum in as many schools nationwide as possible.
- Advocate for legislative or ministerial policy mandating HIV education in schools.
- Train peer educators to serve as role models within their communities and enable them to disseminate drug abuse prevention messages.

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

- Increase awareness and knowledge about Illicit Drug Use among youth aged 11-21, and their parents through a multidimensional outreach campaign. Reinforce fundamental drug abuse prevention principles among youth aged 11-21, their parents and teachers through BCC activities; and
- Mainstream anti-drug messages through outreach efforts of GOC priests in Tbilisi in their respective parishes and communities.
- Provide parent group trainings including participatory guidance and tools to use when talking to their children about healthy choices
- Develop a campaign to get families to openly discourage children from high risk behaviors including early sexual initiation and drug use
- Provide opportunities for creative interactive youth activities such as a poster or skit competition that showcases healthy lifestyle messages which could be shown on TV, YouTube, performed at other schools, etc.
- Develop a comprehensive website for youth and their parents to provide accurate and reliable information about high risk behaviors in a non-threatening and private manner

**Activity 2.2: Build NCDC capacity for BSS surveillance, monitoring, and trend analysis.**

National Center for Disease Control (NCDC) is ultimately responsible for overall HIV/AIDS surveillance in Georgia. However, while data is regularly collected, it is not well analyzed. There is no capacity at NCDC to conduct second-generation surveillance, such as behavioral surveillance surveys (BSS). These surveys provide valuable information on behavioral patterns and prevalence of sexually transmitted infection (STI) and HIV among high risk groups. BSSs provided reliable information on the patterns of IDU, MSM and FSW behaviors, such as use of shared injecting equipment, condom use, age of first injection, as well as on major factors that might lead to the rapid spread of STIs and HIV in Georgia. BSS data serve as a practical tool to measure impact of prevention interventions on behavior change and disease prevalence among the target population and guide future activities. A series of baseline and follow-up BSS were conducted in Georgia between 2002 and 2007 by USAID and GFATM. Although the NCDC participated in these surveys, no framework has been created at the NCDC to conduct such surveys in the future. There are few behavioral specialists at the NCDC with knowledge about and experience in conducting surveys among risk groups. Efforts are needed to increase government capacity in surveillance and other areas to assume financial and implementation responsibility for prevention and disease control as donor sponsorship winds down.

**Interventions:**

- Provide technical assistance in BSS design, implementation, and database management; project management and evaluation, and strategic planning.
- Build and strengthen partnerships between the NCDC and National AIDS Center with NGOs working on HIV Prevention activities.

**Objective 3: Stigma Reduction**

**Activity 3.1: Lead efforts to develop a National HIV Prevention Communication Strategy.**

The development of a coordinated communication strategy at the national level will strengthen the accuracy, unity, and impact of HIV prevention messaging as a collective whole. A national strategy should redirect the fear-based communication that currently predominates toward promotion of positive norms, clear calls to action, and discussion of social-based motivations behind behaviors. A national communication strategy could be included as a part of the new

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

National HIV Response Strategy and outline areas such as messaging content and targets, media approaches, and evaluation of communication efforts.

**Interventions:**

- Coordinate design of a National HIV Prevention Communication Strategy by all interested stakeholders
- Advocate for the National Prevention Communication Strategy endorsement
- Provide leadership on the necessity of reducing stigma and discrimination and assist in incorporating this into the overall communication strategy
- Contribute to HIV curricula revision for doctors, pharmacists, nurses, or other health professionals.
- Media training to cover HIV prevention issues.

**Activity 3.2: Engage in national policy dialogue to reform laws which impede effectiveness of prevention activities.**

In the rapidly evolving context of healthcare reform, several policy-level issues need to be addressed, such the development of a National HIV Prevention Strategy, the evaluation of different funding schemes for HIV treatment (i.e insurance coverage or continued public health financing), and reducing the overall stigma for persons who are HIV positive. Provision of technical assistance to MoLHSA and the Health Committee in Parliament is needed to help Georgia's decision makers safeguard HIV as a public health priority and to ensure the existing legislation does not impede prevention services. Revisions to the AIDS Law as well as the other relevant legislation should be aimed at reducing stigma, ensuring patient confidentiality, and prohibiting hospitals and clinics from denying medical care to persons on the basis of their HIV positive status. Areas in need of immediate policy focus are:

National Prevention Strategy  
AIDS Law revision  
Mandatory HIV education in schools  
Future HIV Treatment Financing  
Future Treatment Service Delivery

**Expected Results:**

Through interventions with high-risk groups, the program will ensure that critical prevention needs are being met on the ground and have a vehicle through which to develop the NGO sector. At the same time, involvement on the ground level will give additional credibility to advance political and capacity-building agendas.

Implementation of the activity will demonstrate to the general public and health practitioners that the HIV epidemic can be constrained and even reversed. The program will increase demand for VCT services by high risk groups simultaneously with reducing HIV related stigma in the general population. Willingness to be tested for HIV and to change behavior afterward (if found to be HIV-positive) are inversely related to the level of perceived stigma in the community. This is another argument for supporting stigma-reduction efforts in the general population.

The civil sector will be strengthened as the engine for change through carrying out community level interventions and providing VCT services. Activity will contribute to building the organizational, managerial, technical and political capacity of existing local NGOs and will work

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section C*

to incubate new NGOs. The activity will lead to more efficient policy environment for long-term sustainability of HIV prevention.

**Targets:**

- Increase coverage of interventions aimed at IUDs to 60% (from the current 20%) to impact group-level behavior change.
- Increase access to VCT by 30% among all risk groups by expanding access to services.
- Preserve prevalence in each risk groups (IDUs, MSM, and FSWs) under 5% to maintain low prevalence status in the country
- 80 % of general population seeing stigma reduction campaign messages
- 60% of health providers reached with HIV/AIDS stigma reduction messages
- 10,000 students reached through the combined Healthy Lifestyles curriculum and Fostering healthy lifestyle program
- Awareness about HIV increases by 40% across baseline in all risk groups
- Safe sex and injecting practices improved by 30% across baseline in all groups
- At least 1,000 IDU partners reached every year of the project
- Key legislation or national policies affecting HIV/AIDS revised

**C.6 IMPLEMENTATION AND MANAGEMENT PLAN**

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

**C.7 PERFORMANCE MONITORING PLAN**

The contractor's performance shall be evaluated based on the completion of specific tasks as outlined in the Task Order, adherence to the work plan, and reports submitted to the Contracting Officer's Technical Representative (COTR). Monitoring will be an on-going, collaborative process with the participation of the implementing partner, USAID, counterparts, other partners and concerned parties. USAID plans to conduct project mid-term evaluation o/a April 2012 to revalidate the relevance of the project in attaining the expected results.

**END OF SECTION C**

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

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

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

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

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

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

### **D.2 BRANDING STRATEGY**

The USAID| Georgia Branding Strategy for this task order is as follows:

- **Program or Project Name:** HIV Prevention Project
- **How the materials and communications will be positioned:** HIV Prevention Project will use full branding and the USAID tagline “From the American People” on materials and communications, which may be translated into local language as appropriate. Co-branding and no-branding will only be considered on a case-by-case basis as considered appropriate by the Contracting Officer’s Technical Representative (COTR) and Contracting Officer (CO).
- **Desired level of visibility:** HIV Prevention Project has a desired high level of visibility since the goal of the project is to support HIV prevention in Georgia through providing information and behavior change communication to the high risk groups and youth, as well as addressing general population to achieve stigma reduction and working with the government on HIV related policy revisions.
- **Any other organizations to be acknowledged:** Project documents will not use the contractor’s logo, but will acknowledge that the document was prepared for USAID by HIV Prevention Project. The logo should say **USAID/Georgia/HIV Prevention Project**
- There are no controls on the contractor’s release or use of data that the contractor or any subcontractor, produces in performing the contract. The IQC contract for this Task Order states that copyrights and rights to data shall be in accordance with the clause of the IQC Contract, entitled, “Rights in Data – General” (FAR 52.227-14).

### **D.3 BRANDING IMPLEMENTATION PLAN AND MARKING PLAN**

With reference to ADS 320.3.2.2 the Contractor shall prepare a Branding Implementation Plan describing how it will implement the Branding Strategy. The Branding Implementation Plan shall describe how the program will be promoted to beneficiaries and host country citizens.

With reference to ADS Sections 320.3.2.3 and 320.3.2.4 the Contractor shall also prepare a Marking Plan that will enumerate all of the public communications, commodities and program materials that visibly bear or will be marked with the USAID identity. Contract deliverables to be marked with the USAID Identity must follow design guidance for color, type, and layout in the USAID Graphics Standard Manual.

**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 TASC3 Indefinite Quantity Contract, Section F.6, Monitoring and Evaluation Plan.

**END OF SECTION E**

**SECTION F – DELIVERIES OR PERFORMANCE**

**F.1 PERIOD OF PERFORMANCE**

(a) The estimated period of performance for this task order is five (5) years. The estimated start of this task order is o/a September 30, 2009 and the estimated completion date is September 29, 2014.

(b) Subject to the cost plus fixed fee amount of this task order, the TO COTR may extend the estimated completion date, provided that the extension does not cause the elapsed time for completion of the work, including the furnishing of all deliverables, to extend beyond 60 calendar days from the original estimated completion date. Prior to the original estimated completion date, the contractor shall provide a copy of the TO COTR’s written approval for any extension of the term of this task order to the Contracting Officer; in addition, the contractor shall attach a copy of the TO COTR’s approval to the final voucher submitted for payment.

(c) It is the contractor's responsibility to ensure that the TO COTR-approved adjustments to the original estimated completion date do not result in costs incurred that exceed the ceiling price of this task order. Under no circumstances shall such adjustments authorize the contractor to be paid any sum in excess of the task order amount.

(d) Adjustments that will cause the elapsed time for completion of the work to exceed the original estimated completion date by more than 60 calendar days must be approved in advance by the Task Order Contracting Officer (TOCO).

**F.2 DELIVERABLES SCHEDULE AND REPORTING REQUIREMENTS**

The following deliverables and reports are required under the Task Order. All deliverables and reports will be in English unless otherwise specified by the COTR.

**F.2.1 Deliverables**

Reference	Deliverables
C.5, Objective 1 Prevention in primary risk groups	<ul style="list-style-type: none"> <li>• Increased coverage of interventions aimed at IUDs to 60% (from the current 20%) to impact group-level behavior change.</li> <li>• At least 1,000 IDU partners reached every year of the project</li> <li>• Increased access to VCT by 30% among all risk groups by expanding access to services</li> <li>• Preserve prevalence in each risk groups (IDUs, MSM, and FSWs) under 5% to maintain low prevalence status in the country</li> <li>• Awareness about HIV increases by 40% across baseline in all risk groups</li> <li>• Safe sex and injecting practices improved by 30% across baseline in all groups</li> </ul>

*HIV Prevention Project  
RFTOP No.114-09-012  
Section F*

C.5 Objective 2 Intervention in groups likely to be infected next (youth)	<ul style="list-style-type: none"> <li>• 10,000 students reached through the combined Healthy Lifestyles curriculum and Fostering healthy lifestyle program</li> <li>• NCDC capacity for BSS surveillance, monitoring, and trend analysis strengthened;</li> </ul>
C.5, Objective 3 Stigma Reduction	<ul style="list-style-type: none"> <li>• 80 % of general population seeing stigma reduction campaign messages</li> <li>• 60% of health providers reached with HIV/AIDS stigma reduction messages</li> <li>• National HIV Prevention Communication Strategy developed</li> <li>• Key legislation or national policies affecting HIV/AIDS revised</li> </ul>

**F.2.2 Reports and Other Deliverables**

In addition to the requirements set forth for submission of reports in Sections I and J, and in accordance with AIDAR clause 752.242-70, Periodic Progress Reports, the contractor shall submit the following reports to the COTR:

(a) Performance Monitoring Plan: The implementing partner will develop and submit a final performance monitoring plan (PMP) to the COTR at USAID/Georgia for review and approval within first two months after the award is made. The PMP Plan shall track standard indicators of F structure, as well as other project-specific performance indicators (both input/output and impact) suggested by the implementing partner and/or USAID, indicator targets and milestones, relevant timeframe for achieving those, baseline information, and data quality assessment plans. Other contextual data that could be of interest to USAID include indicators and indices generated by the Department of Statistics of Georgia, as well as by the National Center for Disease Control and National AIDS Center, UNAIDS, WHO and GFATM.

(b) Updated Performance Monitoring Plan: The implementing partner will be responsible for collecting and submitting to USAID/Georgia all applicable indicator data on a semi-annual basis, in April and October. Data collected in April will cover the period from October 1 through March 31 (the first six months of a fiscal year), while data collected in October will cover the period from April 1 through September 30 (the second half of a fiscal year). Updated PMP will be an indispensable part of the project's annual Implementation Plan in order to ensure that the PMP plan effectively captures and adequately measure the expected outputs/results/impact outlined in the implementation plan.

(c) Monthly Reports: The Contractor shall provide to the COTR, within 5 days after the end of each month, a report on the activities undertaken during the month. The monthly report should seek to be a brief yet precise, description of the activities, with emphasis on issues that have arisen, impacts made, constraints encountered, and suggestions for additional actions that might be taken. The monthly report should also include the Contractor's accrued monthly expenditures. The COTR is responsible for transmitting this information to the USAID financial management office responsible for the contract.

*HIV Prevention Project  
RFTOP No.114-09-012  
Section F*

(d) Annual Work plans: Annual Work plans shall be required of the Contractor that will detail the work to be accomplished during the upcoming year. The scope and format of the Annual Workplan will be agreed to between the Contractor and the COTR during the first thirty days after the award of the contract. These Annual Work plans may be revised on an occasional basis, as needed, to reflect changes on the ground and with the concurrence of the COTR.

The first Annual Workplan shall be submitted within 30 days of award of the contract. The workplan should include the estimated monthly funding requirements during the upcoming year of program implementation, necessary to meet all program objectives within the contract. USAID will respond to the workplan within ten calendar days.

(e) Quarterly Financial Reports are due the last week of October, January, April, and July of each Fiscal Year.

(f) Final Report: The Contractor shall prepare a final report that matches accomplishments to the specific paragraphs of the Scope of Work. The final report will be drafted to allow for incremental improvements in the process, both generally within USAID and specifically with respect to this contract.

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

Camille Garcia  
Contracting Officer  
USAID/Caucasus  
Regional Contracting Office  
11 George Balanchine Street  
Tbilisi 0131, Georgia  
Phone 995 32 544-128  
Email: cgarcia@usaid.gov

The Cognizant Technical Officer (CTO) will be designated separately.

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

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

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

The contractor is authorized 5 day workweek. No overtime or premium pay is authorized under this Task Order. A six-day workweek with no premium pay may be authorized by the Contracting Officer or COTR for specific tasks/individuals on a case-by case basis.

**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/Caucasus, the Office of Health and Social Development (HSD) shall provide technical oversight to the Contractor through the designated COTR. The contracting officer shall issue a letter appointing the COTR for the task order and provide a copy of the designation letter to the contractor.

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

The COTR must accept and approve deliverables before payment may be made.

### **G.4 INVOICES**

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to the Financial Management Office (FM). 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.

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:

Financial Management Office  
USAID/Caucasus  
11 George Balanchine Street  
Tbilisi 0131, Georgia

**END OF SECTION G**

## **SECTION H – SPECIAL TASK ORDER REQUIREMENTS**

### **H.1 KEY PERSONNEL**

The contractor shall provide the following key personnel for the performance of this task order:

- A. Chief of Party
- B. Team Leaders/Senior Experts

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

### **H.2 AUTHORIZED GEOGRAPHIC CODE**

The authorized geographic code for procurement of goods is 000 (US) and 110 (NIS) and for the procurement of services under this Task Order is 935.

### **H.3 LANGUAGE REQUIREMENTS**

All deliverables shall be produced in English, unless otherwise specified by the COTR.

### **H.4 GOVERNMENT FURNISHED FACILITIES OR PROPERTY**

(a) 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 CO.

(b) If at any time it is determined that the contractor, or any of its employees or consultants, have used U.S. Government facilities or personnel either in performance of the contract itself, or in advance, without authorization in, in writing, by the Contracting Officer, then the amount payable under the contract shall be reduced by an amount equal to the value of the U.S. Government facilities or personnel used by the contractor, as determined by the contracting officer.

(c) If the parties fail to agree on an adjustment made pursuant to this clause it shall be considered a "dispute" and shall be dealt with under the terms of the "Disputes" clauses of the contract.

### **H.5 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.6 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.7 PERIODIC PROGRESS REPORTS (JULY 1998) (CIB 98- 21)**

(a) The contractor shall prepare and submit progress reports as specified in **Section F.2** 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.

## **H.8 EXECUTIVE ORDER ON TERRORISM FINANCING**

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

## **H.9 REPORTING ON TAXATION OF U.S. FOREIGN ASSISTANCE**

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

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

(i) Contractor name.

(ii) Contact name with phone, fax and e-mail.

(iii) Agreement number(s).

(iv) Amount of foreign taxes assessed by a foreign government [each foreign government must be listed separately] on commodity purchase transactions valued at \$500 or more financed with U.S. foreign assistance funds under this agreement during the prior U.S. fiscal year.

(v) Only foreign taxes assessed by the foreign government in the country receiving U.S. assistance are to be reported. Foreign taxes by a third party foreign government are not to be reported. For example, if an assistance program for Lesotho involves the purchase of

*HIV Prevention Project  
RFTOP No.114-09-012  
Section H*

commodities in South Africa using foreign assistance funds, any taxes imposed by South Africa would not be reported in the report for Lesotho (or South Africa).

(vi) Any reimbursements received by the Contractor during the period in (iv) regardless of when the foreign tax was assessed plus, for the interim report, any reimbursements on the taxes reported in (iv) received by the contractor through October 31 and for the final report, any reimbursements on the taxes reported in (iv) received through March 31.

(vii) The final report is an updated cumulative report of the interim report.

(viii) Reports are required even if the contractor did not pay any taxes during the report period.

(ix) Cumulative reports may be provided if the contractor is implementing more than one program in a foreign country.

(c) Definitions. For purposes of this clause:

(i) "Agreement" includes USAID direct and country contracts, grants, cooperative agreements and interagency agreements.

(ii) "Commodity" means any material, article, supply, goods, or equipment.

(iii) "Foreign government" includes any foreign governmental entity.

(iv) "Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

(d) Where. Submit the reports to: Financial Management Office (FM), USAID/Caucasus; 11 George Balanchine Street Tbilisi 0131, Georgia.

(e) Sub agreements. The contractor must include this reporting requirement in all applicable subcontracts, sub grants and other sub agreements.

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

## **H.10 USAID DISABILITY POLICY - ACQUISITION (DECEMBER 2004)**

(a) The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website: [http://www.usaid.gov/about\\_usaid/disability/](http://www.usaid.gov/about_usaid/disability/) .

*HIV Prevention Project  
RFTOP No.114-09-012  
Section H*

(b) USAID therefore requires that the contractor not discriminate against people with disabilities in the implementation of USAID programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing this contract. To that end and within the scope of the contract, the contractor's actions must demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

## **H.11 GRANTS UNDER CONTRACTS**

Subject to the conditions below, this clause provides for a USAID direct contractor to execute grants with non-governmental organizations (non-profits or for-profits) to help support NGO capacity building, prevention activities, training, policy advocacy, or media and public outreach. The grant program must meet the following conditions for approval:

- (1) According to provisions in the base contract, the total value of any individual grant to any U.S. organization must not exceed **\$100,000 over the life of the Task Order. This limitation does not apply to grant awards to non-U.S. organizations.**
- (2) It is not feasible to accomplish USAID objectives through normal contract and grant awards executed by USAID because either:
  - (a) The burden of executing a number of small grant activities is particularly difficult for the responsible USAID Mission or office; or
  - (b) The grant program is incidental and relatively small in comparison to other technical assistance activities of the contractor.
- (3) USAID must be significantly involved in establishing selection criteria and must approve the actual selection of grant recipients. USAID may be less significantly involved when grants are quite small and are incidental to the contractor's technical activities.
- (4) USAID must ensure that the requirements that apply to USAID-executed grants will also apply to grants that a USAID contractor executes.
- (5) USAID must retain in the contracting arrangement the ability to terminate the grant activities unilaterally in extraordinary circumstances.
- (6) USAID does not require HCA approval when a contractor will only be managing or administering grants awarded by USAID.
- (7) USAID does not authorize contractors to execute or administer cooperative agreements on USAID's behalf.

**END OF SECTION H**

## **SECTION I – CONTRACT CLAUSES**

### **I.1 REFERENCE: TECHNICAL ASSISTANCE AND SUPPORT CONTRACT (TASC3) INDEFINITE QUANTITY CONTRACT (IQC)**

### **I.2 AIDAR 752.7028 DIFFERENTIALS AND ALLOWANCES (JULY 1996)**

(This clause does not apply to TCN or CCN employees. TCN and CCN employees are not eligible for differentials and allowances, unless specifically authorized by the cognizant Assistant Administrator or Mission Director. A copy of such authorization shall be retained and made available as part of the contractor's records which are required to be preserved and made available by the "Examination of Records by the Comptroller General" and "Audit" clauses of this contract).

(a) Post differential. Post differential is an additional compensation for service at places in foreign areas where conditions of environment differ substantially from conditions of environment in the continental United States and warrant additional compensation as a recruitment and retention incentive. In areas where post differential is paid to USAID direct-hire employees, post differential not to exceed the percentage of salary as is provided such USAID employees in accordance with the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 500 (except the limitation contained in Section 552, "Ceiling on Payment") Tables-Chapter 900, as from time to time amended, will be reimbursable hereunder for employees in respect to amounts earned during the time such employees actually spend overseas on work under this contract. When such post differential is provided to regular employees of the Contractor, it shall be payable beginning on the date of arrival at the post of assignment and continue, including periods away from post on official business, until the close of business on the day of departure from post of assignment en route to the United States. Sick or vacation leave taken at or away from the post of assignment will not interrupt the continuity of the assignment or require a discontinuance of such post differential payments, provided such leave is not taken within the United States or the territories of the United States. Post differential will not be payable while the employee is away from his/her post of assignment for purposes of home leave. Short-term employees shall be entitled to post differential beginning with the forty-third (43rd) day at post.

(b) Living quarters allowance. Living quarters allowance is an allowance granted to reimburse an employee for substantially all of his/her cost for either temporary or residence quarters whenever Government-owned or Government-rented quarters are not provided to him/her at his/her post without charge. Such costs are those incurred for temporary lodging (temporary quarters subsistence allowance) or one unit of residence quarters (living quarters allowance) and include rent, plus any costs not included therein for heat, light, fuel, gas, electricity and water. The temporary quarters subsistence allowance and the living quarters allowance are never both payable to an employee for the same period of time. The Contractor will be reimbursed for payments made to employees for a living quarters allowance for rent and utilities if such facilities are not supplied. Such allowance shall not exceed the amount paid USAID employees of equivalent rank in the Cooperating Country, in accordance with either the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 130, as from time to time amended, or other rates approved by the Mission Director. Subject to the written approval of the Mission Director, short-term employees may be paid per diem (in lieu of living quarters allowance) at rates prescribed by the Federal Travel Regulations, as from time to time

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section I*

amended, during the time such short-term employees spend at posts of duty in the Cooperating Country under this contract. In authorizing such per diem rates, the Mission Director shall consider the particular circumstances involved with respect to each such short-term employee including the extent to which meals and/or lodging may be made available without charge or at nominal cost by an agency of the United States Government or of the Cooperating Government, and similar factors.

(c) Temporary quarters subsistence allowance. Temporary quarters subsistence allowance is a quarters allowance granted to an employee for the reasonable cost of temporary quarters incurred by the employee and his family for a period not in excess of (i) 90 days after first arrival at a new post in a foreign area or a period ending with the occupation of residence (permanent) quarters, if earlier, and (ii) 30 days immediately preceding final departure from the post subsequent to the necessary vacating of residence quarters, unless an extension is authorized in writing by the Mission Director. The Contractor will be reimbursed for payments made to employees and authorized dependents for temporary quarters subsistence allowance, in lieu of living quarters allowance, not to exceed the amount set forth in the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 120, as from time to time amended.

(d) Post allowance. Post allowance is a cost-of-living allowance granted to an employee officially stationed at a post where the cost of living, exclusive of quarters cost, is substantially higher than in Washington, D.C. The Contractor will be reimbursed for payments made to employees for post allowance not to exceed those paid USAID employees in the Cooperating Country, in accordance with the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 220, as from time to time amended.

(e) Supplemental post allowance. Supplemental post allowance is a form of post allowance granted to an employee at his/her post when it is determined that assistance is necessary to defray extraordinary subsistence costs. The Contractor will be reimbursed for payments made to employees for supplemental post allowance not to exceed the amount set forth in the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 230, as from time to time amended.

(f) Educational allowance. Educational allowance is an allowance to assist an employee in meeting the extraordinary and necessary expenses, not otherwise compensated for, incurred by reason of his/her service in a foreign area in providing adequate elementary and secondary education for his/her children. The Contractor will be reimbursed for payments made to regular employees for educational allowances for their dependent children in amounts not to exceed those set forth in the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 270, as from time to time amended.(See Standardized Regulation 270)

(g) Educational travel. Educational travel is travel to and from a school in the United States for secondary education (in lieu of an educational allowance) and for college education. The Contractor will be reimbursed for payments made to regular employees for educational travel for their dependent children provided such payment does not exceed that which would be payable in accordance with the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 280, as from time to time amended.

(See Standardized Regulation 280) Educational travel shall not be authorized for regular employees whose assignment is less than two years.

*HIV Prevention Project  
RFTOP No. 114-09-012  
Section I*

(h) Separate maintenance allowance. Separate maintenance allowance is an allowance to assist an employee who is compelled, by reason of dangerous, notably unhealthful, or excessively adverse living conditions at his/her post of assignment in a foreign area, or for the convenience of the Government, to meet the additional expense of maintaining his/her dependents elsewhere than at such post. The Contractor will be reimbursed for payments made to regular employees for a separate maintenance allowance not to exceed that made to USAID employees in accordance with the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 260, as from time to time amended. (See Standardized Regulation 260)

(i) Payments during evacuation. The Standardized Regulations (Government Civilians, Foreign Areas) provide the authority for efficient, orderly, and equitable procedure for the payment of compensation, post differential and allowances in the event of an emergency evacuation of employees or their dependents, or both, from duty stations for military or other reasons or because of imminent danger to their lives. If evacuation has been authorized by the Mission Director the Contractor will be reimbursed for payments made to employees and authorized dependents evacuated from their post of assignment in accordance with the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 600, and the Federal Travel Regulations, as from time to time amended. (See Standardized Regulation 600)

(j) Danger pay allowance. (1) The contractor will be reimbursed for payments made to its employees for danger pay not to exceed that paid USAID employees in the cooperating country, in accordance with the Standardized Regulations (Government Civilians, Foreign Areas), Chapter 650, as from time to time amended. (See Standardized Regulation 650)

(2) Danger pay is an allowance that provides additional compensation above basic compensation to an employee in a foreign area where civil insurrection, civil war, terrorism or wartime conditions threaten physical harm or imminent danger to the health or well-being of the employee. The danger pay allowance is in lieu of that part of the post differential which is attributable to political violence. Consequently, the post differential may be reduced while danger pay is in effect to avoid dual crediting for political violence.

**END OF SECTION I**

## **SECTION J – ATTACHMENTS**

The following is the list of attachments:

1. HIV Prevention Assessment in Georgia. March 2009. Susan Kingston and Dawn Spellman through the Global Health Technical Assistance Project.

USAID FORM 1420-17 - CONTRACTOR BIOGRAPHICAL DATA SHEET USAID FORM 1420-  
Please locate the form at <http://www.usaid.gov/forms/> .

**END OF SECTION J**

**SECTION K – Certifications and Representations**

Not required.

**END OF SECTION K**

## **SECTION L – INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS**

### **L.1 GENERAL**

The Government anticipates the award of one (1) cost plus fixed fee term task order as a result of this RFTOP; however, it reserves the right to make multiple awards or no award.

### **L.2 GENERAL INSTRUCTIONS TO OFFERORS**

- (a) RFTOP Instructions: If an Offeror does not follow the instructions set forth herein, the Offeror's proposal may be eliminated from further consideration or the proposal may be down-graded and not receive full or partial credit under the applicable evaluation criteria.
- (b) Accurate and Complete Information: Offerors must set forth full, accurate and complete information as required by this RFTOP. The penalty for making false statements to the Government is prescribed in 18 U.S.C. 1001.
- (c) Offer Acceptability: The Government may determine an offer to be unacceptable if the offer does not comply with all of the terms and conditions of the RFTOP.
- (d) Proposal Preparation Costs: The U.S. Government will not pay for any proposal preparation costs.
- (e) Separate Proposals: Regardless of the method used, the Technical Proposal and Cost Proposal must be kept separate from each other. Technical Proposals must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit.

### **L.3 RECEIPT OF PROPOSALS AND DELIVERY INSTRUCTIONS**

- (a) Proposals submitted in response to this RFTOP will be received in the following manner:
  - (1) Technical and price proposals will be submitted separately.
  - (2) Format for the **technical proposal** must be in Microsoft Word, Times New Roman font size 12. There is no specified font for graphics and charts.
  - (3) Format for the **price proposal** must be compatible with Microsoft Excel. The narrative for the price proposal must be in Microsoft Word, Times New Roman font size 12. There is no specified font size for graphics and charts.
  - (4) Proposals must be single sided, page numbered and contain a table of contents. The sections and annexes in the technical and price proposals must be tabbed and listed in the table of contents.

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

- (5) Technical proposals must be limited to 15 pages. This page limit does not include cover pages, dividers, table of contents, charts, resumes, letters and annexes. If the page limit is exceeded, USAID has the right to evaluate the first 15 pages only.

Any questions in response to this solicitation must be submitted in writing via email to Camille Garcia, Contracting Officer, [cgarcia@usaid.gov](mailto:cgarcia@usaid.gov) no later than Monday, July 6, 2009 by 2:00 p.m. Georgian Time.

- (b) Closing Date and Time.** All proposals in response to this RFTOP must be received by 09:00 a.m. Tbilisi, Georgia time on the closing date indicated on the cover page of this RFTOP. **Proposals must remain valid for acceptance by USAID until 01/31/2011.** Faxed copies will not be accepted.

IQC firms wishing to submit a proposal to implement this activity must submit their proposals by the closing date noted above. Proposals shall be submitted via e-mail to Ms. Yana Adelberg, Acquisition Specialist, Regional Contracting Office, USAID/Caucasus at [yadelberg@usaid.gov](mailto:yadelberg@usaid.gov), or [rcocaucasus@usaid.gov](mailto:rcocaucasus@usaid.gov).

In addition to sending proposals via email, Offeror's may also submit proposals in hard copy. If an Offeror chooses to submit hard copies in addition to the electronic submission, the hard copies should be submitted in envelopes with "RFP 114-09-012" inscribed thereon to:

Regional Contracting Office  
USAID/Caucasus  
11, George Balanchine Street  
Tbilisi, 0131, Georgia

If hard copy proposals are submitted, cost and technical proposals must be submitted in separate envelopes/packages. Four copies of the technical proposal and two copies of the cost proposal are required. If proposals are submitted via Commercial Courier please allow a minimum of five days handling time in order to meet the above deadline for receipt of proposals. Proposals that are not received by the RCO/USAID/Caucasus by the deadline above shall be considered "late" and may not be accepted.

- (c)** The information requested below must be placed in sealed envelopes clearly marked on the outside with the following information:

**RFP No.: 114-09-012**

Title: HIV Prevention Project

- (1) Technical and Price /Business proposals must be kept separate from each other. Technical proposals must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit.
- (2) Companies should retain for their records one copy of the proposal and all enclosures which accompany their proposal. Erasures or other changes must be

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

initialed by the person signing the proposal. To facilitate the competitive review of the proposals, USAID will consider only those proposals complying with instructions set forth in Section L of this RFP.

- (e) **Electronic Copies.** Each original and copy of the Technical and Cost Proposal submitted by the Offeror must contain one 3.5” computer disk or on a CD-ROM (CD-ROM preferred) with full electronic versions of all documents included in the proposal. All electronic documents must be saved in a “text accessible” format.

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

The Technical Proposal must address how the Offeror intends to carry out the tasks described in Section C. It must contain a clear understanding of the work to be undertaken and the responsibilities of all parties involved. As annexes to the Technical Proposal, the Offeror must submit the following:

- (a) **Preliminary Performance Monitoring Plan:** The Contractor shall develop a preliminary Performance Monitoring Plan (PMP) for submission with their proposal. This preliminary plan will describe the proposed monitoring and reporting system for capturing data on the key indicators identified in Section C.1.3, as well as those measuring results under the Expected Results in Section C.5 with data disaggregated appropriately for gender and location. A preliminary plan for data validation, as well as the contractor procedures for the safeguarding of information on human subjects should also be included.
- (b) Resumes for the proposed personnel
- (c) Branding Implementation Plan and Marking Plan (refer to Section D)

The Technical Proposal will be organized in the order indicated below.

- Factor 1: Technical Approach
- Factor 2: Key Personnel
- Factor 3: Institutional Capacity and Management Plan
- Factor 4: Past Performance

#### **Factor 1: Technical Approach**

In the Technical Approach section, the Offeror shall:

- Propose a suitable technical approach that will ensure achieving the results, objectives, and other requirements set forth in the RFTOP;
- Propose innovative approaches and strategies in program design and technical interventions;

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

- Define the problem and the vision of what will be accomplished at the end of the project and conduct a detailed analysis of potential obstacles, risks and problems that could be encountered during the project implementation;
- Explain how the project will position itself within the GoG's health sector reform plans;
- Explain how the project will build upon the previous USAID funded SHIP Project, the Healthy Women in Georgia Healthy Lifestyles course, and the Fostering Healthy Lifestyles among Georgian Youth project (described in Section C);
- Propose benchmarks and indicators that are consistent with the "F" framework;
- Explain how the proposed activities serve to respond to gender issues and how the gender issues will be managed under this project;
- Describe the project's long-term impact and exit strategy as well as how the project will be institutionalized and sustained;
- Describe its plan to achieve cost savings and efficiency.

**Factor 2: Key Personnel**

In the Key Personnel section, the Offeror shall address the following:

**a. Chief of Party**

The Offeror is required to specify a Chief of Party who will head the Contractor's team and make regular reports to the USAID Contracting Officer's Technical Representative (COTR). The Chief of Party will be responsible for the overall management and implementation of the project. S/he will supervise project implementation and ensure that the project meets its planned results. The Chief of Party will represent and coordinate with other donors, and public and private cooperating country organizations and institutions, and be the point of contact for all purposes of this project, unless delegations of authority are presented to and agreed by the USAID COTR.

The Chief of Party must have a Masters degree with PhD preferable, from an accredited university in a relevant field, such as Public Health, Sociology, Social Work or Communications. S/he must have at least 10 years of international experience (E&E experience desirable) in working in HIV prevention and control related projects, including community-level stigma reduction activities aimed at IDUs, MSM, FSW, and youth. S/he must be familiar with the second generation surveillance methodologies, including Behavior Surveillance Surveys. S/he must have proven leadership and management skills to effectively and efficiently implement the project activities described in this RFTOP. S/he must have proven ability to work effectively, responsively, and collaboratively with funding organizations, donors, and public and private cooperating country organizations and institutions. S/he must have extensive project management and grants management experience and thorough understanding of the gender, ethnic and other social, economic, institutional, and political factors that may affect implementation of the project or achievement of the project's results and objectives. Familiarity with the institutional setting in Georgia in which this project will be implemented and with USAID performance management, grants management, and contract reporting requirements is highly desirable. The Chief of Party must be fluent in English and must possess excellent oral and written communication skills. Knowledge of Georgian is desirable, but not required.

**b. Team Leaders/Senior Technical Experts**

The Offeror is required to specify Team Leaders/Senior Experts who will be expected to cover the following areas:

- 1) Prevention in Primary risk groups
- 2) Youth activities
- 3) IEC and Stigma reduction
- 4) Policy development and capacity building

The experts should have master level academic degrees and at least 6 years of practical experience in relevant fields.

Senior Technical Experts must demonstrate technical expertise in providing training and technical assistance similar to that required in this RFTOP. They must have project management and grants management experience and the successful experience in developing or managing partnerships for strengthening HIV Prevention is highly desirable. They should be familiar with the institutional setting in Georgia in which this project will be implemented and should have understanding of the gender, ethnic and other social, economic, and political factors that may affect implementation of the project or achievement of the project's results and objectives. The Senior Technical Experts must be fluent in Georgian and must possess excellent English language oral and written skills.

**Factor 3: Institutional Capacity and Management Plan**

**a. Institutional Capacity**

The Offeror shall:

- Demonstrate the capability to staff, organize, manage, and implement the full range of activities required to achieve the project's goals and objectives described in Section C;
- Document its and its partners' international reputation and relevant knowledge, ability and experience in designing and implementing programs in broad areas of HIV prevention, including surveillance and stigma reduction, voluntary testing and counseling, policy advocacy and information education and communication; medical education;
- Describe its proposed organizational structure;
- Describe its strategy to ensure an expedient, smooth and effective launch of activity implementation;
- Describe its prior experience in working in the countries of E&E region.

**b. Management Plan**

The Offeror shall:

- Describe its management plan to effectively staff, organize, and manage the scope and range of activities described in this RFTOP;
- Demonstrate its ability to manage sub-contracts or sub-agreements;
- Describe the relationship between home office and in-country staff to permit agile, timely, and responsive implementation.

**Factor 4: Past Performance**

In the Past Performance section, the Offeror will list up to three (3) of the most relevant contracts within past six years for efforts similar to the work in the subject proposal. The most relevant indicators of performance are contracts of similar size, scope, and complexity.

Provide for each of the contracts listed above a list of contact names, job titles, mailing addresses, phone numbers, e-mail addresses, and a description of the performance to include:

- Scope of work or complexity/diversity of tasks;
- Primary location(s) of work;
- Term of performance;
- Skills/expertise required;
- Dollar value;
- Contract type, i.e., fixed-price, labor hour, etc.

(USAID recommends that you alert the contacts that their names have been submitted and that they are authorized to provide performance information concerning the listed contracts if and when USAID requests it.)

**L.5 COST PROPOSALS**

This cost proposal will be used for the purpose of evaluating cost for the award of the HIV Prevention task order under the TASC3 IQC. Offerors must submit a separate Cost/ Proposal and include the following information. All pages must be sequentially numbered, and each part must be separated by a tab or colored divider page. Failure to include all information, or to organize the proposal in the manner prescribed, may result in rejection of the proposal as being unacceptable. The following guidance is provided with respect to the organization of the cost proposal.

**L.5(a) COST-PLUS-FIXED-FEE BUDGET**

Detailed budgets (in unlocked MS Excel format including formulas), budget notes (in MS Word) and supporting documents (e.g. documents that support the calculation of costs included in the spreadsheets such as Negotiated Indirect Cost Rate Agreements, Bio Data Sheets, cost agreements with subcontractors, etc.) shall be included in the cost proposal. Offerors shall submit a budget with sufficient detail, which in conjunction with the budget notes and supporting documentation, will allow USAID to determine cost realism and reasonableness for implementation of the program. The budget, and all discussion of costs, including the budget notes, shall be organized consistent with the cost categories specified below, as applicable:

<b>Direct Labor</b>	\$ _____
Salary and Wages	\$ _____
Fringe Benefits	\$ _____
Consultants	\$ _____
<b>Other Direct Costs</b>	\$ _____
Travel, Transportation, Per Diem and Miscellaneous (Visas, inoculations, etc.)	\$ _____
Allowances	\$ _____

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

Equipment and Supplies	\$ _____
Subcontracts (see note below)	\$ _____
Facilities Costs	\$ _____
Textbook and Related Materials Costs	\$ _____
Training Costs	\$ _____
Sub-grants	\$ _____
Any Other Direct Cost	\$ _____
<b>Indirect Costs</b>	<b>\$ _____</b>
Overhead	\$ _____
G&A	\$ _____
Material Overhead	\$ _____
<b>Total Estimated Cost</b>	<b>\$ _____</b>
<b>Fixed Fee</b>	<b>\$ _____</b>
<b>Total Est. Cost Plus Fixed Fee</b>	<b>\$ _____</b>

Further definitions of these cost categories are included in Section L.6(d)(3) below. In addition to an overall task order budget organized consistent with the categories above, Offerors shall provide information, either in a separate spreadsheet or included in the overall spreadsheet, that specify the detailed costs for each year.

Budgets for individual subcontractors should include the same cost element breakdowns in their budgets as applicable, unless the subcontract cost details are included in the overall budget spreadsheet.

The budgets must be in US currency.

The budget notes must include the Offeror’s assumptions when presenting their budget. Budget notes are required. While Offerors have discretion to tailor the budget notes to its approach, USAID repeats that, between the detailed budgets and the budget notes, sufficient information must be provided to allow a thorough, complete and fair analysis of the costs proposed.

**L.5(b) Budget Estimate**

The Total Estimated Cost Plus Fixed Fee for this order is estimated to be between \$6.8 million and \$7 million. The cost proposal should reflect the amount necessary and prudent to perform the requirements, as described in the Offeror’s technical approach. The Offeror should strive for cost realism and efficiency.

**L.5(c) Personnel**

The cost proposal shall contain completed biographical data sheets (AID Form 1420-17) for all proposed personnel (for the prime and all subcontractors). Offerors are reminded not to include AID Form 1420-17 in the technical proposal. This form includes cost information and should only be included in the cost proposal.

**L.5(d) Detailed Cost Proposal Instructions and Additional Information**

The following additional detailed instructions are provided for use in developing the cost proposal.

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

(1) *Operational Assumptions:*

For the purposes of preparing the cost proposal, the offeror may assume the following:

- Field office is located in Tbilisi, Georgia.

(2) *Indirect Costs and Fixed Fee:*

All indirect rates that Offerors propose (in the above budget format) must not exceed those ceiling rates stated in Section B.7 of the respective TASC3 contracts. The fixed fee proposed must not exceed the fixed fee ceiling stated in Section B.8 of the respective TASC3 contracts. If any of the indirect costs noted above do not apply, please identify in the proposal that these categories are not applicable. Offerors shall provide all current Negotiated Indirect Cost Rate Agreements for itself and any subcontractors who are claiming indirect costs as supporting documents in the Cost Proposal.

(3) *Cost Definitions:*

The following definitions of types of costs should be utilized in preparing the cost proposal.

Salary and Wages: FAR 31.205-6, AIDAR 732.205-46 and AIDAR 752.7007 provides for compensation for personal services. Direct salary and wages should be proposed in accordance with the offeror's personnel policies and meet the regulatory requirements. For example, costs of long-term and short-term personnel should be broken down by person years, months, days or hours.

Fringe Benefits: FAR 31.205-6 provides for allowances and services provided by the contractor to its employees as compensation in addition to regular wages and salaries. If fringe benefits are provided for as part of a firm's indirect cost rate structure, see FAR 42.700. If not part of an indirect cost rate, a detailed cost breakdown by benefits types should be provided.

Consultants: FAR 31.205-33 provides for services rendered by persons who are members of a particular profession or possess a special skill and who are not officers or employees of the contractor. For example, costs of consultants should be broken down by person years, months, days or hours.

Travel, Transportation, and Per Diem: FAR 31.205-46, AIDAR 731.205-46 and AIDAR 752-7032 provide for costs for transportation, lodging, meals and incidental expenses. For example, costs should be broken down by the number of trips, domestic and international, cost per trip, per diem and other related travel costs.

Equipment and Supplies: FAR 2.101 provides for supplies as all property except land or interest in land, FAR 31.205-26 provides for material costs, and FAR 45 prescribes policies and procedures for providing Government property to contractors, contractors' use and management of Government property, and reporting, redistributing, and disposing of contractor inventory. For example, costs should be broken down by types and units, and include an analysis that it is more advantageous to purchase than lease.

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

Subcontracts: FAR 44.101 provides for any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. Cost element breakdowns should include the same budget items as the prime as applicable.

Allowances: AIDAR 752.7028 provides for differentials and allowances with further references to Standardized Regulations. For example, allowances should be broken down by specific type and by person, and should be in accordance with offeror's policies and these regulations.

Training: Participant training is prohibited under this task order, though it is possible that AIDAR 752.7019 and ADS 253 may be applicable to some of the development training that will be provided under the task order contemplated by this RFTOP. Under this order, training is expected to include training for teachers, school principals, inspectors and MENFP. For all types of training, costs should be broken down by types of training, participants and types of costs (e.g. honoraria, materials, facilities, etc.).

Textbooks and Related Materials: This should include all textbooks and other learning materials purchased for school cluster interventions and accelerated learning program, other than training materials.

Sub-grants: Grants under Contracts are expected to be authorized under this order. USAID anticipates small grants to community organizations including school committees, local youth organizations and others. This cost item shall only include the amounts included in the sub-grants, exclusive of administrative and other support costs.

Other Direct Costs: FAR 31.202 and FAR 31.205 provides for the allowability of direct costs and many cost elements. For example, costs should be broken down by types and units.

Overhead, G&A and Material Overhead: FAR 31.203 and FAR 42.700 provides for those remaining costs (indirect) that are to be allocated to intermediate or two or more final cost objectives. For example, the indirect costs and bases as provided for in an offeror's indirect cost rate agreement with the Government, or if approved rates have not been previously established with the Government, a breakdown of bases, pools, method of determining the rates and description of costs.

Fixed Fee: FAR 15.404-4 provides for establishing the profit or fee portion of the Government pre-negotiation objective, and provides profit-analysis factors for analyzing profit or fee. For example, proposed fee with rationale supported by application of the profit-analysis factors.

*(4) Salary Costs:*

For personnel, labor must be specified by days. No unburdened base daily rate may exceed the current maximum daily rate for Agencies without a Certified SES Performance Appraisal System (AWPACS). The total number in a year, which should be no more than 2080 hours, may not exceed the annual salary of the AWCPAS.

*(5) Freedom of information Act of 1981:*

Pursuant to this Act, the public is entitled to request information from Agency contract files. As a general rule, information will be disclosed except:

*HIV Prevention Project  
RFTOP No.114-09-012  
Section L*

- (i) Information submitted in response to a Request for Proposal, prior to award of the contract or other instrument, or amendments thereto.
- (ii) Information properly classified or administratively controlled by the Government.
- (iii) Information specifically exempted from disclosure under the Freedom of Information Act.

Upon award of contracts resulting from this solicitation, the Government will disclose, use or duplicate any information submitted in response to the solicitation to the extent provided in the contract and as required by the Freedom of Information Act.

*(6) Information Concerning Work-Day, Work-Week, and Paid Absences:*

(A) The Offeror and each proposed subcontractor shall indicate the number of hours and days in its normal work-day and its normal work-week, both domestically and overseas, for employees and consultants.

(B) A normal work-year, including paid absences (holidays, vacations, and sick leave) is 2,080 hours (260 days x 8 hours per day). However, some organizations do not have an 8-hour workday, and some accounting systems normally provide for direct recovery of paid absences by using a work-year of less than 2,080 hours to compute individuals' unburdened daily rates. Nevertheless, equitable comparison of various salaries, and comparison against the newly established rate for agencies without a certified SES performance appraisal system (AWCPAS) require that if an offeror does not use a standard work-year of 2,080 hours, then the offeror (or any subcontractors that this applies to) must provide, through a chart or other method, information that converts its proposed level of effort to a 2,080 hour work-year. The proposal shall describe the number of paid absence days permitted by the prime's practices and policies, and a discussion of how paid absence costs are normally recovered by the prime. No unburdened base daily rate may exceed the current maximum daily rate for Agencies without a Certified SES Performance Appraisal System (AWPACS).

**END OF SECTION L**

## **SECTION M - EVALUATION FACTORS FOR AWARD**

### **M.1 GENERAL INFORMATION**

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

For overall evaluation purposes, technical factors are considered *significantly more important than cost/price factors*

### **M.2 TECHNICAL PROPOSAL EVALUATION CRITERIA**

The criteria below are presented by major category, with relative weights assigned to indicate level of importance. Offerors should note that these criteria serve: (a) as the standard against which all proposals will be evaluated, and (b) to identify the significant matters that Offerors should address in their proposals. The technical proposal will be evaluated according to the following factors and the guidance in Section L.4. The four (4) criteria are listed below. The relative weight for each factor is also indicated below. All sub-criteria are weighted equally.

- Factor 1: Technical Approach (40 points)
- Factor 2: Key Personnel (30 points)
- Factor 3: Institutional Capacity and Management Plan (20 points)
- Factor 4: Past Performance (10 points)

#### **Factor 1: Technical Approach (40 points)**

- Soundness of the proposed technical approach to achieve the results, objectives, and other requirements set forth in the RFTOP;
- Degree to which the proposed approaches and strategies in program design and technical interventions are innovative;
- Demonstrated understanding of the problem and the vision of what will be accomplished at the end of the project; quality of the analysis of potential obstacles;
- Demonstrated understanding of how the project will position itself within the GoG's health sector reform plans;

*HIV Prevention Project  
RFTOP No.114-09-012  
Attachments*

- Ability to build upon the previous USAID funded SHIP Project, the Healthy Women in Georgia Healthy Lifestyles course, and the Fostering Healthy Lifestyles among Georgian Youth project (described in Section C);
- Degree to which the proposed benchmarks and indicators are consistent with the “F” framework;
- Degree to which the proposed activities serve to respond to gender issues and the ability to manage gender issues;
- Soundness of the project’s long-term impact and quality of its exit strategy as well as degree to which the project will be institutionalized and sustained;
- Soundness of the Offeror’s plan to achieve cost savings and efficiency.

**Factor 2: Key Personnel (30 points)**

- a. Relevant qualifications and experience of the proposed Chief of Party, including language fluency as appropriate (English and Georgian), management and other skills described in Section L.4;
- b. Relevant qualifications and experience of the proposed Senior Technical Experts, including language fluency as appropriate (English and Georgian), management and other skills described in Section L.4.

**Factor 3: Institutional Capacity and Management Plan (20 points)**

a. Institutional Capacity

- Demonstrated its capability to staff, organize, manage, and implement the full range of activities required to achieve the project’s goals and objectives described in Section C;
- Documented its and its partners’ international reputation and relevant knowledge, ability and experience in designing and implementing programs in broad areas of HIV prevention, including surveillance and stigma reduction, voluntary testing and counseling, policy advocacy and information education and communication; medical education;
- Extent to which the proposed organizational structure is managerially streamlined, practical and efficient;
- Soundness of its strategy to ensure an expedient, smooth and effective launch of activity implementation;
- Ability to demonstrate its prior experience in working in the countries of E&E region is desirable.

b. Management Plan

- Soundness of the proposed management plan to effectively staff, organize, and manage the scope and range of activities described in this RFTOP;
- Ability to manage sub-contracts or sub-agreements;
- Appropriateness of the relationship between home office and in-country staff to permit agile, timely, and responsive implementation.

**Factor 4: Past Performance (10 points)**

Past performance will be assessed in terms of:

- Quality of product or services;
- Cost control;
- Timeliness of performance;
- Customer satisfaction;

- Business relations;
- Subcontracts management.

### **M.3 COST PROPOSAL EVALUATION**

Cost/price will be evaluated through a combination of cost analysis, price analysis, and cost realism, as deemed necessary to ensure best value to the Government.

Cost Realism analysis shall be performed to determine the extent to which the various elements of the Offeror's proposal reflect a clear understanding of requirement; are consistent with the various elements of the Offeror's technical proposal and are realistic for the work to be performed. Cost realism may affect the evaluation of the Offeror's understanding of the requirement.

All rates proposed by the Offeror must be allowable, allocable, reasonable and consistent with the rates in the Offeror's TASC3 IQC.

**END OF SECTION M**