



USAID | ZAMBIA

FROM THE AMERICAN PEOPLE

December 3, 2009

SUBJECT: Contract No. GHS-I-00-07-000XX.00 Request for Task Order Proposals (RFTOP) for the Zambia Integrated Health Systems Strengthening Program

Dear Offeror:

USAID/Zambia is seeking proposals for a new program entitled the Zambia Integrated Systems Strengthening Program (ZISSP) under the Technical Assistance and Support Contract III Indefinite Quantity Contract No. GHS-I-00-07-000XX-00. USAID/Zambia intends to award and manage the task order for the ZISSP with a total estimated cost in the range \$96 million to \$99 million, for a period of five years from the date of award. Subject to the availability of funding, USAID/Zambia will provide initial resources of approximately \$10,000,000 for ZISSP activities in the following four elements:

- HIV/AIDS (from the President's Emergency Plan for AIDS Relief or PEPFAR);
- malaria (from the President's Malaria Initiative);
- family planning/reproductive health (FP/RH); and,
- maternal, newborn, and child health.

In subsequent years, the ZISSP will receive funding from these accounts, subject to evolving priorities for programming and availability of funding. The overall availability of funds for the program is subject to Washington's approval processes via Zambia's annual Country Operational Plan for activities supported by the PEPFAR and Operational Plan for all other activities supported by U.S. foreign assistance.

The new program builds on the current program, known as the Health Services and Systems Program (HSSP), launched in 2004 and ending in 2010 with a greatly enhanced community mobilization component. ZISSP will improve health outcomes by strengthening health systems and service delivery associated with HIV, malaria, family planning, nutrition, and maternal, neonatal and child health.

ZISSP has the following main objective:

1. Increase utilization of public health interventions at district and community levels, through a health systems strengthening approach, in the interlinked areas of HIV/AIDS, malaria, family planning, maternal newborn and child health and nutrition.

Specific objectives include:

United States Agency for International Development
Office of Acquisition and Assistance Office (OAA)
351 Independence Avenue
P O Box 32481
Lusaka 10101
Zambia

Telephone +260.21.1254303/6
Fax +260.21.1254532
URL <http://www.usaid.gov/zm>

1. Improve management skills of health care providers in targeted districts.
2. Achieve 85% of a range of population-based malaria indicators by 2011.
3. Increase contraceptive use in target districts by at least 1.5 percentage points per year.
4. Increase the proportion of deliveries with assistance from a medically trained provider.
5. Achieve policy change supporting efforts to increase the proportion of mothers who receive a postnatal check-up within 24 hours of delivery.

Please see attached RFTOP incorporated herein for the services to be carried out under the resulting task order. The technical and cost proposals need to be prepared in accordance with the attached RFTOP and the basic IQC.

USAID reserves the right to award without discussions, or hold additional rounds of negotiations. Therefore, offerors are encouraged to provide their best offer. The cost and technical proposals must be submitted both electronically and in hard copy by Friday, January 22, 2010, at 1700 hours (5:00 PM, Lusaka, Zambia time) to Ms. Cecilia Kasoma, Acquisition Specialist, through the OAA e-mail address: aaa-solicit-lusaka@usaid.gov

Any information given to a prospective offeror concerning this solicitation will be furnished to all other prospective offerors as an amendment to this solicitation. All questions concerning this RFTOP must be received by the undersigned not later than Monday, December 21, 2009 at 1700 hours (5:00 PM, Lusaka, Zambia time) and if an amendment with answers/clarifications is needed, it will be sent promptly to all prospective offerors.

Please note that the issuance of this solicitation does not constitute any commitment on the part of the U.S. Government to award a task order, nor will USAID reimburse costs incurred in proposal preparation. Should you require any clarification, you may contact Cecilia Kasoma at 260-211-254-303/6 or via e-mail at aaa-solicit-lusaka@usaid.gov.

Sincerely,



Charles E. Mosby
Contracting Officer
USAID/Zambia

IQC TITLE: TECHNICAL ASSISTANCE AND SUPPORT CONTRACT 3 (TASC 3)

SECTION A - REQUEST FOR TASK ORDER PROPOSAL (RFTOP)

ACTIVITY TITLE: ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM (ZISSP)

1	RFTOP Number	611-2010-02
2	Date of RFTOP	December 03, 2009
3	Issuing Office	USAID/Zambia
4	Contracting Officer	Mr. Charles E. Mosby USAID/Zambia Office of Acquisition and Assistance(OAA) Fax: 260-211-254532 E-mail: cmosby@usaid.gov
5	Proposals to be submitted to	Ms. Cecilia Kasoma USAID/Zambia Office of Acquisition and Assistance (OAA) Fax: 260-211-254532 E-mail: aaa-solict-lusaka@usaid.gov
6	Proposals due	January 22, 2010
7	Payment Office	See Section G.5
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	Name: Phone: Fax: E-mail:
14	Person Authorized to sign RFTOP	
15	Signature	
16	Date	

SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

The United States Agency for International Development (USAID) to Lusaka requires support for the development, implementation, management, and evaluation of an integrated health systems strengthening program aimed at increasing use of public health interventions in the interlinked areas of HIV/AIDS, family planning, malaria, maternal neonatal and child health, and nutrition as detailed in Section C.

B.2 CONTRACT TYPE AND SERVICES

This is a Cost Plus Fixed Fee (CPFF) Contract. The Contractor must perform the services set forth in the task order at prices consistent with Section B.

B.3 ESTIMATED COST AND FIXED FEE

The Total Estimated Cost of this acquisition is in the range \$96 million to \$99 million with fixed fee. The fixed fee for the task order shall not exceed the ceilings set forth in Section B.8 of the IQC. The U.S. dollar costs must be limited to reasonable, allocable, and allowable costs determined in accordance with FAR 52.216-7, Allowable Cost and Payment, and FAR 52.216-8, Fixed Fee, A-21 (for universities), and A-122 (non-profit).

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

B.4. INDIRECT COSTS

The contract clause entitled “Allowable Cost and Payment”, 52.216-7, specifies that the indirect cost rates shall be established for each of the Contractor’s accounting periods which apply to the resulting Task Order. The indirect rate for the task order shall not exceed the ceilings set forth in Section B.7 of the IQC.

B.5 PAYMENT

The paying office is reflected in section G.5.

[END OF SECTION B]

SECTION C – STATEMENT OF WORK

C.1 BACKGROUND AND CONTEXT

C.1.1 Overview of Zambia’s Achievements and Needs in the Health Sector

Zambia continues to make progress towards achievement of the United Nations (UN) Millennium Development Goals (MDGs) and the objectives of the 2006-2010 National Health Strategic Plan (NHSP). (Table 1).

Table 1. Indicators, Targets and Progress towards MDGs (sources: Central Statistical Office and Ministry of Health, Government of the Republic of Zambia; Demographic and Health Surveys 2002/2007)

Indicator	Target	2002 Zambia Demographic & Health Survey	2007 Zambia Demographic & Health Survey
Total Fertility Rate 15-49 yrs (%)	Not specified	5.9	6.2
• Urban		4.3	4.3
• Rural		6.9	7.5
Contraceptive prevalence rate (%)*	35 (NHSP)	25.3%	32.7%
Maternal mortality ratio per 100,000 live births	162 (MDG)	729	591
Adult HIV/AIDS prevalence rate		15.6%	14.3%
Under 5 mortality rate per 1,000 live births	63 (MDG)	168	119
Infant mortality rate per 1,000 live births	36 (MDG)	95	70
New Malaria cases per 1,000 population	121 (MDG)	377**	358**

*Any Modern Method ** Source: Ministry of Health Management Information System

C.1.1.1 HIV/AIDS

The 2007 Zambia Demographic and Health Survey (DHS) Report indicates a decline in adult HIV prevalence from 15.6% to 14.3%. The number of patients on antiretroviral therapy (ART) increased from 40,000 in 2006 to 207,000 in December 2008. The percentage of HIV positive pregnant women accessing programs for Prevention of Mother to Child Transmission (PMTCT) increased from 29.7% in 2006 to 36% in 2007. The Ministry of Health (MOH) home-based care programs reached 57,000 clients in 2007, and NGO programs reached 105,110 clients in the first quarter of 2008 (the national target per the NHSP is 200,000 in 2010). The major USG funded counseling and testing (CT) service provider (Society for Family Health) reported a significant increase in CT uptake between 2006, when an average of 1000 clients were seen per month, and 2009 when an average of 15,000 clients were seen per month.. In the Zambia program, linkages between HIV and other health services, including maternal neonatal and child health (MNCH), and family planning (FP) are predominantly uni-directional i.e., with other health services referring patients for HIV screening or services, but not the reverse. Tuberculosis is the one exception in that the linkage is bidirectional.

C.1.1.2 Malaria

In 2007, clinical malaria cases accounted for approximately 45% of all hospitalizations and outpatient attendances (MOH Health Management Information System or HMIS). The 2008 Malaria Indicator Survey (MIS) showed a 54% reduction in the parasitemia rate and 69% reduction of severe anemia in children under five since the 2006 MIS. A recent World Health Organization (WHO) assessment of HMIS data, found that there was 66% decline in deaths due to malaria from 2001 to 2008. Achievements are attributed to increased use of insecticide-treated nets (ITN), indoor residual spraying (IRS), case management using artemisinin-based combination therapy, intermittent preventive treatment in pregnancy (IPTp), and a coordinated information, education and communication (IEC) campaign.

C.1.1.3 Family Planning

The total fertility rate (TFR) increased from 5.9 in 2002 to 6.2 in 2007. The overall figure, while still very high compared to other countries in the region, masks important differences between urban and rural areas – the rural fertility rate is 7.5 and among the highest in the world. The modern contraceptive prevalence rate (CPR) among married women increased from 25.3% in 2002 to 32.7% in 2007. Though CPR continues to increase, unmet need for family planning remains high with 36% of women of reproductive age wanting no more children and 39% wanting to space their next birth (ZDHS 2007 Report). In addition, more than 42% of the population of Zambia is under 15 years of age and has implications for family planning interventions in the years to come.

C.1.1.4 Maternal, Neonatal and Child Health

Under-five and neonatal mortality rates declined between 2002 and 2007. However, neonatal mortality, primarily due to infection, asphyxia, and prematurity has not been significantly reduced. The major causes of morbidity in children under five are malaria, respiratory infection (including pneumonia), diarrhea disease, eye infection, and malnutrition, together accounting for 87% of all visits to health facilities.² The proportion of children using ITNs increased from 6.5% to 28% between 2002 and 2007. Immunization coverage dropped from above 80% in previous years to 72% in 2007. The maternal mortality ratio (MMR) declined between 2002 and 2007,³¹ moving from 729 to 591 per 100,000 live births. Births assisted by skilled attendants have improved slightly, moving from 43% 2002 to 46% in 2007. Health facility based deliveries have increased from 30% in 2002 to 50% in 2007.

C.1.2 Overview of the Health Sector Response by the Government of the Republic of Zambia (GRZ)

C.1.2.1 Ministry of Health (MOH)

In 1992, the Government of the Republic of Zambia (GRZ) initiated health sector reforms aimed at decentralizing health service delivery to the district levels, integrating relevant services, and focusing on preventive rather than curative care. The reforms have focused on improving

²¹United Nations Millennium Development Goals, Zambia Status Report, 2008

²Zambia Demography and Health Survey 2007

primary health care and implementing a basic health care package of high-impact interventions through the public health system.

The GRZ NHSP 2006-2010 promotes access, as close to the community as possible, of high quality, cost-effective health services that contribute to achieving the MDGs for health and national health priorities. The NHSP identifies child health, nutrition, reproductive health, HIV/AIDS, sexually transmitted infections, tuberculosis, and malaria as public health priorities. Related to these priorities, the MOH aims to:

- Reduce the under-five mortality from 168 per 1,000 live births to 134 by 2011, and to 63 by 2015;
- Increase access to integrated reproductive health and family planning services that reduce maternal mortality ratio from 729 per 100,000 live births to 547 by 2011 and to 162 by 2015;
- Halt and begin to reduce the spread of HIV/AIDS and STIs by increasing access to quality HIV/AIDS and STI interventions; and
- Halt and reduce the incidence of malaria by 75% and mortality due to malaria in children under five years of age by 20%.

In conjunction with the development of the NHSP, the MOH restructured the organization of the health sector to support the decentralization of planning and service delivery (Table 2), including the authority delegated for key management tasks, and approximately 60% of resources sent to district level. Little change in strategic direction is anticipated in the next National Health Strategic Plan (2011 to 2014) which is due to be released in mid 2010.

Table 2. Organization of the health sector in Zambia

Level	Entity	Major Role
Central	Ministry of Health (MOH)	Develop national policies, protocols and guidelines
Provincial	Provincial Health Offices (PHO)	Oversees public health facilities and services
District	District Health Management Teams (DHMTs) and Hospital Management Teams (HMTs)	Implement health services conforming to national standards
Community	Neighborhood Health Committees (NHCs) and Health Center Committees (HCCs)	Mobilize communities to identify health needs and use of health services

C.1.2.2 National HIV/AIDS/STI/TB Council (NAC)

The GRZ created the NAC through an Act of Parliament in 2002 with a mandate to develop and implement a multi-sectoral response to HIV/AIDS.

Linked with the NHSP, the 2006-2010 National HIV/AIDS/STI/TB Strategic Framework (NASF) specifies six priority action areas:

- Intensifying prevention of HIV
- Expanding treatment, care, and support for people affected by HIV/AIDS
- Mitigating the socioeconomic impact of HIV/AIDS
- Strengthening the decentralized response by mainstreaming HIV/AIDS
- Improving the capacity for monitoring by all partners
- Integrating advocacy and coordination of the multi-sectoral response

Guiding principles for programming in all priority action areas under the NASF include:

- Adoption of a human rights, pro-poor, sustainable, and evidence-based approach
- Greater involvement of people living with HIV/AIDS
- Commitment to gender equity
- Implementation of the “Three Ones” principles (i.e., one national coordinating authority, one strategic framework, and one monitoring and evaluation framework)

To support implementation of the NASF, specifically, decentralization of the multi-sectoral response, the NAC established the following organizations, roles and responsibilities (Table 3):

Table 3. Organization of the multi-sectoral HIV/AIDS response in Zambia

Level	Entity	Major role
Central	National HIV/AIDS/STI/TB Council Secretariat	Develops national technical guidelines to coordinate the multi-sectoral HIV/AIDS response
Provincial	Provincial AIDS Task Forces (PATFs)*	Integrates HIV/AIDS activities into multi-sectoral planning efforts by the Provincial Development Coordinating Committees
District	District HIV/AIDS Task Forces (DATFs)*	Integrates HIV/AIDS activities into multi-sectoral planning efforts by the District Development Coordinating Committees
Community	Community HIV/AIDS Task Forces	Mobilize communities to identify health (including HIV) needs and use health services

*Provincial Health Offices and District Health Management Teams have representation on PATFs and DATFs respectively and these task forces are usually chaired by Provincial Medical Officers and District Directors of Health.

The National Scale-Up Plan for PMTCT and Pediatric HIV 2007-2010 served as the impetus for the rapid expansion of PMTCT and pediatric ART services. The plan specifies strengthening program management and coordination of pediatric HIV prevention, care, treatment and support activities at all levels; providing comprehensive PMTCT and pediatric HIV prevention, care, support and treatment at all levels; strengthening links between PMTCT, the provision of pediatric and adult ART, and child survival, nutrition and reproductive health services; and strengthening monitoring and evaluation systems, including surveillance and research of HIV care and ART services.

C.1.3 Cooperating Partner Responses

Assistance for the health system in Zambia is provided by multilateral and bilateral partners through general or sectoral budget support and/or through project support. They include:

- 1) The Swedish International Development Agency (SIDA): \$3 million between 2007 and 2010 in sectoral budget support and nearly \$1 million between 2003 and 2008 for NGO projects on HIV prevention and institutional capacity building;
- 2) The Royal Netherlands Embassy (RNE) and the Canadian International Development Agency (CIDA) provide sectoral budget support;
- 3) The UK Department for International Development (DfID) provides an average of £20 million per year (since 2005) in general budget support, and over £10 million between 2004 and 2008 for NGO projects on youth peer education and OVC programming;
- 4) The Japan International Cooperation Agency (JICA) supports the HIV/AIDS and Tuberculosis Control Project and has also provided support for malaria activities;
- 5) The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) has provided large-scale assistance to support the GRZ's comprehensive HIV/AIDS, malaria, and health systems strengthening programming. Through Round 8, GFATM will support health systems strengthening including human resource development. GFATM approved Phase II of Zambia's Round 4 malaria grant and approved a Round 7 grant (malaria and TB);
- 6) The United Nations Children's Emergency Fund (UNICEF): Supports PMTCT and pediatric treatment, ITN distribution, child health weeks;
- 7) The UN Fund for Population Activities (UNFPA) will provide \$2 million between 2007 and 2010 for HIV prevention, including condom procurement;
- 8) The World Bank designated Zambia a Malaria Booster Project Country and planned to provide \$20 million for malaria control and prevention between 2006 and 2010. The World Bank supports the National Malaria Control Centre (NMCC) with indoor residual spraying (IRS), supply chain management and health systems development;
- 9) The Bill and Melinda Gates Foundation, Clinton Foundation HIV/AIDS Initiative (CHAI);
- 10) The Global Alliance Vaccine Initiative (GAVI); and
- 11) The Malaria Control and Evaluation Partnership in Africa (MACEPA); Support to the MOH/NMCC in Zambia includes technical assistance for monitoring and evaluation of malaria interventions including biannual Malaria Indicator Surveys and geocoding for the IRS program, support for emergency procurement and distribution of LLINs in 2006, an integrated IEC/BCC/advocacy initiative, and program support that includes information technology, infrastructure, and staff training opportunities.

C.1.4 Overview of the Health Sector Response by the United States Government (USG) in Zambia

Zambia is a focus country for the President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI), and other initiatives in family planning and maternal and child health. PEPFAR is implemented through an integrated response by United States Agency for International Development (USAID)/Zambia, the Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), the Department of State (DOS), and the Peace Corps. The PMI is led by USAID and implemented together with CDC. Globally, the PMI is overseen by a Washington based PMI Coordinator and an Interagency Steering Group made up of

representatives of USAID, CDC, the Department of Health and Human (HHS), the Department of State, the Department of Defense, the National Security Council, and the Office of Management and Budget. USAID is responsible for the programming of funds for family planning and maternal and child health activities.

C.1.4.1 USAID/Zambia's Current Health Programs

USAID/Zambia' programs support national strategic plans and are in line with the principles of the Paris Declaration on Aid Effectiveness. USAID, along with other bilateral donors, the international financing institutions, European Union, and the United Nations system, developed and signed the Joint Assistance Strategy for Zambia (JASZ) 2007-2010, the 2006 Memorandum of Understanding (MOU) for Cooperating Partners in the health sector, and the 2009 Addendum.

USAID/Zambia's health sector response aligns with the NHSP and NASF and focuses on the following three key areas:

- Zambians taking action for health
- Achievement and maintenance of high utilization of key health interventions
- Health systems strengthened

Current major USAID/Zambia-supported health programs include:

C.1.4.1.1 Zambia Prevention, Care, and Treatment Partnership

The Zambia Prevention, Care, and Treatment Partnership (ZPCTII, prime partner Family Health International) works with the MOH, PHOs and District Health Management Teams (DHMTs) to strengthen and expand HIV/AIDS related services in five provinces: Central, Copperbelt, Luapula, Northern, and North Western. ZPCT supports the GRZ goals of reducing the burden of HIV/AIDS and providing ART by implementing technical, program and management strategies to initiate, improve, and scale-up PMTCT services, CT and clinical care services for people living with HIV/AIDS (PLHA) including ART. Under ZPCT I, HIV/AIDS services were expanded to 219 health facilities in 34 districts in the five target provinces. ZPCT II, a follow-on project, is working in the same geographic and program areas.

C.1.4.1.2 Private Sector Social Marketing Program

Private Sector Social Marketing Program (prime partner Population Services International/Society for Family Health – PSI/SFH) markets and promotes products and services for malaria, FP, and MNCH and HIV. Products include oral contraceptives, long-lasting insecticide treated nets (LLINs), point-of-use water treatment products, male and female condoms, fixed-site and mobile counseling and testing services and male circumcision.

C.1.4.1.3 Health Communications Partnership

Health Communications Partnership (HCP, prime partner Johns Hopkins University Center for Communication – JHU/CCP) uses community mobilization and communication tools to promote better health seeking behavior. The program strengthens community organizations and

leadership around key health issues in 22 districts and supports national health information, education and communication campaigns. It develops job aids, radio programs, health talk lines, and video- and poster-based media. HCP strengthened over 1,000 Neighborhood Health Committees (NHCs), as well as the Safe Motherhood Action Groups which operate under the NHC umbrella, by creating and distributing job aids and integrated tools to health centers to strengthen male involvement in PMTCT, FP, antenatal care (ANC), and maternity activities. Though the project ends in December 2009, USAID anticipates continued engagement in behavior change communication activities beyond that date.

C.1.4.1.4 The Public Sector Logistics and Commodity Procurement Program

The Public Sector Logistics and Commodity Procurement Program (implemented by the Partnership for Supply Chain Management/John Snow International) and USAID/DELIVER (implemented by John Snow International) work with the MOH and Medical Stores Limited (MSL), a parastatal company based in Lusaka, to provide technical assistance in supply chain management and to procure a range of commodities, including, malaria rapid diagnostic test kits, HIV test kits, HIV-related laboratory supplies, ARV drugs, and drugs for the treatment of opportunistic infections and malaria.

C.1.4.1.5 Tuberculosis Control Assistance Program

Tuberculosis Control Assistance Program (TB-CAP, prime partner Dutch Tuberculosis Foundation [(KNCV)]) strengthens TB control by implementing the directly observed treatment short-course (DOTS), strengthening management of TB/HIV, increasing community and patient involvement and awareness, renovating laboratories, improving laboratory services and training lab technicians.

C.1.5 USAID/Zambia's Current Health Services and Systems Program

C.1.5.1 Approach of the current project

The overall program objectives are: to achieve and maintain high coverage for key health interventions; to improve the quality of key health interventions; and to strengthen systems for the delivery of these interventions. HSSP assists with curriculum development, training and supervision. The program provides Clinical Care Specialists to each of the nine provinces to assist the PHO with PMTCT and ART, malaria, reproductive health (RH), and child health/nutrition. The program focuses on districts with greatest need; rural/remote districts (i.e., MOH "C" and "D" districts)³ that also experience greater disease burden and human resource shortages. The program has served a technical and catalytic role at the national and provincial levels in advancing high impact interventions and practices. The current program worked with the MOH to develop the Zambian Health Workers Retention Scheme (ZHWRS) for rural health professionals, and has supported NHSP priorities in child health, malaria, and reproductive health/family planning.

³The MOH has divided the 72 districts into 4 categories based on remoteness and deprivation of health services. Thus, the districts in the A category are urban, B are peri-urban districts, C are rural districts while D are most rural districts. There are 11 districts in category A, 7 districts in B, 33 in C and there are 21 districts in category D

C.1.5.2 Results of HSSP

C.1.5.2.1 HIV/AIDS

- In partnership with the MOH, HSSP staff reviewed and provided feedback on the action plans for all 72 districts and ensured that 60% of districts had at least one facility offering a minimum package of HIV/AIDS services. This work included analyzing human resource and training needs, implementing an antiretroviral therapy information system in 76% of the facilities nationwide, and developing a mechanism to accredit ART providers in the private sector. Clinical Care Specialists offer technical support and supervision to health workers to improve quality, with special emphasis on HIV/AIDS services.

C.1.5.2.2 Malaria

The Program:

- Provides technical assistance, as well as logistical and financial support, to implement an indoor residual spraying program that in 2008 covered 762,479 households and protected 4.2 million people in 15 of the 36 IRS districts.
- Trained supervisors and sprayers (in all 36 IRS districts) and supports storage, logistics, distribution, insecticide waste disposal and environmental protection activities.
- Rehabilitated an insectary at National Malaria Control Center (NMCC) and is assisting NMCC to establish a mosquito colony to support entomological and parasitological surveys as well as routine insecticide resistance monitoring.
- Trained 186 health care workers in clinical management using artemisinin-based combination therapy in 2008. Additional work to support intermittent preventive therapy (IPTp) in pregnancy has included a rapid assessment of the status of IPTp and focused antenatal care (FANC) in all 14 districts of Central and Eastern Provinces in order to determine the appropriate interventions for increasing the uptake of IPTp and FANC services.

C.1.5.2.3 Family Planning:

The Program:

- Trained 307 providers in long-acting family planning methods in 43 of the 72 districts in Zambia with coverage of all nine provinces. Family planning is integrated with reproductive and maternal health.

C.1.5.2.4 Maternal Health

The Program:

- Strengthened antenatal care, delivery, and post-abortion care in target districts through establishing and equipping training sites, training of trainers and providers, and developing practice guidelines.

- Supported the GRZ to develop and implement a plan to scale up emergency obstetric and neonatal care (EmONC) in all 72 districts by 2011 (only 9% of pregnant women with complications received emergency obstetric care⁴).
- Trained 16 national trainers in eight provinces who, in turn, trained 242 health providers in 40 districts (December/2008).
- Supported scale up of training for the active management of the third stage of labor, and explored the introduction of misoprostol, to prevent postpartum hemorrhage.

C.1.5.2.5 Newborn Health

The Program:

- Supported the integration of newborn interventions in the national IMCI program.
- Expanded the number of facilities that are able to provide EmONC services which increased the availability of newborn resuscitation in 41 districts.
- Developed a position paper on scaling up home care of newborns may inaugurate a community-based newborn program.

C.1.5.2.6 Child Health

The Program:

- Trained health workers in all 72 districts to perform facility-based integrated management of childhood illnesses (IMCI).
- Trained 1,500 community health workers (CHW) in Community-based IMCI (c-IMCI) in 11 districts. Newborn care and HIV/AIDS management have been integrated in IMCI algorithms.
- Worked with MOH to implement the Reach-Every-District (RED) strategy in all 72 districts. This has resulted in increased vaccination coverage.

C.1.5.2.7 Nutrition

The Program:

- Collaborated with MOH to provide vitamin A supplementation and de-worming through the Child Health Weeks. About 90% of eligible children have received Vitamin A supplementation.
- Worked with the MOH and the National Food and Nutrition Commission, to develop the essential nutrition package for infants and children.

C.1.5.3 Sustainability of current program

HSSP was designed to be implemented consistently within and through established government structures. Project technical staff utilized an interactive approach, integrating the project

⁴EmOC is defined as the care given to pregnant women with obstetric complications to prevent maternal deaths. It includes services that can save the lives of the majority of women with obstetric complications. A health facility provides Basic EmOC when it can perform the following six functions: Administer parenteral antibiotics, parenteral oxytocics, parenteral anticonvulsants, manual removal of the placenta, removal of retained products of conception and assisted vaginal delivery (instrumental delivery). Comprehensive EmOC includes Basic EmOC plus Caesarean Section and blood transfusion services.

activities and emerging best practices into mainstream service delivery and support systems. HSSP works with counterparts to build robust and resilient health systems that adapt to changing needs and absorb new challenges and resources. Technical assistance provided by HSSP is assimilated by the MOH staff and sustainability is an integral feature of program activities. Specifically the Program has:

- Facilitated the development and dissemination of appropriate standard guidelines, protocols, plans (program specific and human resources), and budgets.
- Assisted the MOH with implementation of a facility-level quality improvement program.
- Conducted mentorship programs and case management observations for clinicians in the districts. These activities ensure that health workers retain important knowledge and skills when the project concludes.
- Assisted the MOH to build the capacity of district staff in health services planning for HIV/AIDS, child health, reproductive health and malaria. HSSP has also played a critical role in ensuring that partners become an integral part in the MOH planning process.
- Supported the review and improvement of the HMIS by working closely with the MOH Provincial Data Management Specialists, District Health Information Officers and other partners (European Union, ZPCT, CDC, Centre for Infectious Disease Control in Zambia (CIDRZ), and the World Health Organization (WHO)) to develop and disseminate the HIV/AIDS reporting systems which have been integrated into the overall MOH HMIS.
- Worked with and developed relationships at all levels of the system and with a diverse group of partners within the public and private sectors, the University of Zambia and other training institutions, statutory bodies, and numerous NGOs in Zambia.

C.2. STATEMENT OF NEED

The Health Services and Systems Program (HSSP, prime partner Abt Associates) works in partnership with the MOH to support increased access to quality health services and to strengthen health systems in the HIV, malaria, reproductive health and MCH domain. This RFTOP will continue support for selected activities under HSSP, refocusing and updating the range of activities to include significant emphasis on community level interventions. HSSP ends in July 2010, with support beyond 2009 limited only to high priority malaria interventions.

C.2.1 Vision Statement

The Zambia Integrated Systems Strengthening Program (ZISSP) will improve health outcomes by strengthening health systems and service delivery associated with HIV, malaria, family planning, and maternal, neonatal and child health and nutrition at national, provincial, district and community levels. ZISSP will improve management skills among health care providers as part of human resources for health (HRH) strengthening effort. ZISSP will also improve technical capacity among health care providers to implement key health interventions.

C.2.2 Purpose

ZISSP will increase utilization of public health interventions at district and community levels, through a health systems strengthening approach, in the interlinked areas of HIV/AIDS, malaria, family planning, maternal newborn and child health and nutrition.

C.2.3 Program technical areas

The Program's key technical emphases are:

- i. HIV prevention and other HIV/AIDS services;
- ii. Malaria treatment and prevention, including indoor residual spraying;
- iii. Family planning services including delay, spacing and limiting of births;
- iv. Maternal, neonatal and child health services, focusing on safe delivery and newborn care; and
- v. Child survival interventions, including Community Integrated Management of Childhood Illnesses.

C.2.4 Anticipated Outcomes of this Program

As a result of the activities under these tasks, the following quantifiable and non-quantifiable outcomes are anticipated. Outcomes are presented according to their predominant source of funding.

C.2.4.1 HIV:

- 1) Improved budget execution in target districts;
- 2) Improved management skills of health care providers in target districts;
- 3) Decreased HIV risk behavior in target communities.

C.2.4.2 Malaria:

- 1) President's Malaria Initiative goals of 85% achievement of a range of population-based indicators will have been met by 2011 (stipulated in more detail below);
- 2) Subsequent malaria-related goals will also be achieved.

C.2.4.3 Family Planning:

- 1) Increase contraceptive use in target areas by at least 1.5 percentage points per year.

C.2.4.4 Maternal, Newborn and Child Health:

- 1) In target areas, increase the proportion of deliveries with assistance from a medically trained provider (target: 52%, up from 47% in 2007, based on DHS data)
- 2) Achieve policy change supporting efforts to increase the proportion of mothers who receive a postnatal check-up within 24 hours of delivery (target: 20%, up from 9.8% in 2007, based on DHS data).

C.3 OBJECTIVES

The overall objective of ZISSP is to increase use of public health interventions at the district and community levels. ZISSP places increased emphasis on capacity building and systems strengthening for key public health interventions, including HIV/AIDS, malaria, family planning and maternal, neonatal, child health and nutrition. ZISSP aims to address a number of challenges which constrain improvement of Zambian health services, including health worker recruitment and retention; building capacity and management skills of district and provincial management teams; increasing the ability of communities to improve their health outcomes; improving

linkages between communities and health facilities; and ensuring expanded and appropriate integration of service delivery. An important aspect of expanded integration is pursuit of win-win public private partnerships (PPPs) and/or Global Development Alliance (GDA). While ZISSP will address several specific and important outcomes at both the national and provincial levels, the major thrust of the program will be focused at the district level. In general terms, the programmatic emphasis will be 20% national, 10% provincial, 40% district, 30% community-based.⁵

ZISSP has the following main objective:

1. Increase utilization of public health interventions at district and community levels, through a health systems strengthening approach, in the interlinked areas of HIV/AIDS, malaria, family planning, maternal newborn and child health and nutrition.

Specific objectives include:

1. Improve management skills of health care providers in targeted districts.
2. Achieve 85% of a range of population-based malaria indicators by 2011.
3. Increase contraceptive use in target districts by at least 1.5 percentage points per year.
4. Increase the proportion of deliveries with assistance from a medically trained provider.
5. Achieve policy change supporting efforts to increase the proportion of mothers who receive a postnatal check-up within 24 hours of delivery.

C.4 SCOPE OF WORK

C.4.1 Geographic Scope

ZISSP will operate at the national level, in all nine provinces and in at least 27 target districts. Districts will be selected through a consultative post-award process with the GRZ/MOH, and will be based on a range of criteria including, but not limited to HIV prevalence, the need to increase prevention programs, malaria incidence, unmet demand for FP, use of contraception, use of delivery and postpartum services, expressions of interest and commitment from the local authorities, and availability of funds. Final selection of target districts will be made by USAID in consultation with the MOH. Final approval of the selection of target communities will be made by USAID in consultation with district authorities.

C.4.2 Major Tasks

Task 1: Strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide.

Task 2: Improve management and technical skills in order to increase use of quality health services within target districts on a sustainable basis.

Task 3: Increase community involvement in the production of health.

⁵ For operational reasons, this distribution may not reflect the distribution of staff or of budgets.

Task 4: Ensure service delivery and other activities are effectively integrated at all appropriate levels of the health system through joint planning with partners, in-kind activities, and appropriate PPPs.

Task 5 (Option) : Support for the Global Hunger and Food Security Initiative.

C.4.3 Intervention Areas

C.4.3.1 Task 1: Strengthen the ability of the MOH at the national level to plan, manage, supervise, and evaluate delivery of health services nationwide

Vision: Activities conducted as part of this task will lead to improved MOH capacities in key programmatic areas, improved functioning, for improved and sustainable health outcomes

Purpose: 1) To build MOH capacity to resolve difficult challenges facing the health sector, including human resources management capacity, recruitment and retention of doctors and clinical staff, and the need for increased national capacity to oversee the delivery of family planning, EmONC, child health and nutrition and malaria services. 2) In tandem with USAID Mission staff, actively participate in Technical Working Groups (TWGs) that operate as part of the Sector Wide Approach (SWAp) coordination mechanisms to increase collaboration and coordination among cooperating partners. Strong support for TWGs will encourage meaningful joint planning and discussion of health policies, service coverage information, capacity building, and lessons learned across the country.

It is encouraged to second Zambians in all the sub-tasks under Task 1. Seconded personnel will mentor MOH counterparts responsible for human resource management as well as family planning, MNCH, nutrition and malaria services. Seconded staff will be withdrawn from MOH once capacity to effectively manage the abovementioned services has been built. A mid-term review of the project will determine whether seconded staff are still required, with the expectation that seconded staff will be phased out before the project's end. A sustainability plan and explicit exit strategy must be developed to facilitate long-term preservation of the benefits of these interventions.

C.4.3.1.1 Task 1.1: Second personnel to the MOH to support human resources for health, family planning, child health & nutrition and EmONC services

C.4.3.1.1.1 Sub-Task 1.1.1: Human Resources for Health

A. Background

A chronic, severe human resources shortage exists in Zambia. About one-third of public healthcare provider positions at various levels are vacant. The vacancy rate is highest (54%) for doctors and other clinical staff. Sub-standard worker performance and low productivity compound the problem. This shortage of human resources in health is particularly acute in rural areas where health workers face more difficult working conditions as well as limited housing and educational opportunities for their families. There are many reasons for the shortage including death due to HIV/AIDS; retirement; resignation due to low salaries and poor working conditions;

emigration; and competition for staff from donors, NGOs or international agencies which offer better salary and employment conditions.

To address the human resource shortage, the GRZ developed the Human Resources for Health Strategic Plan (HRHSP) 2006-2010. The goal of the plan is to ensure “an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality services.”

The key objectives of the plan are to:

- Establish a coordinated approach to planning across the sector;
- Increase numbers of trained and equitably distributed staff;
- Improve productivity and performance of health workers; and
- Strengthen human resource planning, management and development systems.

The MOH established the Zambia Health Workers’ Retention Scheme (ZHWRS) in 2003 to increase the number of health professionals providing essential care services including HIV-related treatment and services in the most remote areas in Zambia. The Scheme is part of the HRHSP, and provides both financial and non-financial incentives to these health professionals to work in designated health and/or training facilities for a period of three years. The monetary incentive is in the form of an allowance contingent on the cadre of the health worker and the category of the district. The MOH prioritized Zambia’s 72 districts according to pre-determined criteria, and divided them into four separate categories (namely A, B, C and D). Fifty-four districts are categorized as C and D, and represent the most severely underserved.

The non-monetary incentives, aim at improving the work and living conditions in these remote areas, and include: rehabilitation/construction of staff houses; vehicle loans for doctors; rehabilitation of health facilities and nurse training schools; provision/replacement of medical equipment or teaching materials; provision of motor bikes, solar panels and radio communication systems to health facilities and staff houses; and improvement of water supply to the facilities.

The MOH drafted guidelines that clearly spell out the processes, procedures, roles and responsibilities for the recruitment, administration, monitoring & evaluation, and reporting of this initiative. The MOH also provides regular financial reports to the Cooperating Partners currently supporting the Scheme (such as the U.S., the Netherlands, the European Union, Canada, Sweden, and Britain). The Human Resource Technical Working Group advises the MOH on all issues regarding the implementation of the HRHSP, including the Retention Scheme.

The MOH faces severe financial constraints,⁶ making it difficult to implement the Retention Scheme. The GRZ has sought financial support from the Cooperating Partners (CPs) to scale up the scheme to include medical officers, medical licentiates, nurse tutors, para-medical lecturers, nurses, midwives and environmental health technologists. The goal was to place 1,650 health workers on the scheme by 2008. By the end of 2008 only 40% of the target was achieved.

⁶ Annual Report on the Management and Implementation of the Zambian Health Workers Retention Scheme 2007, Feb 2008

Although the GRZ has received financial and technical support from the CPs, coordination of the Scheme within MOH, lack of a functional human resource information system, and paucity of a dedicated middle level HR/management specialists, have rendered the oversight and management of the Scheme ineffective.

USAID Support to ZHWRS under HSSP: HSSP assisted the MOH to develop the technical guidelines for the management of the Retention Scheme. HSSP also supported the placement of 119 health workers, including 23 doctors, 33 nurse tutors, 31 clinical officers, and 32 nurses. HSSP also participated on the Human Resource Technical Working Group (HRTWG); provided technical assistance to the MOH and NAC, and, sponsored capacity building workshops in human resource management, planning and development. HSSP also participated in MOH head quarters, provincial and district planning launches of the operational plans of the National HRHSP.

B. Anticipated Outcomes

- Strengthened capacity of GRZ to attract and retain health worker staff for key rural positions.
- Strengthened human resource information system.
- Improved evidence-based decision making to determine models for improving the performance of health care workers.
- Strengthened workforce performance systems to improve productivity and retention of health workers for the delivery of HIV/AIDS, malaria, FP, and MNCH and nutrition services.

C. Interventions

Required:

- i. ZISSP will second one full-time human resource specialist in the Directorate of Human Resources and Administration (DHR&A) to build capacity in HRH management.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the human resource specialist at MOH.
- iii. ZISSP will collaborate with other stakeholders to advance the HRH agenda in Zambia.

Others:

- i. The offeror will propose other interventions that support achievement of Sub-Task 1.1.1.

D. Illustrative Activities

- Work with the MOH to establish baselines for staffing levels, distribution, attrition and other health worker characteristics in the target rural health zones.
- Strengthen routine HR reporting from facility to district, province and national level.

- Support the development, implementation and monitoring of the human resource information system for effective HRH development and management.
- Work with DHR&A to integrate the ZHWRS into the payroll management and establishment control or P MEC and to decentralize the management of ZHWRS to the PHO.
- Work with DHR&A to explore and support flexible and non-conventional employment and financing arrangements to recruit, deploy and retain essential staff, building on the existing ZHWRS.
- Over the course of the task order, transition from payment of substantial direct incentives to ZHWRS supported staff toward other interventions supporting retention efforts. The offeror should plan to cease payment of direct monetary incentives by the end of year three.
- Review and define roles and responsibilities of technical and administrative staff in health facilities and community level staff.
- Design and implement simple systems to manage absences.
- Develop systems to monitor performance and reward good performance or sanction unsatisfactory performance.
- Review implementation of mandatory rural posting policy and explore options for reviving and expanding it to other cadres.
- Explore short term strategies to address current shortages in rural areas, e.g. accelerated curricula for essential cadres, autonomy to local levels to contract retirees, renewing contracts of non-Zambian doctors.
- Explore pay for performance models being piloted in Zambia for possible scale up.
- Support the establishment of a Zambia Health Workforce Observatory⁷.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.1.1.2 Sub-Task 1.1.2: Family Planning

A. Background

Zambia's TFR (6.2) is among the highest in Africa. Though CPR continues to increase, unmet need for family planning remains high, particularly in rural areas. These statistics signal a need for a greater emphasis on family planning throughout the health system. Excellent policies exist to promote integrated reproductive health (IRH) in line with the concepts of the International Conference on Population and Development (ICPD). However, these policies have not been fully resourced or implemented. Further, because the concept of IRH includes many possible interventions, family planning risks being subsumed into an array of services with no clear focus or prioritization.

The MOH Reproductive Health Adviser and other staff have responsibility for all matters dealing with reproductive health policy, clinical practice guidelines, planning, budget requests,

⁷The functions of the observatory would include, HRH monitoring and evaluation; research and analysis; information sharing and dissemination, engaging with policy-makers and relevant stakeholders; capacity building for HRH; and contribution to health systems strengthening.

and program oversight. They do not have sufficient time and resources to build a robust family planning program. Much of the day-to-day work of implementation rests with the DHMT. The 2008 Mid-term Review of the NHSP notes that the 2006 to 2008 period shows mixed results for FP services and that FP services will need a specific budget and plans, especially in rural areas, to increase availability and access to FP services (information, counseling and commodities). The MTR laments the fact that adolescent reproductive health has received “limited attention” in the face of “high adolescent sexual activity and negative reproductive health outcomes for the 15 to 19 years age group.”⁸ USAID, therefore, intends that ZISSP will work with the MOH to emphasize FP interventions to achieve the following outcomes:

B. Anticipated Outcomes

- Increased availability of, access to, and use of FP services including information, counseling, and commodities, particularly in rural areas;
- Strengthened integration of FP and HIV/AIDS services;
- Increased availability of youth friendly services related to sexual and reproductive health, unintended pregnancies and STIs, and HIV prevention and care; and
- Increased male involvement in FP interventions.

C. Interventions

Required:

- i. ZISSP will second one full-time technical specialist in the Directorate of Public Health & Research (PH&R) to build capacity to ensure that FP receives a higher visibility within the government’s general focus on integrated reproductive health and to identify gaps and opportunities for the scale up of family planning services particularly at the district and community levels.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the technical specialist at MOH.
- iii. ZISSP will collaborate with other stakeholders to advance the FP agenda in Zambia.

Others:

- i. The offeror will propose other interventions that support achievement of Sub-Task 1.1.2.

D. Illustrative Activities

- Develop specific plans to ensure increased availability and access to FP information, counseling, and services to address the unmet need for FP, especially in rural areas.
- Work with implementing partners and key individuals in the MOH to plan for gradually increasing basket fund support for contraceptive procurement as part of the package of essential medicines.

⁸ ZDHS 2002; ZDHS 2007

- Provide leadership in exploring alternative funding sources for FP, e.g., through the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), bilateral donors and private foundations.
- Identify and initiate activities related to increasing demand for FP among men and also increasing their understanding and acceptance of their partner's contraception preferences, including long-term and permanent methods.
- Identify and address gaps and opportunities for adolescent sexual and reproductive health and youth-friendly services.
- Develop and implement youth-friendly reproductive health services to increase access and use by young people.
- Provide FP information and counseling as part of HIV-focused CT.
- Improve the capacity of the MOH to organize and oversee the work of the clinical trainers in the nine provinces.
- Scale up skills development and programs to diminish provider bias particularly related to long term and permanent methods.
- Participate as a member of RH-related TWGs.
- As appropriate, assist in establishment of a FP-focused TWG sub-group and/or adolescent reproductive health group or sub-group.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.1.1.3 Sub-Task 1.1.3: Emergency Obstetric and Newborn Care (EmONC)

A. Background

Access to EmONC assures a woman's ability to have a safe and healthy pregnancy, delivery, post-delivery period and a healthy newborn. Complications associated with pregnancy and childbirth is the leading cause of death and disability among women of reproductive age in developing countries. A maternal death is the death of a woman while pregnant or within 42 days of the termination of her pregnancy from any cause related to or aggravated by the pregnancy or its management. The leading causes of maternal death are hemorrhage, sepsis, complications resulting from unsafe abortion, prolonged or obstructed labor and hypertensive disorders. A skilled birth attendant who can provide basic and comprehensive emergency obstetric and newborn care is a major factor that can lead to decreased maternal and newborn mortality. A major challenge is ensuring accessibility to these services, especially in rural areas.

The MOH, with UNICEF and HSSP support, conducted a nationally representative survey (2005) in 277 health facilities to assess the availability of EmONC in the country. Even though 70% of health facilities had maternity wings, only 9% of pregnant women with complications received EmONC. The case fatality rate among women who received treatment for complications was more than double (2.4%) that of the WHO recommendation. Apart from stethoscopes, blood pressure machines, cord clamps, and needle holders, the rest of basic equipment were lacking in labor wards. Most health centers had the basic drugs but not in sufficient quantity, and just 16% of facilities performed infection prevention practices according to standard guidelines.

Prompted by the findings of the study, the MOH established an EmONC Technical Working Group and developed a four-year plan. The plan includes assessments and strengthening of district facilities (18/year). The goal is to cover all 72 districts by 2011. With support from HSSP, the MOH recruited a national EmONC Coordinator, introduced the “direct entry” midwifery program in January 2008 that allowed students to enter the midwifery program directly instead of completing a two-year nursing program as a prerequisite. The MOH also developed plans to construct maternity annexes in 60% of health facilities without maternity wings, and expand the number of maternity waiting shelters in 50% of the hard to reach health facilities. Maternal death review (MDR) committees were formed at provincial, district and community levels and, MDR tools were introduced in 18 districts throughout nine provinces.⁹

Despite these efforts to accelerate EmONC training, the MOH’s 2008 technical update on reproductive health reports that no health center in Zambia currently provides full, basic EmONC services and only 77 % of the hospitals provide some form of comprehensive EmONC.¹⁰ There is a lack of providers trained in EmONC as well as a lack of basic equipment and drugs.

Postnatal care (PNC) is a particularly weak link in the continuum of care for women and children. The national policy recommends postnatal care within one week and at six weeks after delivery. Since most maternal and newborn deaths occur during the first 24 hours, and within the first week after birth, a woman should be seen within 24 hours and within 2-3 days of the delivery. Only 12 % of pregnant women receive PNC within two days, the most vulnerable period for both mother and baby and only 14 % receive postnatal care within one week as recommended by the national policy (ZDHS 2002).

B. Anticipated Outcomes

- Increased availability of, access to, and use of EmONC information and services, particularly in the rural areas;
- Improved and effective integration of EmONC activities with HIV/AIDS, malaria, FP and, MCH services.

C. Interventions

Required:

- i. ZISSP will second one full-time technical specialist in the Directorate of PH&R to build capacity to ensure that EmONC receives a higher visibility within the government’s general focus on integrated reproductive health and to identify gaps and opportunities for the scale-up of EmONC services particularly at the district and community levels.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the technical specialist at MOH.
- iii. ZISSP will collaborate with other stakeholders to advance the EmONC agenda in Zambia.

⁹ Joint Annual Review for 2007, Main Report. MOH, Zambia, April 2008

¹⁰ Integrated Reproductive Health Technical Update, MOH, 2008

Others:

- i. The offeror will propose other interventions that support achievement of Sub-Task 1.1.3.

D. Illustrative Activities

- Assist the Ministry to scale up EmONC in target districts;
- Provide support to strengthen maternal death audits at national, provincial, district, and health center, and community levels;
- Assist in development of a comprehensive approach to reduce postpartum hemorrhage (PPH) among all women regardless of place of delivery;
- Facilitate scale up of active management of the third stage of labor (AMTSL) in target health facilities;
- Help the MOH staff organize, supervise and mentor clinical trainers in the nine provinces in the area of EmONC;
- Participate as member of EmONC-related TWGs to update national policy and strategy documents and clinical guidelines as appropriate and;
- Provide support to strengthen postnatal care according to the most current recommendations favoring early contact.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.1.1.4 Sub-Task 1.1.4: Child Health and Nutrition**A. Background**

In its commitment to the MDGs, GRZ agreed to reduce the under-five mortality rate by two-thirds, from 191 (baseline year 1990) to 63 (target year 2015) per 1,000 live births. Achieving this reduction also entails a parallel decrease in child malnutrition. To track the country's progress, USAID/Zambia supported GRZ's Central Statistics Office in conducting the DHS once every five years since 1992.

Infant and child health has improved in Zambia, while deaths during the neonatal period remain problematic. Between 1992 and 2007, the under-five mortality rate decreased by 38 percent (from 191 to 119 per 1,000 live births), well ahead of the progress in sub-Saharan Africa (10 percent decrease, from 185 to 166 per 1,000 live births) and across all developing countries (22 percent decrease, from 106 to 83 per 1,000 live births). The marked decline in Zambia occurred as a result of the reductions in both infant and child mortality. However, neonatal mortality has not changed significantly during the same period. Zambia will not achieve the additional 47 percent reduction in the under-five mortality rate necessary to attain its MDG target without substantial improvement in newborn care.

Nearly 60 per cent of early childhood deaths in Zambia occur before a child's first birthday, with nearly 30 percent occurring within the first month of life. The major causes of these deaths in Zambia, like other developing countries, include respiratory infection, diarrheal diseases, malaria, measles and other vaccine-preventable diseases, acute respiratory infections, and

HIV/AIDS. Integrated child survival programming encompasses prevention of mother-to-child HIV transmission, vaccinations in early childhood, and prevention and prompt treatment of illnesses.

The National Food and Nutrition Commission (NFNC) was created in 1967 with the mandate to develop policies and strategies, and coordinate food and nutrition activities. In 2004, the NFNC developed a Strategic Plan and subsequently underwent restructuring. The NFNC has contributed a Food and Nutrition Chapter to the 5th National Development Plan [2006-2011], developed the Infant and Young Child Feeding (IYCF) Operational Strategy, the Micronutrient Operational Strategy, and the National Food and Nutrition Policy. Although nutrition activities are being implemented in Zambia, there is little attention paid to chronic undernutrition. The HMIS regularly collects data on underweight prevalence (under five years of age) at the district level, but the data is not fully utilized. There are ongoing projects implementing growth monitoring/promotion activities, and pilot positive deviance activities.

Although malnutrition worsened during 1992 – 2002, stunting (indicating chronic malnourishment) decreased from 47 to 39 percent, and wasting (indicating acute malnourishment) decreased slightly from 5 to 4.7 percent between 2002 and 2007. Such improvement occurred in part due to greater compliance with universally recommended infant feeding practices. For example, exclusive breastfeeding among infants aged up to six months increased from 11 to 61 percent between 1992 and 2007.

Chronic undernutrition is a serious public health problem in Zambia and a significant contributory factor to under-5 mortality. It is estimated that 54% of under-5 deaths are associated with undernutrition. Undernutrition includes a wide array of effects including *intrauterine growth restriction* (IUGR) resulting in low birthweight; *underweight*, a reflection of low weight-for-age; *stunting*, a chronic restriction of growth in height indicated by a low height-for-age; *wasting*, an acute weight loss indicated by a low weight-for-height; and less visible *micronutrient deficiencies*. Undernutrition is caused by a poor dietary intake that may not provide sufficient nutrients, and/or by common infectious diseases, such as diarrhoea. These conditions are most significant in the first two years of life, highlighting the importance of nutrition in pregnancy and the window of opportunity for preventing undernutrition from conception through 24 months of age.

B. Anticipated Outcomes

- Increased availability of, access to, and use of high impact child health and nutrition services at district and community levels.
- Improved strategic and operational capacity of MOH to plan, oversee, and evaluate child health and nutrition services.
- Improved and effective integration of child health and nutrition activities with HIV/AIDS, malaria, FP and maternal and newborn services.

C. Interventions

Required:

- i. ZISSP will second one full-time technical specialist in Directorate of PH&R to build capacity to assure that child health & nutrition services receive a higher visibility among MOH public health priorities and to identify gaps and opportunities for the scale-up of child health & nutrition services particularly at the district and community levels.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the technical specialist at MOH.
- iii. ZISSP will collaborate with other stakeholders to improve child health and nutrition in Zambia.

Others:

- i. The offeror will propose other interventions that support achievement of Sub-Task 1.1.4.

D. Illustrative Activities

- Work with the MOH and PHOs to scale up evidence-based interventions for child health and nutrition at district and community levels;
- Advocate for addressing the continuum of maternal and child undernutrition;
- Review the existing strategies and program to ensure that priority is given to interventions with demonstrated impact on maternal and child undernutrition;
- Advocate for the expansion and improving the educational opportunities for health workers in child health and nutrition.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.1.2 Task 1.2: Strengthen the ability of the NMCC and the MOH to coordinate, oversee and scale up indoor residual spraying (IRS) and other malaria interventions nationwide.

The purpose of this sub-task is to strengthen the organizational technical capacity of the NMCC to plan, coordinate, monitor, and evaluate a comprehensive malaria prevention and control program in Zambia.

A. Background

The 2008 Malaria Indicator Survey (MIS) shows significant progress in the fight against malaria in recent years. More than 70% of households own at least one insecticide-treated net (ITN), and 47% of children under five had slept under an ITN the night preceding the Survey. Approximately 60% of pregnant women took two or more doses of intermittent preventive treatment in pregnancy (IPTp). However, the survey revealed a decrease in the percentage of children under-five treated with an ACT within 24 hours of onset of fever, from 13% to 8%.

A.1. Indoor residual spraying:

Zambia has a well-established IRS program. The national strategy prioritizes IRS to urban and peri-urban areas in a total of 36 districts. The MOH/NMCC has responsibility for coordinating and managing the IRS program nationally and District Health Management Teams (DHMTs) are responsible for implementation in their districts.

A.2. Case management:

NMCC guidelines recommend laboratory diagnosis for any patient with suspected malaria at hospitals and rural health centers where laboratory diagnostic services are available. The MOH/NMCC and partners have actively worked to expand the role and availability of malaria diagnostic services through improvements in microscopy and the introduction of rapid diagnostic tests (RDTs) where microscopy services are not available. HSSP also provided training to HCWs in health centers and hospitals in clinical management using artemisinin-based combination therapies in accordance with NMCC guidelines.

A.3. Intermittent preventive treatment of pregnant women:

Despite high IPTp coverage levels, the 2008 MIS showed gaps in two-dose IPTp coverage among poorer women, and women in rural areas. In order to increase demand for IPTp in these areas, HSSP supported strengthening of focused antenatal care (FANC) in Eastern and Central provinces to increase the uptake of IPTp.

A.4. Monitoring and Evaluation (M&E):

It will be critical to strengthen the M&E program at NMCC as the malaria incidence decreases in Zambia. NMCC will need to establish a robust surveillance system, including active case detection and reporting by name and locality with local follow up by health workers.

A.5. Other issues:

PMI, like the President's Emergency Plan for AIDS Relief (PEPFAR), is focused on meeting the needs of individual countries. Nevertheless, guidance, reporting requirements, indicators, and new technical knowledge may result in periodic revisions from USG, regarding approaches, activities, operations research needs, and drug protocols. Therefore, the Offeror should design a flexible program that can accommodate such changes, if needed.

B. Anticipated outcomes

- Improved coverage and use of malaria interventions at the district and community levels by 2011 (based on PMI targets):
 - ✓ 85% of houses in geographic areas targeted for IRS will have been sprayed;
 - ✓ 85% of pregnant women and children under five will have slept under an ITN the previous night or in a house that has been sprayed with IRS in the last 12 months;
 - ✓ 85% of women who have completed a pregnancy in the last two years will have received two or more doses of IPTp during that pregnancy;
 - ✓ 85% of households with at least one ITN and/or sprayed with IRS in the last 12 months.
 - ✓ 85% of government health facilities have ACTs available for treatment of uncomplicated malaria; and

- ✓ 85% of children under five with suspected malaria will have received treatment with an ACT within 24 hours of onset of their symptoms.
- Strengthened M & E program at NMCC
- Increased number of districts with active case detection and response either through pilot projects or scaling up named case reports and response in specified low incidence districts
- Improved technical capacity of NMCC staff

C. Interventions

Required:

- i. ZISSP will second 5 full-time technical specialists at the NMCC to include:
 - M&E specialist to build capacity to coordinate oversight for active surveillance and response.
 - IRS advisor to provide TA and build capacity for the training of IRS supervisors and sprayers.
 - Logistics advisor to provide TA and build capacity for logistics of spray operations, refurbishment of storage facilities, and waste disposal in conjunction with an NGO.
 - Geographic Information System (GIS) Specialist.
 - An entomologist to support the NMCC's entomology functions.
- ii. ZISSP will support the key malaria control interventions, including malaria case management with artemisinin-based combination therapy (ACT), insecticide-treated bed nets (ITN), intermittent preventive treatment of pregnant women (IPTp), and indoor residual spraying (IRS).
- iii. The ZISSP country team will provide appropriate technical and analytical backstopping to the technical specialists at NMCC.
- iv. The ZISSP team will collaborate with other stakeholders on malaria issues.

Others:

- i. The offeror will propose other interventions that support achievement of Task 1.2.

D. Illustrative Activities

- Provide technical assistance to NMCC for the monitoring and evaluation of the IRS program;
- Facilitate the final disposal of IRS waste in conjunction with in-country partners;
- Support epidemiological, entomological and insecticide resistance surveys;
- Support the development of NMCC-sponsored insectary;
- Procure IRS personal protective equipment and other IRS-related commodities;
- Contribute to implementation costs, and provide technical assistance to the IRS program, including training of IRS supervisors and spray operators;

- Conduct rapid assessment of the status of IPTp and FANC in target districts in order to determine the appropriate interventions for increasing the uptake of IPTp and FANC services;
- Provide technical updates for District Health Offices (DHO) and health workers on FANC and IPTp;
- Support the bi-annual roll out of the Malaria Indicator Survey and other relevant surveys; and
- Work with NMCC to generate a quarterly M & E newsletter that includes district level data.

Offerors are encouraged to propose similar or complementary innovative activities that will assist with achievement of anticipated outcomes.

C.4.3.1.3 Task 1.3: Actively participate in and support selected Technical Working Groups (TWGs)

The purpose of this activity is to ensure that USAID and its cooperating partners are fully engaged in the national dialogue about policy, technical interventions, and approaches to the key issues in service delivery. In Zambia, national level TWGs provide an important venue for all the donors and implementing partners to share experiences and lessons learned from their ongoing programs. This open discussion helps partners to avoid duplication in design or geographic placement of future activities, as well as reaching consensus with the GRZ on key technical interventions and other issues.

A. Background

The 2008 MTR agreed on the importance of TWGs and noted that some groups meet regularly but are ineffective and that they need to be revitalized.

B. Anticipated Outcomes

- Strengthened technical focus and collaboration among MOH, USG, other CPs and NGOs working in HIV/AIDS, malaria, FP/RH, and MNCH
- Increased relevance and field application of issues tabled by selected TWGs
- Improved timeliness and inclusiveness of selected TWG meetings
- Advocate for the creation of TWGs or sub-groups of TWGs focused on interventions of concern to USAID, especially FP, adolescent health, and community health

C. Interventions

Required:

- i. The technical specialists will take a leadership role and participate regularly in TWGs related to HIV/AIDS Prevention, Malaria, HRH, and Maternal and Newborn and Child Health and nutrition.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the technical specialists at MOH/NMCC.

- iii. ZISSP will also collaborate with other stakeholders on issues related to HIV/AIDS prevention, malaria, HRH, and maternal and newborn and child health and nutrition.

Others:

The offeror will propose other interventions that support achievement of Task 1.3.

D. Illustrative Activities

- As needed, coordinate and organize selected TWG meetings.
- Undertake dissemination of key reports or relevant lessons learned by TWG members.
- Collaborate and share information with USG partners who participate in the IEC/Health Promotion TWG.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.2 Task 2: Improve management and technical skills in order to increase use of quality health services within target districts

Vision: As a result of this task, health personnel at provincial, district and facility level will have increased technical and managerial skills required to plan, implement, supervise and monitor health interventions which will lead to improved health outcomes. The technical disciplines of HIV, malaria, FP, MNCH and nutrition will provide the platforms for building these skills.

Purpose: The purpose of this task is to assure that District and Provincial Health Offices can better plan, manage, supervise, and evaluate health services at the district and community levels. The task will build and strengthen linkages between:

- PHO and technical offices of MOH/NMCC at the national level
- PHO and DHMTs
- DHMTs and health facilities
- Health facilities and communities

Anticipated Outcomes;

- Strengthened capacity of Provincial Health Offices to support Districts' technical and management needs;
- Improved management skills which assist district teams to effectively plan, manage and supervise HIV/AIDS, malaria, FP, and MNCH services;
- Improved coordination and synergy of HIV/AIDS, malaria, FP and MNCH services among partners at district level;
- Improved capacity of district teams to undertake needs-based training in management and technical areas; and
- District teams better understand the health needs of the communities which they serve.

C.4.3.2.1 Task 2.1: Increase capacity of provincial health team to perform technical and program management functions in support of the district health teams

The purpose of this element is to provide skilled clinical services specialists and management specialists in each of the nine provinces to increase the capacity of PHOs to help district teams better plan, manage, supervise, and evaluate health services in their respective districts.

A. Background

The PHOs are responsible for coordinating and supervising the implementation of the NHSP and health service delivery, in general, in their respective districts, and for providing necessary technical support to all health service institutions. Thus, planning, management and budgeting processes have devolved to the PHO which may vary in their level of preparedness to deal with those programming elements. Many health staff at provincial, district and facility level need improved management skills to effectively oversee the myriad activities under their purview.

B. Technical approach

ZISSP will provide a clinical care and management team composed of a clinical care specialist and a management/leadership skills improvement specialist to be based in the provincial health offices in each of the nine provinces. Team members will mentor MOH counterparts at provincial level. Clinical care specialists will be phased over to GRZ support before the end of the program. The clinical care specialist will help district and facility staff identify and solve technical problems, provide supportive supervision for key interventions and, as required, train¹¹ and mentor district health staff in HIV prevention and services, malaria interventions, FP, MNCH, including EmONC, and nutrition interventions. The ZISSP team will assist provincial, district and facility staff to strengthen the management skills needed to translate plans into implementation. ZISSP must understand and address the tension between off-site trainings and service delivery, particularly at staff-challenged peripheral facilities. As with staff seconded to MOH headquarters and NMCC, the contractor will develop an explicit exit plan for clinical care and management teams.

Innovative technical approaches are encouraged, such as “management detailing,” a concept akin to the pharmaceutical detailing undertaken by sales representatives who visit sites to promote their products. Coaching and mentoring for management skills improvement could occur during these visits. Such an approach would minimize staff absences from facilities and enhance continued service delivery. Approaches could use a case study model to explore relevant management solutions to common issues facing staff at various levels in the health sector. Other approaches that balance on-site and off-site components are encouraged, such as development of management and leadership skills curricula or other mechanisms to develop skills while balancing the need for offsite and onsite training.

C. Anticipated outcomes

- Strengthened capacity of PHO staff to mentor/coach staff in districts to improve technical and management performance

¹¹ Off-site trainings should be minimized. Innovative on-the-job skills transfer should be the norm under ZISSP

- Improved coordination and synergy of HIV/AIDS, malaria, FP and MNCH services among partners at provincial level
- Improved capacity of clinical care specialists to plan and undertake needs-based training within districts
- A management and leadership skills improvement program established
- Improved management skills of health services personnel

D. Required Interventions

- i. Place one full-time clinical care specialist in each of Zambia's nine PHOs.
- ii. Place one full-time management specialist in each of Zambia's nine PHOs.
- iii. Jointly select target districts for community level interventions (after project is awarded¹²).
- iv. Develop a management and leadership skills improvement approach for health care providers at appropriate levels that balances offsite didactic and onsite mentoring activities.
- v. The ZISSP country team will provide appropriate technical and analytical backstopping to the clinical care and management specialists at PHOs.
- vi. ZISSP will also collaborate with other stakeholders on issues related to HIV/AIDS prevention, malaria, HRH, and maternal and newborn and child health and nutrition.

Others:

The offeror will propose other interventions that support achievement of Task 2.1.

E. Illustrative activities

- Clinical care specialists provide ongoing coaching and needs-based assistance to districts to identify and solve technical problems and provide supportive supervision for key interventions.
- Clinical care specialists undertake needs-based mentoring and training for provincial, district and facility health staff in HIV prevention and services, malaria interventions, FP, MNCH, including EmONC, nutrition and other key health interventions.
- Management specialists visit district and facility based staff in target districts in ongoing coaching interactions focusing on enhanced management and leadership skills.
- Clinical and management specialists facilitate provincial and district planning processes.
- Facilitate and support provinces and districts to coordinate CPs working in the province to include stakeholders' meetings, periodic workshops or other means to increase cross-

¹² Offerors should not approach districts to solicit interest in participation in the project. Entities unfamiliar with the USAID acquisition process can be confused and frustrated by multiple approaches/requests. A well considered plan for district selection, with suggested criteria for inclusion, is all that is required at the proposal stage.

fertilization and discussion among those involved in delivery of HIV/AIDS, malaria, FP, or MNCH services.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.2.2 Task 2.2: Enhance the capacity of district teams to increase use of quality health services in facilities and communities

The purpose of this task is to ensure that district teams are able to efficiently plan, manage, supervise, and evaluate health services in their respective districts.

A. Background

The NHSP intends that DHMTs will serve as the major implementing agencies for the NHSP including development of 3-year budgets¹³ and annual action plans. In most districts, the full promise of decentralized health systems management has yet to be realized. Services are often piecemeal. Providers may have received training but many critical issues, such as regular supplies of essential drugs or contraceptives, remain unresolved, and the bottlenecks frustrate managers, health care providers and clients. The management capacity of the DHMTs, while improving, needs more attention.

B. Anticipated Outcomes

- Strengthened technical capacity of district staff to assure delivery of quality health services in district facilities and communities
- Improved capacity of district staff to plan and undertake needs-based training within districts
- Strengthened management capacity of district staff
- Improved coordination and synergy of HIV/AIDS, malaria, FP and MNCH services among all partners at the district level
- Improved management and leadership skills of district and health facility staff

C. Required Interventions

- i. ZISSP teams with PHOs and DHMTs jointly define focus communities within each target district.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the clinical care and management specialists at PHOs.
- iii. ZISSP will also collaborate with other stakeholders on issues related to HIV/AIDS prevention, malaria, HRH, and maternal and newborn and child health and nutrition.

Others:

¹³Medium Term Expenditure Frameworks (MTEF)

The offeror will propose other interventions that support achievement of Task 2.2.

D. Illustrative activities for the clinical care specialist and management specialist team

- Assist the district level annual planning process.
- Assist DHMTs with financial and management issues.
- Provide support to the DHMT to plan and implement semi-annual Child Health Week campaigns within the district.
- Assist DHMT in providing ongoing coaching and needs-based assistance to health staff at facility and community levels to identify and solve technical problems.
- Assist DHMT to provide supportive supervision for key interventions of HIV prevention and services, malaria interventions, FP, MNCH, including EmONC and IMCI at facility and community levels.
- Assist DHMT to undertake needs-based mentoring and training for health facility staff and CHWs in HIV prevention and services, malaria interventions, FP, MNCH, including EmONC and c-IMCI.
- Provide leadership, training, and supervision to CHWs on the use of RDTs and ACTs.
- Support the DHMT to coordinate stakeholders and groups working within the district. Activities might include stakeholders' meetings, periodic workshops or other means to increase cross-fertilization and discussion among those involved in delivery of HIV/AIDS, malaria, FP, MNCH and nutrition services.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.2.3 Task 2.3: Implement the district component activities of the malaria program in coordination with Provincial and District teams

A. Purpose

This task is the provincial- and district-level extension of national malaria prevention and control activities. It will be implemented in direct support of the national malaria control strategy and activities.

B. Anticipated outcomes

As a result of the activities undertaken through this subtask, provinces and districts will contribute to the outcomes anticipated in the national malaria control strategy, outlined in Task 1.

C. Illustrative Activities

- Provide support for transportation and logistics during the spray campaign.
- Refurbish facilities for IRS waste disposal and storage.
- Mapping (geocoding) of IRS structures.

- Train (& provide post training technical support) health care workers in clinical management using artemisinin-based combination therapies in accordance with NMCC guidelines and work with an NGO to promote the appropriate use of RDTs.
- Work through the clinical care specialists to strengthen the DHO capacity to supervise health facilities and sensitize communities (focusing on male involvement) and community leaders to FANC and IPTp.
- Assure integration of malaria interventions with HIV/AIDS, FP, and MNCH activities in the same locations.

C.4.3.3 Task 3: Improve community involvement in the production of health in targeted areas

Vision: As a result of activities implemented under this task, individuals and communities will improve a) their ability to adopt appropriate health promotion and disease prevention behavior b) their capacity to provide appropriate health care services and prevention activities and c) their linkages to the formal health care service delivery system. The technical disciplines of HIV, malaria, family planning, MNCH and nutrition will serve as platforms for improved community involvement in health.

Background: Community health workers (CHWs)¹⁴ play an essential role in the national health system in Zambia. In an environment where there is a critical shortage of trained health professionals, CHWs are the first line of care for patients with most health needs. In some rural areas a CHW offers the only option for health care of any kind. However, the government currently offers no regular compensation to CHWs for their services. Community health workers report feeling underappreciated and overworked, and are leaving their posts in high numbers. The high turn over among the CHWs is partially due to inadequate monetary and non-monetary incentive schemes and a vacuum in the provision of the CHW drug kits over the past two years and specifically in the limited provision of anti-malaria treatment. The low retention rates create a gap in health services and growing losses of time and resources for training replacements. The MTR notes the lack of a strategy by MOH for community health services and yet many public health intervention areas are increasingly relying on community health interventions to take services closer to their clients. The MOH and its partners are examining the potential of the CHW approach to maximize HRH through task shifting. MOH is in the process of developing a comprehensive CHW strategy that will take into account the various current CHW efforts by different NGOs and the Government and address how CHWs are recruited, trained, organized and compensated.

¹⁴ A CHW can be a volunteer, selected by the community in order to assist with preventive, promotive and basic curative health interventions (home management of illnesses and referral) at community level. One CHW typically serves a population of 500 people. CHWs receive a training of six weeks and collaborate with the neighborhood health committees (NHCs) and Frontline Health Workers. A CHW is provided with a CHW drug kit which contains basic essential drugs. A trained traditional birth attendant (tTBA) is a volunteer who assists the community with reproductive health related interventions. She receives a training of six weeks and serves a population of 1,000 people in a catchment area. The tTBAs are provided with a TBA kit. A community based volunteer (CBV) functions in a specific capacity (after an initial training); e.g. Community Based Distributors, Home Based Care Givers, Malaria Control Agents, Psycho-Social Counselors, TB treatment supporters, Area Pump Menders, etc. These CBVs can be trained CHWs at the same time, but this is not always the case.

Technical Approach: Given the diversity of ongoing activities addressed at improving community involvement in health production, ZISSP will adopt a two-pronged approach to improving health at the community level. The first, and largest prong, will be a general approach of facilitating ongoing activities, instead of large scale “community mobilization” activities. The second, and smaller prong, will be a grants under contract mechanism to work with non-governmental, community- and faith-based organizations for increased community-level service delivery. Consistent with USAID Grants under Contract policies, USAID will be involved in grantee selection process.

As further detailed in Task 4, ZISSP will ensure an appropriately holistic approach to community level health care provision and linkages to the formal health care sector, maximizing results that can be achieved through the diverse funding sources. ZISSP shall emphasize health related outcomes in community-level programming.

Anticipated Outcomes

- Enhanced ability of community groups to respond to HIV/AIDS, malaria, FP, MNCH and nutrition;
- Improved ability of CHWs to deliver HIV/AIDS, malaria, FP, MNCH and nutrition services;
- Effective community-based family planning service delivery systems in place and reaching target groups;
- Improved linkages between community groups and the formal health service delivery system;
- Effective community-based behavior and social change communication programs in place and reaching key target groups;
- Increased youth and male involvement in HIV/AIDS prevention, malaria, FP, MNCH and nutrition activities.

C.4.3.3.1 Taks 3.1: Undertake effective health communication programs at the community level

The purpose of this subtask is to mobilize communities to change inappropriate health behaviors into suitable, healthy behaviors.

A. Background

Zambia has numerous programs which incorporate health education and promotion activities. Since 2005, the production and distribution of HIV/AIDS IEC materials have vastly increased. School health promotion initiatives have concentrated on skills training for HIV prevention. HIV prevention and awareness materials produced by MOH include C&T, PMTCT and pediatric treatment posters, stigma and discrimination, call to action brochures, and home-based care.

Other materials were produced by a wide range of organizations with broad funding from a myriad of partners. Materials promote malaria prevention, World Breastfeeding Week, Child Health Week, vitamin A, and de-worming among other topics. The MTR found that materials for underfunded sectors such as child health, reproductive health, nutrition and environmental health

are less available. Some of the existing materials are either inappropriate or need to be translated, reproduced and disseminated to communities. Funding from different donors/programs often provides different incentives for CHWs which can cause competition and dissension. At the same time, high staff turnover of CHWs responsible for community health education and promotion means that trained staff to provide health promotion is frequently not available. Finally, the MTR noted that some community-based IEC could be better undertaken by peer groups including, for example, in- and out- of-school youth, women's groups, church groups, or business groups.

B. Technical approach

ZISSP will implement a cohesive strategy to identify and address barriers to care, including cultural or economic barriers, provider bias, or key rumors and misinformation about FP, malaria, MNCH and HIV practices. ZISSP will work with the new Health Communication Program to define the kinds of communication materials, methods and channels that are needed to address these barriers. ZISSP will develop a rapid, "cascading" approach to mobilizing communities to change inappropriate health behaviors into suitable, healthy behaviors. In most cases, ZISSP will not develop or generate IEC materials but will disseminate and/or utilize those materials developed by other USG or partner programs. Appropriate channels and approaches to promoting healthful practices and behaviors might include community rural radio transmissions, "soap operas" or other series; market day events such as health fairs, community theater, puppet shows, mobile video transmissions; workplace or church programs; and/or innovative use of cell phone technology.

C. Anticipated Outcomes

ZISSP undertakes innovative approaches to broadly disseminate information about healthy behaviors related to HIV/AIDS, malaria, FP, MNCH and nutrition at the community level.

D. Required Interventions

- i. Work closely with USAID's new health communication project to ensure that proposed community behavior change approaches and programs conform to strategies, plans and materials developed for country-wide implementation.
- ii. The ZISSP country team will provide appropriate technical and analytical backstopping to the clinical care and management specialists at PHOs in information, education, communication/behavioral change communication (IEC/BCC) activities.
- iii. ZISSP will also collaborate with other stakeholders on IEC/BCC issues related to HIV/AIDS prevention, malaria, HRH, and maternal and newborn and child health and nutrition.

Others:

The offeror will propose other interventions that support achievement of Task 3.1.

E. Illustrative Activities

- Identify gaps of existing IEC materials based on community needs.
- Define appropriate channels and approaches to promote correct practices and behaviors.
- Appropriately address myths and misconceptions in technical focus areas.
- Assure availability of appropriate information about HIV/AIDS, malaria FP, MNCH and nutrition.
- Seek opportunities to deliver messages to post-partum women and spouses.
- Promote the condom as an acceptable method of contraception and HIV prevention (i.e. dual protection) within marriages.
- Implement the communication strategy and develop a workplan to reach men and youth in community settings.
- Work with USAID's new health communication project, the Health Education Unit in MOH, and stakeholders to conduct formative research on behavior related to sexual behavior, beliefs regarding HIV/AIDS prevention, PMTCT, C&T, malaria prevention, FP, MNCH and nutrition.
- Define a continuum of care behavior strategy and link interventions to behavioral impacts.
- Implement national campaigns at the community level to
 - ✓ increase demand for and correct usage of ITNs, including campaigns and events such as World Malaria Day;
 - ✓ increased demand for and correct use of ACTs;
 - ✓ assure demand for IRS; and
 - ✓ provide information related to malaria in pregnancy.
- Assure consistent messaging on bed net use and reasons for non-use and acceptance/refusal of IRS.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.3.2 Task 3.2: Support improved community health worker services for key health interventions

The purpose of the this subtask is to build the capacity of community health workers to provide appropriate HIV, malaria, family planning MNCH and nutrition interventions.

A. Background

A.1. HIV/AIDS Services:

The MOH developed CHW manuals in collaboration with private partner organizations. The CHW handbook (2005) is still being used (albeit outdated), however, new manuals have been developed, including: (i) Manual for Home Based Care, (ii) PMTCT Reference Manual for lay counselors and (iii) Guidelines for nutrition programs. MOH is still finalizing the draft Community Health Worker Strategy which it produced in 2008. This strategy will include; a common and defined set of services that all CHW will be expected to provide, the development of a standardized national training curriculum, the development of this strategy with broad participation from all relevant stakeholders, and inclusion of the strategy as an addendum to the MOH 2008 Training and Development Plan.

A.2. Malaria Services:

The strategy of the National Malaria Control Centre (NMCC) is to strengthen community management through orientation of the 5,040 community health workers who have already been trained on c-IMCI to correctly use Rapid Diagnostic Tests (RDTs) and artemisinin-based combination therapy (ACTs). The MOH/NMCC plans to introduce first-line treatment of artemether-lumefantrine (AL) into CHW kits in a coordinated effort with the expansion of community IMCI. The strategic plan calls for CHWs to provide AL after performing a RDT. These policy initiatives calling for the expansion of ACT and RDT diagnosis by CHWs are under review by the Zambia Medical Council and the Pharmaceutical Regulatory Authority. However, the phased introduction of RDTs and ACTs at the community level has been delayed pending Pharmaceutical Regulatory Authority approval. As of March 2009, only 14 districts had begun community management.

A.3. FP Services:

For community based FP to be effective, CHWs need to be appropriately trained, supervised, and have an assured supply of contraceptives. In Zambia, community based distribution (CBD) workers are currently allowed to distribute condoms and oral contraceptives up to three cycles at a time. Few community based distributors (CBD) exist. The purpose of community-based distribution of contraceptives is to assure that FP information, and commodities are available through channels outside the clinic setting.

Among the providers themselves, some have negative attitudes toward long term and permanent methods of contraception, especially toward the intrauterine device (IUD) that limit clients' access to these methods and motivation to provide them. Some of this "bias" is due to lack of skill and confidence to provide the method. Few providers have received technical updates in contraception and competency-based training in IUD and implant insertion/removal. Many providers harbor skepticism surrounding the effectiveness of fertility awareness methods. Misconceptions may exist surrounding other methods of family planning.

A.4. Maternal and Newborn Care:

Zambia has a community based structure that potentially can be mobilized to impact newborn mortality. The Neighborhood Health Committee (NHC) forms a vital link between the community and the formal health system. Supporting the NHC are various community volunteers (TBAs, CHWs, CBDs) and SMAGs that perform activities affecting maternal and newborn health. However, CHWs, SMAGs, and NHCs are not yet sufficiently competent to provide community-based newborn care. A training manual has been developed for CHWs which includes information on immediate care of the newborn, newborn danger signs, cord care, tetanus toxoid vaccination for prevention of neonatal tetanus, immunization, breastfeeding, and feeding options for HIV positive mothers. USAID's Health Communications Partnership (HCP) has trained about 1,000 members of NHCs in 22 districts. While the MOH has already incorporated sick newborn care in the national IMCI program, the MOH has plans to scale up newborn care, particularly improved home care of newborns. The program will review the role of CHWs and trained TBAs during the newborn period and potentially increase government support for these key community health care agents. A number of pilot community based research studies are currently underway and, upon completion in 2009 and 2010, will be pivotal for informing policy about newborn care in Zambia.

A.5. C-IMCI Services:

The community component of IMCI was introduced in Zambia in 1997. The rationale for C-IMCI is to promote the key family and community practices that are likely to have the greatest impact on child survival, growth and development. A Community-IMCI National Strategic Plan (2006-2009) outlined six priority practices which would be emphasized in Zambia. They include: 1) breastfeeding infants exclusively up to 6 months; 2) starting complementary foods at about six months while continuing to breastfeed; 3) providing under-five children with Vitamin A capsules, deworming tablets and monitoring growth; 4) ensuring that all children complete a full course of immunizations as scheduled before the age of one year; 5) ensuring that all children sleep under insecticide treated nets; and 6) providing health education on appropriate home management of sick children and prompt referral to a health facility. A major challenge to the implementation of c-IMCI is that its implementation is dependent on the CHW, a volunteer with multiple responsibilities and no clear remuneration package. This has resulted in high turn-over, limited and fragmented community level activities. Stock-out of CHW kits also negatively affects some community health activities. The MTR team concluded that “the... activities for c-IMCI require the presence of qualified multi-skilled workers, working in an appropriately equipped and stocked facility; a situation unlikely to be met in the NHSP timeframe.”

B. Proposed Intervention

ZISSP will develop, award and manage grants to local organization under the contract awarded to deliver selected integrated and disease-specific community-level health services for example, CBD of FP, community malaria prevention and control services, HIV/AIDS prevention and care services. This mechanism will complement other activities implemented through existing community groups.

C. Illustrative Activities

- Mobilize and strengthen existing community-based structures.
- Work with other stakeholders and USG partners on explicit and appropriate integration activities.
- Undertake advocacy with other partners to assure availability of CHW and community volunteer’s (CV) kits.
- Improve supportive supervision for facility and c-IMCI (supervisor skills, tools and job aids).
- Strengthen preventive and promotive aspects of C-IMCI.
- Ensure prioritized attention in IMCI relative to top causes of morbidity and mortality.
- Strengthen multi-sectoral planning to address underlying factors for leading causes of under five morbidity and mortality.
- Train CHWs in the use of RDTs and ACTs in their communities in all target districts.
- Improve FP skills through needs-based training for CHWs, CVs, t-TBAs.
- Increase availability of family planning services and information through complementary channels, such as expanded social marketing programs.
- Explore with the MOH at the appropriate level the feasibility of integration of FP into existing community-based PMTCT pilots in Copperbelt and Southern Provinces.

- Integrate the Reach Every District¹⁵ approach into PMTCT to improve follow-up and utilization FP and ART services.
- Strengthen services for mothers and newborns in the post natal period, particularly home visits within 24 hours and on day three to increase encounter points for key family planning messages.
- Assure CHWs and CVs use a “no missed opportunities”¹⁶ approach to informing women about family planning.
- Explore with the MOH at the appropriate level the feasibility of task shifting to expand the scope of the work of community-based distributors (CBD) to provide additional methods.
- Link effective structures with CHWs to identify and refer for postpartum and newborn complications, HIV infected mothers, and HIV exposed newborns.
- Support dissemination and adaptation of best practices and lessons learned from four ongoing Zambian community-based pilot projects.¹⁷ As appropriate, develop and roll out implementation with a strong evaluation component to document the expansion.
- Map current cadres of CHWs in target districts.
- Determine the functionality/performance of CHWs, including training, supervision, equipment and supplies.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.3.3 Task 3.3: Strengthen the involvement of traditional, faith-based and other opinion leaders as change agents for health

The purpose of this sub task is to enhance the capacity of traditional, faith-based and other opinion leaders to act as advocates for health issues within their communities.

A. Background

Successful community-based service delivery involves building the capacity of communities through various health committees and community opinion leaders to take responsibility for health issues in the community. This includes selecting the appropriate volunteers, mobilizing families to immunize their children, promoting the use of family planning, sharing information about appropriate water and sanitation practices, good nutrition, safe birth practices, childhood illnesses, and HIV prevention. In Zambia, Neighborhood Health Committees (NHCs) and Safe Motherhood Action Groups (SMAGs), Malaria Action Teams, among others, have in the past been mobilized to work on these efforts. In addition, other groups including religious and traditional leaders, community opinion leaders, NGOs, CBOs or others working at the community

¹⁵ ‘Reaching Every District’ (RED) is the name given to a strategy of district capacity building to address common obstacles to increasing immunization coverage, with a focus on planning and monitoring.

¹⁶ Using every encounter whether for immunization, growth monitoring or other reasons to include information about family planning benefits and methods

¹⁷ First Breath (Zambia University Teaching Hospital and University of Alabama); Lufwanyama Neonatal Survival Project (Boston University SPH, World Vision/Zambia, Lufwanyama DHMT and Tropical Disease Research Center); Community Based Newborn and Maternal Child Health Initiative (University of Zambia); and Community Based PMTCT services in Sinazongwe (HSSP)

level should be capacitated to act as advocates for their area with district health authorities and other government agencies, NGOs, and donors to encourage improvement of health services, water sources and other public health needs of the community.

B. Anticipated Outcomes

- Communities mobilized for HIV/AIDS prevention, malaria, FP, MNCH and nutrition services;
- Traditional, faith-based and other opinion leaders promote healthy practices among their constituents;
- Existing economic structures (cooperatives, workplaces, etc.) utilized to support HIV/AIDS prevention and services, malaria, FP, MNCH and nutrition programs.

C. Illustrative Activities

- Work with SMAGs, NHCs and other organized or informal community groups within and outside the traditional health care sector.
- Build technical and programmatic management competencies of community groups for sustainable community mobilization activities.
- Link relevant groups with CHWs to assist with HIV/AIDS, malaria, FP, and MNCH referrals.
- Engage with a broad range of community actors, including dairy cooperatives, agricultural extension workers, workplace health programs, drug shops, faith-based leaders, teachers, CBOs and other such organizations to identify alternative ways to get HIV/AIDS, malaria, FP, and MNCH information to their constituencies.
- Support MOH efforts to develop a CHW strategy.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.4 Task 4: Ensure service delivery and other activities are effectively integrated at all appropriate levels in the health system through joint planning and in-kind activities with partners, and appropriate public private partnerships (PPP).

Vision: As a result of interventions conducted under this task, health sector service delivery and other activities will be as appropriately and effectively integrated¹⁸ as possible. A number of funding sources have accompanying restrictions that constrain service integration, leading to potential missed opportunities. Under this task, the contractor will actively seek out opportunities for effective service integration and provide appropriate solutions that will result in fewer missed opportunities and better health outcomes. General principles include avoiding integration for the sake of integration; sufficient flexibility to accommodate varying degrees of receptivity to proposals for service integration; and adaptability of the integration approach to accommodate different micro-level service delivery environments across the country.

¹⁸ Effective integration requires the organization, coordination and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact, and use. Integration should improve health outcomes.

A. Background

Integration possibilities are numerous, and may include activities such as family planning service integration into selected HIV service delivery activities, perhaps counseling and testing, FANC or PMTCT services. Another example could be cross training of skilled birth attendants in FP, HIV/AIDS and MNCH. In all cases, the contractor will ensure appropriate use of resources, at all times abiding by the requirements associated with each funding source. Other examples could be public private partnerships and/or Global Development Alliances (GDAs) with pre-existing organizations (cooperatives, companies, etc.) that expand access to key health services such as family planning or HIV and malaria prevention.

The GDA is a particular type of public-private partnership that allows USAID to leverage resources from private sector partners and to use those assets in a way that benefits the business interests of the resource partner while furthering the goals of USAID/Zambia. For the purposes of this solicitation, a GDA meets the following criteria: a) at least 1:1 leverage (in cash and in-kind) of USAID resources; b) common goal defined for all partners; c) jointly-defined solution to a health problems; d) non-traditional resource partners (companies, foundations, etc.); e) shared resources, risks and results, with a preference for additionality of impact; and f) innovative, sustainable approaches to development. For more information on the GDA, please visit http://www.usaid.gov/our_work/global_partnerships/gda/

B. Technical approach:

As part of the Program, the contractor shall work with partners to deliver appropriately integrated family planning, MNCH, malaria, nutrition, HIV/AIDS and related services. Key targets for activity integration are other USAID and USG-funded activities. However activities conducted by other partners should also form part of the potential integration universe. Integration shall have three key features, among others. First, the package of appropriately integrated services shall link HIV/AIDS, health, and related social services at all levels, including home, community, health facilities implemented by diverse providers including family/community members, community/faith-based groups, and government entities in logical and feasible ways. Second, the implementation of appropriately integrated services shall feature systems and networks for coordination and referrals within and between the community, district, and provincial levels of the health system. Third, the management of appropriately integrated services shall reflect coordinated use of resources to maximize health benefits. Integration may be done for service delivery, commodities, human resource, information systems financing and leadership or other appropriate aspects of health systems strengthening and service delivery.

The contractor shall also develop appropriate public-private partnerships with appropriate private sector partners with the goal of increasing access to the key health services represented by this activity. To formulate public private partnerships and possible GDAs, offerors should not approach potential partners or request any letter of commitment until after the project has been awarded. Partners unfamiliar with the USAID acquisition process may be confused and frustrated by multiple applicant/proposal requests. This may damage the relationship between USAID, the offeror and the partners after the award has been made. A sound PPP and/or GDA strategy and approach is all that is required for the proposal.

C. Anticipated Outcomes

- USAID resources and proposed results are complementary to and not duplicative of activities undertaken by other USG programs, the GRZ and other donors;
- Lessons learned from programs across Zambia provide models for replication within the country and to other countries in the region;
- Integrated health services available in broader range of sustainable settings, leading to improved health outcomes;
- ZISSP reach and health benefits will be expanded by “donation” of services to key USG programs which, because of funding account restrictions or other reasons, cannot provide those services themselves (e.g., appropriate family planning services delivered as part of home-based care, youth, counseling and testing and other suitable HIV prevention, care and treatment activities). Grants under contract may be an example of one method in which this result may be achieved.

D. Proposed Interventions

- i. Work within the existing structures and coordinating mechanisms of the GRZ, USG, and other Cooperating Partners.
- ii. Develop and maintain partnerships with other partners to implement joint activities while meeting funding specifications through:
 - a. Participating in national-level TWGs
 - b. Participating in stakeholder meetings and ad-hoc meetings convened by the GRZ at national, provincial or district levels.
- iii. Work with the PHOs and DHMTs to integrate ZISSP program activities into work plans and budgets.
- iv. To eliminate duplication of effort, share information, materials, and resources with other health programs in the same locations. This includes but is not limited to IEC or training materials; workshops or trainings programs and venues; field supervision visits.
- v. Make every effort to co-locate offices with other USG partners serving in the same provinces, districts, towns.
- vi. Work with MOH and other stakeholders to explore opportunities for public private partnerships with appropriate entities for improved delivery of HIV/AIDS, malaria, FP, MNCH and nutrition services.

E. Illustrative Activities

- Participate in the training of trainers (TOTs) on national policies, protocols, or guidelines;
- Jointly train district and community level health workers, based on needs-based assessments;
- Jointly develop annual work plans with the PHOs and DHMTs;
- Contribute to the development and/or review of national policies, protocols, and training and IEC materials;
- Train personnel from USG-funded HIV prevention, care and treatment activities in family planning service delivery;
- Contribute to the development and implementation of logistics management, M&E, and quality assurance/quality improvement (QA/QI) systems;

- Share technical information and lessons learned from program implementation;
- Contribute to national reviews and evaluations.
- Develop, award and manage grants to local organization and/or US-based NGOs under the contract awarded to deliver selected integrated health interventions.

Offerors are encouraged to propose similar or complementary innovative activities that will achieve anticipated outcomes.

C.4.3.5 *Optional Task 5: Support for the Global Hunger and Food Security Initiative*

Vision and Purpose: As requested, support key goals and objectives of the Global Hunger and Food Security Initiative that are consistent with the overall goals and objectives of this scope of work.

Background: The GHFS is a rapidly evolving, whole of U.S. Government response to food security throughout the world. The overall goal is *Increase Agricultural Growth and Expand the Staple Food Supply*. The initiative consists of four key pillars:

- a. Increased Agricultural Productivity;
- b. Reduced Trade and Transportation Barriers;
- c. Sound Market Based Principles for Agriculture; and
- d. Accelerated Participation of the Ultra Poor in Rural Growth.

A further seven principles guide program interventions:

1. Increase agricultural productivity by expanding access to quality seeds, fertilizers, irrigation tools, and the credit to purchase them and the training to use them.
2. Stimulate the private sector by improving the storage and processing of foods and improving rural roads and transportation.
3. Maintain natural resources including helping countries adapt to climate change.
4. Expand knowledge and training by supporting R&D and cultivating the next generation of scientists.
5. Increase trade so small-scale farmers can sell their crops far and wide.
6. Support policy reform and good governance.
7. Support women and families in agricultural development.

At this time, precise definition of health-related Program activities that will support these goals is evolving. Activities could support women and families and the poor. Addressing malnutrition and its determinants, in addition to the other nutrition activities conducted as part of other tasks, could form a significant component of these optional activities. Offerors are requested to propose and conduct activities that support these goals and that are consistent with GFSR principles and task order parameters. The ceiling for these activities is \$10 million over the course of the task order.

C.4.4 Deliverables

The Contractor is invited to propose deliverables that it would deem as suitable products or services within the context of the tasks described above. The Contractor's proposed deliverables will be reviewed and, if accepted by USAID, will become part of the Deliverables of this task order.

C.4.5 Guiding Principles and Requirements

To complete these tasks, the contractor shall fulfill the following key principles and requirements, as described in section J:

- a. Alignment,
- b. Partnerships,
- c. Linkages,
- d. Innovation,
- e. Continuity of care,
- f. Zambian leadership and human resources support,
- g. Gender integration,
- h. Attention to the environment
- i. Sustainability
- j. Resource Integration

Over the course of the task order, the GRZ and USG will develop new policy frameworks and strategic plans. Hence, the contractor shall modify activities, based on formal communication from USAID/Zambia, to reflect the priorities and resources associated with these new frameworks/plans.

C.4.5.1 Alignment

ZISSP shall align, to the maximum extent possible, with the current and future strategic and policy frameworks developed by the GRZ. In particular, the program's alignment with the NHSP must support the MOH's efforts in making progress toward the Health Millennium Development Goals. Additionally, ZISSPs technical approaches must reflect the promising practices as compiled in national and international policies, protocols, guidelines, and standards for prevention, care, and treatment.

C.4.5.2 Partnerships

ZISSP must consult the PHOs, DHMTs, and private sector facilities to assess the needs and to determine the coverage of existing health services within districts and communities. As part of its partnerships with the PHOs and DHMTs, the Program must ensure that its activities figure into the annual work plans of these governmental entities. Additionally, the Program should propose organizational sub-partners, including community and faith-based groups, to provide support in particular intervention areas, such as promoting health-seeking behaviors.

C.4.5.3 Linkages

To avoid missed opportunities in providing related health services attributable to the vertical nature of externally supported health and development programming, ZISSP shall pursue linkages with other programs managed by USAID/Zambia and those supported by other agencies/organizations. Examples of linkages include the development of joint implementation plans and agreements with the DHMTs and HMTs that reflect a coordinated set of activities implemented by multiple programs in the same locations.

C.4.5.4 Innovation

Innovative approaches are encouraged to address the health needs and encourage health-seeking behaviors among diverse client populations. ZISSP should seek to introduce appropriate new health products and services, based on formative research and in consultation with the MOH, USAID/Zambia, Pharmaceutical Regulatory Authority of Zambia (for health products), and Medical Council of Zambia (for health services).

C.4.5.5 Continuum of Care (CoC)

The Program shall support the delivery of health services based on the CoC framework. This framework entails linkages between different types of health services (promotive, preventive, curative, rehabilitative.) delivered at all levels (individual, family, community, health facilities, etc.) by diverse providers (family, community or faith-based groups, private, governmental entities, etc.). Implementation of the CoC occurs through the development of networks, led by governmental entities, community or faith-based groups, for seamless service delivery through coordinated planning, programmatic consolidation, and/or referrals within and between the different levels of the health system. For example, the period from pregnancy to 24 months of age is a crucial window of opportunity for reducing undernutrition and its adverse effects. Program efforts should focus on this segment of the continuum of care – maternal, newborn and child health.

C.4.5.6 Zambian Leadership Development and Human Resource Support

The Contractor shall hire Zambian personnel, *excluding* active service employees of the GRZ, to implement the program (refer to the key personnel section for more information). Additionally, the Program shall build the competencies among Zambian staff at all levels through professional development activities, preparing them to assume senior technical and management roles and responsibilities in health, including family planning, MNCH, malaria and HIV/AIDS programs. Examples of professional development activities could include training, mentoring, field trips, and appropriate management opportunities. However, this will not include postgraduate training. In line with the GRZ and USG policies, the Program shall implement plans and procedures for remuneration and retention of staff. In particular, it should provide staff living with HIV/AIDS with ARV treatment and support those affected by HIV/AIDS with counseling services and appropriate leave policies.

C.4.5.7 Gender Integration

USAID/Zambia expects program activities to fully support the GRZ's National Gender Policy, which requires all policies, programs, plans, projects, and national budgets to integrate gender considerations in the pursuit of sustainable economic growth, job creation, better household security, and poverty reduction. USAID/Zambia identifies gender as a program quality issue addressed by supporting implementation of activities to reduce inequities in access to and use of health products, services, and information by males and females as well as by collecting and reporting sex-disaggregated data to track progress in achieving these reductions. As part of their proposals, Offerors must delineate key gender factors that influence access to and use of health products, services, and information by both male and female clients based on measurable indices, and building on HSSP's experiences, devise specific interventions, with which to resolve the issues/problems, and put in place the appropriate means to track and report progress. Although this Program will receive funding from all accounts, the Offeror shall take into account PEPFAR's priority gender strategies which include increasing gender equity in HIV/AIDS activities and services; reducing violence and coercion; addressing male norms and behaviors; increasing women's legal protection; and increasing women's access to income and productive resources. USAID/Zambia expects that the Contractor will strive for equity in access to, control over, and management of resources – as influenced by gender considerations – by introducing appropriate organizational structures and personnel processes.

C.4.5.8 Attention to the Environment

A separate annex (Attachment J.2) spells out the requirements on environmental considerations, and USAID/Zambia expects that the Contractor shall in addition to these requirements, conduct an early evaluation of the environmental concerns and develop an environmental monitoring, and mitigation plan (EMMP) for Mission concurrence and approval.

C.4.5.9 Sustainability

ZISSP shall enable stakeholders at all levels to determine and carry out their respective roles in the overall health sector response, sustaining the socio-demographic and health gains in the long term. ZISSP will ensure sustainability by strengthening the health systems for improved service delivery and working within the existing Government structures. Linkages between governmental entities, organizational partners, community/faith-based groups, and other stakeholders shall operationalize inter-dependency for technical, human, and other resources. Mobilization of communities shall foster mutual relationships of support and accountability between client populations and service providers. Alignment of the Program with the GRZ's strategic and policy frameworks as well as Program-supported development of technical, management, and leadership competencies among Zambians shall reinforce indigenous ownership and responsibility of the overall health sector response. As part of their technical approaches and activities, offerors must propose strategies which contribute to the coordinated efforts and interactions between stakeholders leading to sustained achievements in child health, integrated reproductive health, HIV/AIDS and STIs, and malaria. Examples of strategies include capacity building of staff in health facilities as well as institutionalization of Program activities by governmental, commercial and/or private sector entities. The offeror must assist the MOH continue to build capacity and to institutionalize quality improvement and related systems at the community, health center, district, provincial and national levels to ensure that the health system

at all levels is robust. Particular emphasis must be given to sustainability planning with regard to staff seconded to government departments.

Offerors must respond to the following requirements in their proposals:

- a. Propose a sustainability framework or model that develops local capacity to:
 - i. Foster a shared commitment and consensus between partners/stakeholders on priorities and programming in child health, integrated reproductive health, HIV/AIDS and STIs, and malaria ;
 - ii. Carry out technical and management tasks to design, implement, and evaluate interventions in child health, integrated reproductive health, HIV/AIDS and STIs, and malaria at various levels;
 - iii. Establish partnerships with diverse organizations and secure funding from broad range of sources;
 - iv. Improve organizational learning by integrating lessons learned and innovations and reconfiguring and repositioning the organization; and,
 - v. Monitor and respond to changes in the development and health contexts.
- b. Propose a plan and describe the processes to track the progress and assess the effectiveness of developing capacity and build sustainability. The plan must include appropriate indicators and benchmarks.
- c. Identify existing strategies, policies, and guidelines that the program must follow to support the implementation of activities and development of technical, management, and leadership capabilities among Zambians. Describe major legal, regulatory, policy, and organizational reforms needed to facilitate sustainable improvements in health status during the implementation phase and after the program ends.
- d. Describe the processes to assess and address organizational capacity development needs for the GRZ, proposed sub-contractors, and other partners/stakeholders.
- e. Describe the processes to scale up and institutionalize demonstration or pilot projects/activities in the Zambian health system (including relevant civil society and private sector organizations), given its conditions and constraints.

C.4.5.10 Resource Integration

Funding for this five-year program will come from multiple sub-accounts of the USG's global health and child survival account, including HIV, malaria, family planning/reproductive health and maternal child health. Refer to Section L.4 below for more information on the funding sources. Even though ZISSP activities will generally be integrated, the contractor must maintain the ability to coordinate, track and report separately on how each stream of funding is used, in all cases abiding by the requirements associated with each type of funding. The contractor must have the ability to report expenditure by district. The contractor shall maintain a focus on maximizing results associated with integrated funding and programming, and will not pursue integration for integration's sake.

C.5 GRANTS UNDER CONTRACT (GUC)

This RFTOP includes a mechanism to provide grants under contract (GUC) to facilitate community-level service delivery and local organization capacity building. These grants should contribute to the sustainability of health programming by building organizational capacities in service delivery as well as reaching and mobilizing special populations for service access and use and facilitate appropriate integration of services into other platforms. Offerors may identify local NGO partners that will receive these grants under the ZISSP. Offerors must outline the role(s) of the proposed NGO partner(s) by task and justify how the inclusion of any partner via the GUC mechanism will enhance the overall effectiveness, reach, and success of the program.

C.6 PERFORMANCE MANAGEMENT PLAN

By increasing the use of HIV/AIDS, malaria, family planning and maternal, neonatal, and child health and nutrition services and strengthening the systems for delivering these services, ZISSP will improve the health status of Zambians. The USG has specific indicators that the Contractor will report on, including those from PEPFAR's Next Generation Indicators, the Operational Plan's Foreign Assistance Framework and the Malaria Operational Plan. The Contractor will report on these or other evolving indicators in line with existing and future USG guidance.

In addition, the contractor will propose a performance management plan that enables tracking and attribution of higher level outcomes to project activities. These indicators will be supplemental to those contained in the USG-defined indicator set. National-level results are not USAID/Zambia's sole responsibility, but can only be achieved in collaboration with the GRZ and other CPs.

The performance management plan must explicitly consider dimensions of gender and private sector engagement.

The Contractor will ensure early and efficient program start-up and include meaningful baseline management indicators and targets for the national, provincial, district and community levels. Sources of baseline data include the Zambia 2007 Demographic, program reports, and other ad-hoc studies.

Illustrative PEPFAR' next generation and Foreign Assistance Framework indicators, of which some will be disaggregated by sex, include the following:

C.6.1 HIV/AIDS (PEPFAR)

1. Number of health care workers who successfully completed an in-service training program
2. Number of community health care workers who successfully completed a pre-service training program
3. Number of the intended target population reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards

C.6.2 Maternal and Child health

1. Number of people trained in maternal/newborn health through USG-supported programs
2. Number of people trained in child health care and child nutrition through USG-supported health area programs

3. Number of children less than 12 months of age who received DPT3 in a given year from USG-supported programs
4. Number of children under 5 years of age who received Vitamin A from USG-supported programs

C.6.3 Family Planning/Reproductive health

1. Number of people trained in FP/RH
2. Number of service delivery points providing FP counseling or services
3. Number of people that have seen or heard a specific FP/RH message

C.6.4 Malaria, including illustrative PMI indicators

1. Number of houses sprayed with IRS with USG funds
2. Number of people trained with USG funds to deliver IRS
3. Number of medical and para-medical practitioners trained in evidence-based clinical guidelines
4. Number of people trained with USG funds in malaria treatment or prevention

In addition to the above indicators, the partner will be expected to develop indicators for and report on service integration, gender considerations, environmental protection, sustainability, and other program activities. The illustrative indicators may change in the life of the Program.

C.6.5 Monitoring and evaluation and research capability

Offerors shall propose a monitoring and evaluation plan to track and report on progress as well as demonstrate operational research capability, consistent with funding-stream requirements, to allow for evidence-based decision-making and documentation of the intervention effects and outcomes. Monitoring and evaluation capabilities will include the ability to document progress on outcome level indicators attributable to project interventions at appropriate geographic levels, which will include the community level for some indicators. Cost effective baselines, comparison groups (either geographic or via phased implementation) and periodic availability of results will be important features of a robust monitoring and evaluation system.

C.6.6 Performance Indicators

Offerors shall propose a performance management and evaluation plan to track and report on progress in achieving results (refer to table 5 below for illustrative annual milestones and end-of-program targets for program outcomes). Offerors may propose additional illustrative indicators, milestones, and targets for measuring results in their technical proposals.

As part of the performance M&E process, the contractor shall participate in joint planning, implementation, and evaluation exercises with other implementing partners, GRZ, USAID/Zambia, and other CPs at the national, provincial, and district levels. These exercises will enable stakeholders to track progress against milestones/targets, identify barriers to implementation, and develop solutions to these obstacles. The contractor shall contribute to the Health Management Information System (HMIS) and National HIV/AIDS/STI/TB Monitoring and Evaluation System, among other information systems operated by the GRZ. The contractor shall also participate in mid-term and end-of-program evaluations, funded separately by USAID.

Additionally, the contractor shall have performance M&E reporting requirements, as noted in section F.6.

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 Contracts Officer Technical Representative (COTR).

Table 5. Illustrative annual milestones and end-of-program (EOP) targets for program outputs/outcomes

Task/Indicator	Y 1	Y 2	Y 3	Y 4	Y 5	EOP
Task 1 : Strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide						
1.1 : The number of health workers placed and retained on the Zambia Health Workers retention Scheme supported by USG	119		Scale down			
1.2 : Number of rural health facilities and training institutions improved with USG support in order to facilitate placement of trained health providers	Few					Many
1.3 : Number of people covered by USG-supported health financing arrangements	Baseline	Scale up				
1.4 : Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs	Baseline					
1.5 : Number of improvements to laws, policies, regulations, or guidelines						
1.6 : Number of USG-assisted service delivery points implementing quality assurance/quality improvement (QA/QI) approaches (<i>custom indicator</i>).	Baseline	Scale up				
Task 2 : Improve management and technical skills in order to increase use of quality health services within target districts on a sustainable basis						
<i>HIV/AIDS</i>						
2.1 : Percent of target DHMTs who assess case management in at least 80% of supportive supervision visits.	80	90	90	90	90	90
<i>Maternal and Child health</i>						
2.2 : Number of people trained in maternal/newborn health through USG-supported programs	200	220	300	300	300	1320
2.3 : Number of people trained in child health care and child nutrition through USG-supported health area programs	200	220	230	250	250	1150
2.4 : Number of children less than 12 months of age who received DPT3 in a given year from USG-supported programs	386,000	398,000	409,000	421,000	433,000	2,047,000
2.5 : Number of children under 5 years of age who received Vitamin A from USG-supported programs	2,383,000	2,383,000	2,458,000	2,529,000	2,600,000	13,353,000
2.6 : Percentage/Number of deliveries with a skilled birth attendant (SBA) in USG-assisted program	Baseline	Scale up				
2.7 : Number of women receiving active management of the third stage of labour (AMTSL) through USG-supported programs	Baseline	Scale up				
2.8 : Number of newborns receiving essential newborn care through USG-supported programs	Baseline	Scale up				
2.9 : Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities	Baseline	Scale up				
2.10 : Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs	Baseline	Scale up				
2.11 : Number of cases of child diarrhea treated in USG-assisted programs	Baseline	Scale up				
<i>Family Planning</i>						

Task/Indicator	Y 1	Y 2	Y 3	Y 4	Y 5	EOP
2.12 : Number of service delivery points providing FP counseling or services	135	150	165	180	200	750
2.13 : Percent of married women currently using modern family planning methods in target areas.	33	35	37	39	40	40
<i>Malaria</i>						
2.14 : Percent of targeted houses sprayed with IRS with USG funds	85	85	85	85	85	85
2.15 : Percentage of pregnant women who slept under an ITN the previous night	50	60	70	80	85	85
2.16 : Percentage of children under the age of five years who slept under an ITN the night before	50	60	70	80	85	85
2.17 : Percentage of women who have completed a pregnancy in the last two years received two or more doses of IPTp during that pregnancy	70	75	80	85	85	85
2.18 : Percentage of households with at least one ITN and/or sprayed with IRS in the last 12 months	80	85	85	85	85	85
2.19 : Percentage of children under five with suspected malaria who will have received treatment with ACT with 24 hours of onset of their symptoms	40	45	50	60	70	70
2.20 : Number of people trained with USG funds to deliver IRS	1,700	1,800	1,900	2,000	2,000	9,400
2.21 : Number of people trained with USG funds in malaria treatment or prevention	1350	1485	1630	1800	1980	8,425
2.22 : Number of medical and para-medical practitioners trained in evidence-based clinical guidelines	540	600	660	720	750	3,270
Task 3 : Increase community involvement in the production of health						
<i>MCH, FP & Malaria</i>						
3.1 : Number of community health workers trained in community based malaria, FP, MNCH, & nutrition interventions	2160	2370	2600	2860	3140	13,130
3.2 : Number of people that have seen or heard a specific FP/RH message	800,000	880,000	968,000	1,064,800	1,171,200	4,884,000
3.3 : Number of children reached by USG-supported nutrition programs	Baseline	Scale up				
<i>HIV/AIDS</i>						
3.4 : Number of community health care workers who successfully completed a pre-service training program	2160	2370	2600	2860	3140	13,130
Task 4 : Ensure service delivery and other activities are effectively integrated at all appropriate levels of the health system through joint planning with partners, in-kind activities, and appropriate PPPs.						
4.1 : Number of public private partnerships established or strengthened for HIV/AIDS, FP, Malaria, MNCH & Nutrition services						At least 1
4.2 : (Qualitative indicator) Degree to which health services are appropriately integrated	Baseline description				End line Description	

C.7 TRANSITION ASSUMPTIONS

The current program in this intervention area, HSSP, concludes in 2010, with support beyond 2009 limited to only high priority malaria interventions. The contract for the follow project will likely be awarded in mid-2010.

[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.

A Marking Plan must be developed as part of the contractor's proposal to enumerate the public communications, commodities, and program materials and other items that visibly bear or will be marked with the USAID Identity. As stated in ADS 320.3.2, USAID's policy is that programs, projects, activities, public communications, or commodities implemented or delivered under contracts and subcontracts exclusively funded by USAID are marked exclusively with the USAID Identity. Where applicable, a host-country symbol or ministry logo, or another U.S. Government logo may be added.

Except for the manufacturer's trademark on a commercial item, the corporate identities or logos of contractors or subcontractors are not permitted on USAID-funded program materials and communications, unless specified in the [USAID Graphic Standards Manual](#) or approved in advance by the Principal Officer. The Principal Officer must obtain clearance from the Senior Advisor for Brand Management (LPA) before approving the use of the contractor's logo.

The Marking Plan may include requests for exceptions to marking requirements, to be approved by the CO. ADS 320.3.2.4 describes what the Marking Plan must address while ADS 320.3.2.5 lists the exceptions to Marking Plan requirements.

To ensure that all items are appropriately marked in accordance with this policy, all USAID direct contracts must incorporate a Marking Plan that details the public communications, commodities, and program materials and other items that will bear visibly the USAID Identity.

Specific procedures for developing the Marking Plan are in [Branding and Marking in USAID Direct Contracting](#).

Contract deliverables to be marked with the USAID Identity must follow design guidance for color, type, and layout in the [Graphic Standards Manual](#). Marking Plans should specifically address the following specific contract deliverables or performance requirements:

a. Commodities or equipment provided under humanitarian assistance, disaster relief or development programs, and all other program commodities and equipment funded by USAID contracts, and their export packaging, must prominently display the USAID Identity.

b. Program, project, or activity sites financed by USAID contracts, including visible infrastructure projects (roads, bridges, buildings, etc.) or others that are physical in nature (agriculture, forestry, water management, etc.), must prominently display the USAID Identity. Temporary signs must be erected early in the construction or implementation phase. When construction or implementation is complete, the contractor must install a permanent, durable and visible sign, plaque, or other marking.

c. Public communications financed by USAID contracts that are print products must prominently display the USAID Identity. These communications include, but are not limited to, the following:

- Publications;
- Reports;
- Research results, studies, and evaluations;
- Brochures, leaflets, informational, and promotional materials;
- Folders;
- Success stories;
- Posters;
- Banners and Signs;
- Print PSAs, newspaper supplements and other paid placements such as advertorials;
- (Non-administrative) advertisements about program events/activities;
- Training manuals, workbooks, and guides;
- Press releases, fact sheets, media advisories (*note: the U.S. Ambassador or Public Affairs Officer may request these materials to be distributed on U.S. Embassy letterhead*); and
- Letterhead used for program-related purposes (invitations to events, etc.), as opposed to contractor administrative purposes.

d. Public communications financed by USAID contracts that are audio, visual, or electronic must prominently display the USAID Identity. Such communications include, but are not limited to, the following:

- Web sites;
- Videos;
- CDs and DVDs;
- TV PSAs;
- PowerPoint and other program-related presentations;
- Mass distribution electronic mail sent for program purposes, such as invitations to training events or other widely attended program-related gatherings; and

- Radio PSAs, which must include an audio tag, such as, “made possible by USAID: From the American people.”

e. Studies, reports, publications, Web sites, and all informational and promotional products not authored, reviewed, or edited by USAID must contain a provision substantially as follows:

This study/report/Web site (specify) is made possible by the support of the American People through the United States Agency for International Development (USAID.) The contents of this (specify) are the sole responsibility of (name of organization) and do not necessarily reflect the views of USAID or the United States Government.

f. Events financed by USAID contracts must prominently display the USAID Identity. Such events include, but are not limited to, the following:

- Training courses;
- Conferences;
- Seminars;
- Briefings;
- Exhibitions;
- Fairs;
- Workshops;
- Press conferences;
- Other public meetings and activities; and
- Invitations, press releases, publicity, and media materials, presentations and handouts associated with these events that are produced under a USAID direct contract.

D.2 BRANDING

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

A Branding Implementation Plan (BIP) must be developed which should describe how the program will be promoted to beneficiaries and host-country citizens. It outlines the events (press conferences, site visits, etc.) and materials (success stories, Public Service Announcements [PSAs], etc.) the contractor will organize and produce to assist USAID in delivering the message that the assistance is from the American people.

The Branding Strategy (BS) must identify

- The program or project name;
- How the materials and communications will be positioned (i.e., as from the American People, jointly sponsored by USAID and the host-country government, or in some other way);
- The desired level of visibility; and
- Any other organizations to be acknowledged

As stated in ADS 320.3.2.1, the BS is part of the contract requirements, and the offeror must prepare a BIP to implement the BS with the proposal. The BIPs should specifically address the following:

- How to incorporate the message, “This assistance is from the American people,” in communications and materials directed to beneficiaries, or provide an explanation if this message is not appropriate or possible.
- How to publicize the program, project, or activity in the host-country and a description of the communications tools to be used. Such tools may include the following:
 - Press releases,
 - Press conferences,
 - Media interviews,
 - Site visits,
 - Success stories,
 - Beneficiary testimonials,
 - Professional photography,
 - PSAs,
 - Videos, and
 - Webcasts, e-invitations, or other e-mails sent to group lists, such as participants for a training session blast e-mails or other Internet activities, etc.
- The key milestones or opportunities anticipated to generate awareness that the program, project, or activity is from the American people, or an explanation if this is not appropriate or possible. Such milestones may be linked to specific points in time, such as the beginning or end of a program, or to an opportunity to showcase publications or other materials, research findings, or program success. These include, but are not limited to, the following:
 - Launching the program,
 - Announcing research findings,
 - Publishing reports or studies,
 - Spotighting trends,
 - Highlighting success stories,
 - Featuring beneficiaries as spokespeople,
 - Showcasing before-and-after photographs,
 - Marketing agricultural products or locally-produced crafts or goods,
 - Securing endorsements from ministry or local organizations,
 - Promoting final or interim reports, and
 - Communicating program impact/overall results.

Specific procedures for including BIP requirements are in the mandatory internal reference, [Branding and Marking in USAID Direct Contracting](#).

[END OF SECTION D]

SECTION E - INSPECTION AND ACCEPTANCE

E.1. NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

Same requirement as in the TECHNICAL ASSISTANCE AND SUPPORT CONTRACT 3 (TASC 3) IQC

E.2. INSPECTION AND ACCEPTANCE

USAID inspection and acceptance of services, reports and other required deliverables or outputs shall take place at:

USAID/Zambia
Population, Health and Nutrition Office
351 Independence Avenue

E.3. MONITORING AND EVALUATION

Task order performance evaluation shall be performed in accordance with the performance standards/indicators established under Section C of this task order.

[END OF SECTION E]

SECTION F – DELIVERIES OR PERFORMANCE

F.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

The following contract clauses pertinent to this section are hereby incorporated by reference (by Citation Number, Title, and Date) in accordance with the clause at FAR 52.252-2 CLAUSES INCORPORATED BY REFERENCE" in Section I of this contract. See FAR 52.252-2 for an internet address (if specified) for electronic access to the full text of a clause.

NUMBER	TITLE	DATE
	FEDERAL ACQUISITION REGULATION (48 CFR Chapter 1)	
52.242-15	STOP-WORK ORDER ALTERNATE I (APR 1984)	AUG 1989
52.247-34	F.O.B. DESTINATION	NOV 1991
52.247-48	F.O.B. DESTINATION--EVIDENCE OF SHIPMENT	FEB 1999

F.2 PLACE OF PERFORMANCE

The place of performance under this Task Order is as specified in Section C.

F.3 PERIOD OF PERFORMANCE

- (a) The estimated period of performance for this task order is referenced in blocks 7 and 8, respectively, from the cover page of the TO.
- (b) Subject to the cost plus fixed fee amount of this task order, the TOCOTR 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 TOCOTR'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 TOCOTR's approval to the final voucher submitted for payment.
- (c) It is the contractor's responsibility to ensure that the TOCOTR-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.4 KEY PERSONNEL

USAID/Zambia designates the following five positions as key personnel for the successful completion of the tasks in this RFTOP. However, offerors may propose other staffing configurations with full and appropriate justification.

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

F.4.1 Chief of Party

The Chief of Party will provide overall leadership and management for the Task Order. The Chief of Party will liaise with the COTR as well as with counterparts from other implementing partners, agencies, and organizations to coordinate activities. The Chief of Party will act as the official point-of-contact for the program. The Chief of Party shall have:

- At least a master's degree in public health or a related professional advanced degree;
- At least ten years of experience in public health in developing and/or transitional countries;
- At least eight years of experience as a country/project director in a public health and/or international development project;
- Demonstrated skills, abilities, and experiences to:
 - Lead and manage a program of similar magnitude and complexity;
 - Work collaboratively across technical disciplines;
 - Communicate effectively orally and in writing; and
 - Develop and maintain working relationships with US and foreign governments, development partners, and civil society; and
 - Develop and implement effective partnerships with private sector entities.
- The ability to travel extensively to program locations within Zambia and to other places, as required.

F.4.2 Deputy Chief of Party

The *Deputy Chief of Party* will oversee the implementation of program activities at national, provincial and the 27 districts. The Deputy Chief of Party shall have:

- A master's degree in public health or a related professional advanced degree;
- At least eight years of experience in public health in developing and/or transitional countries;
- At least three years of experience in a management position for a public health and/or international development project;
- Demonstrated skills, abilities, and experiences to:
 - Manage a program of similar magnitude and complexity;
 - Work collaboratively across technical disciplines;
 - Communicate effectively orally and in writing; and
 - Develop and implement effective partnerships with private sector entities.

- The ability to travel extensively to program locations within Zambia and to other places, as required.

F.4.3 Director of Technical Support

The *Director of Technical Support* will provide technical support and oversight in the implementation of program activities. Technical areas/functions include HIV/AIDS, malaria, family planning, maternal, newborn, child health and nutrition. The Director of Technical Support shall have:

- A professional advanced degree in public health or a related field (a clinical degree with experience in medicine, nursing, or an allied health field is desirable);
- At least 10 years of experience in public health in developing and/or transitional countries;
- At least five years of experience in a senior technical position for a public health and/or international development project;
- Demonstrated knowledge, skills, and/or experiences in:
 - Malaria, family planning/reproductive health, and maternal, newborn, child health and nutrition services;
 - HIV/AIDS services;
 - Gender issues, operational research, and other programmatic learning activities as they pertain to HIV/AIDS, malaria, family planning, maternal, newborn, child health and nutrition and development programming.
- Demonstrated skills, abilities, and experiences to communicate effectively orally and in writing; and
- The ability to travel extensively to program locations within Zambia and to other places, as required.

F.4.4 Director of Finance/Administration

The *Director of Finance and Administration* will provide management support and oversight in the implementation of program activities. Management support areas/functions include finance, human resources, information technology, and procurement. The Director of Finance and Administration shall have:

- A bachelor's degree in business administration, organizational management, or a related field;
- At least five years of experience in a management position in the public or private sector (knowledge of and experience in public health and/or international development are desirable) in developing and/or transitional countries;
- Demonstrated knowledge, skills, and/or experiences in accounting, financial planning and management, and procurement, among other management support areas/functions, as required;
- Demonstrated skills, abilities, and experiences to:
 - Manage a program of similar magnitude and complexity;

- Work collaboratively across technical disciplines (HIV, malaria, FP/RH, and MNCH);
- Communicate effectively orally and in writing;
- Manage a contract; and
- Manage sub-grants under a contract.
- The ability to travel extensively to program locations within Zambia and to other places, as required.

F.4.5 Entomologist

The Entomologist will provide technical assistance and guidance to the National Malaria Control Centre (NMCC) on entomological monitoring and evaluation of the IRS program. He or she will ensure that all IRS entomological and epidemiological monitoring activities are planned, budgeted, undertaken, documented and disseminated in a timely and effective manner. Other duties include contributing to capacity building of national entomology staff of NMCC; promoting sustainability of the routine entomological work related to IRS; developing guidelines and standard operating procedures where necessary, to assure quality and high scientific standards in the entomology work; providing technical support to the NMCC and other stakeholders on the IRS-applied research agenda and activities; ensuring, through capacity building and monitoring, the continuous functionality of the insectary and maintenance of the vector colony and providing national and district level support in monitoring the quality of spraying and residual efficacy of insecticides.

At a minimum, the Entomologist shall have:

- Masters Degree (minimum), or a Doctoral Degree, in entomology, medical entomology, or related field
- At least 7 years practical experience working in malaria control programs, specifically in integrated vector control
- Additional training or experience in tropical medicine, malariology, or parasitology is a merit
- Ability to work effectively in teams, as a team member and as a team leader; good communications skills, and strong writing skills
- Ability to take initiative, make appropriate decisions and to manage a research team effectively
- The ability to travel extensively to program locations within Zambia and to other places, as required.

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

As noted in section C, (Zambian leadership and human resources support), USAID/Zambia directs offerors to implement the mission's priority to build sustained indigenous technical and management capacity for the social and economic development of Zambia. Offerors shall therefore strive to hire Zambians, *excluding* active service employees of the GRZ, in key and non-key positions who demonstrate familiarity with the country's demographic and health profile as well as language and cultural expertise. Offerors may propose an expatriate/

international candidate for one of the five key personnel positions. If more than one expatriate/ international candidate is proposed, then offerors must provide full and appropriate justification. After award, the Contracting Officer must approve the replacement of any key personnel.

F.5 DELIVERABLES

The contractor shall deliver specific deliverables for each component of the SOW, cross-referencing the specific section in C and presented in the following format:

Task Number/Description	Deliverables	Delivery Date
1.		
2.		
3.		
4.		

F.6 PROGRESS REPORTING REQUIREMENTS

In addition to the requirements set forth for submission of reports in Sections I and J, and in accordance with AIDAR clause 752.242-70, Periodic Progress Reports, the Contractor shall submit reports, deliverables or outputs as further described below to the COTR (referenced in Sections F.2 and G). All reports and other deliverables shall be in the English language, unless otherwise specified by the COTR.

F.6.1 PEPFAR Country Operational Plans (COPs) Reporting

- a. Activity narratives and targets
- b. Semi-Annual and Annual Progress Reports (SAPRs and APRs)

F.6.2 Performance Management Plan (PMP)

- a. Data collection methodology for data quality assessments
- b. Semi-annual and annual portfolio review presentations

F.6.3 Country Operational Plan (OP) Reporting

The contractor will submit Performance Plans and Reports (PPRs) which will be used to track performance in relation to OP indicators and targets.

F.6.4 Malaria Operational Plan (MOP) Reporting

The contractor will submit annual progress reports which will be used to track performance in relation to MOP indicators and targets.

F.6.5 Ad-hoc analyses, evaluations, studies, operational research and other reports as requested.

F.6.6 Personnel seconded to the Ministry of Health shall submit inception reports within six weeks of commencement of duty. These reports shall include initial assessments of the challenges being faced by the MOH headquarters in human resource management and oversight of the delivery of FP, MNCH and malaria services. Seconded personnel will develop annual plans to address these challenges and submit progress reports on a regular basis.

F.6.7 Grants manual for the sub-granting process (within three months of award)

F.6.8 Quarterly Reports: Quarterly Financial and Progress Reports shall be submitted no later than one month after the end of the quarter. The scope and format of the quarterly reports will be determined in consultation with the COTR.

F.6.9 Work plans:

F.6.9.1 Transition period work plan: The contractor shall be required to submit upon award a transition work plan to ensure that there is no disruption in the high priority malaria interventions that the current program will be conducting.

F.6.9.2 Annual Work plans shall detail the work to be accomplished during the upcoming year. The scope and format of the Annual Work plan 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 Work plan shall be submitted within one month of the contract's effective date. The work plan should include the estimated monthly funding requirements during the upcoming period of program implementation, necessary to meet all program objectives within the contract. USAID will respond to the work plan within five calendar days.

Annual Work plans shall be aligned with the GRZ's annual work planning period, i.e., January to December of each calendar year. The initial and final work plans will cover the time periods between the contract's effective date and December of the calendar year, and January through the project's anticipated completion date, respectively. The contractor will be required to reconcile calendar year work plans with fiscal year plans and reports as necessary.

F.6.10 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.

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

The contractor must note that requirements may change over the course of the task order.

F.7 AUTHORIZED WORK DAY / WEEK

The contractor is authorized up to a six day workweek under this Task Order. Under no circumstance will such approval constitute approval for premium overtime pay, or approval to exceed the total price of the Task Order.

F.8 MONITORING AND EVALUATION PLAN

Evaluation of the Contractor's overall performance shall be conducted jointly by the TOCOTR and the TOCO, and shall form the basis of the Contractor's permanent performance record with regard to this Task Order. The TOCOTR and TOCO will undertake an evaluation at the conclusion of the task order and forward a copy to the USAID/W COTR and CO.

F.9 SUBMISSION OF DEVELOPMENT EXPERIENCE DOCUMENTATION TO PPC/CDIE/DI

In accordance with AIDAR Clause 752.7005 "Submission Requirements for Development Experience Documents (JAN 2004)" (the full text of which is included in Section I), USAID contractors are to submit one electronic and/or one hard copy of development experience documentation (electronic copies are preferred) to the Development Experience Clearinghouse at the following address (rather than the outdated address in the cited clause):

Development Experience Clearinghouse
8403 Colesville Road, Suite 210
Silver Spring, MD 20910
Telephone Number (301)562-0641
Fax Number (301)588-7787
E-mail: docsubmit@dec.cdie.org
<http://www.dec.org>

[END OF SECTION F]

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

The following AIDAR clause pertinent to this section is hereby incorporated by reference (by Citation Number, Title, and Date).

NUMBER	TITLE	DATE
	USAID ACQUISITION REGULATION (48 CFR Chapter 7)	
752.7003	DOCUMENTATION FOR PAYMENT	NOV 1998

G.2 CONTRACTING OFFICER

Contracting Officer
U.S. Agency for International Development (USAID)/Zambia
351 Independence Avenue
Telephone: 260-211-254303
Fax: 260-211-254532
Email: oa-solicit-lusaka@usaid.gov

G.3 CONTRACTING OFFICER’S TECHNICAL REPRESENTATIVE (COTR)

The Contracting Officer’s Technical Representative (COTR) will be designated separately. USAID Population, Health and Nutrition (PHN) office 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.

Population, Health and Nutrition (PHN) Office
U.S. Agency for International Development (USAID)/ Zambia
351 Independence Avenue
Lusaka 10101
Zambia

The Contracting Officer’s Technical Representative (COTR) will be designated separately by the Contracting Officer.

G.4 PAYING OFFICE

The contractor must submit invoices to the payment office indicated on the Cover Page of the Task Order. Generally, this will be the USAID Washington Office/Bureau if payment is through Letter of Credit or the USAID/Zambia Controller Office if payment is through cost reimbursement.

Note: If a contractor requires payment through an existing Letter of Credit (LOC), a specific request must be submitted to the Task Order Contracting Officer for consideration.

G.4.1 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 Controller, USAID/Zambia. One copy of the voucher and the invoice shall also be submitted to the Contracting Officer and the COTR.

Electronic submission of invoices is encouraged. 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:

Controller
U.S. Agency for International Development (USAID)/ Zambia
351 Independence Avenue
Lusaka 10101
Zambia

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

G.5 ACCOUNTING AND APPROPRIATION DATA

The continuation of the activities under this task order is authorized through the estimated completion date of this Task Order subject to the availability of funds, approval of any new USAID strategy documents, approval of any new strategic and policy frameworks developed between the U.S. Government (USG) and the Government of the Republic of Zambia (GRZ), and the successful performance of the Contractor.

Funds will be obligated on an incremental basis and appropriate fund cites provided.

G.6 TECHNICAL DIRECTIONS/RELATIONSHIP WITH USAID

(a) Technical Directions is defined to include:

- (1) Written directions to the Contractor which fill in details, suggest possible lines of inquiry, or otherwise facilitate completion of work;
- (2) Provision of written information to the Contractor which assists in the interpretation of drawings, specifications, or technical portions of the work statement;
- (3) Review and, where required, provide written approval of technical reports, drawings, specifications, or technical information to be delivered. Technical directions must be in writing, and must be within the scope of the work as detailed in Section C.

(b) The Contracting Officer, by separate designation letter, authorizes the COTR to take any or all action with respect to the following which could lawfully be taken by the Contracting Officer, except any action specifically prohibited by the terms of this task order:

- (1) Assure that the Contractor performs the technical requirements of the task order in accordance with the contract terms, conditions, and specifications.
- (2) Perform or cause to be performed, inspections necessary in connection with a) above and require the Contractor to correct all deficiencies; perform acceptance for the Government.
- (3) Maintain all liaison and direct communications with the Contractor. Written communications with the Contractor and documents shall be signed as "Contracting Officer's Technical Representative" with a copy furnished to the Contracting Officer.
- (4) Issue written interpretations of technical requirements of Government drawings, designs, and specifications.
- (5) Monitor the Contractor's production or performance progress and notify the Contractor in writing of deficiencies observed during surveillance, and direct appropriate action to effect correction. Record and report to the Contracting Officer incidents of faulty or nonconforming work, delays or problems.
- (6) Obtain necessary security clearance and appropriate identification if access to Government facilities is required. If to be provided, ensure that Government furnished property is available when required.

LIMITATIONS: The COTR is not empowered to award, agree to, or sign any task order or modifications thereto, or in any way to obligate the payment of money by the Government. The COTR may not take any action which may impact on the task order schedule, funds, scope or rate of utilization of LOE. All contractual agreements, commitments, or modifications which involve prices, quantities, quality, schedules shall be made only by the Contracting Officer.

- (c) In the separately-issued COTR designation letter, the CO designates an alternate COTR to act in the absence of the designated COTR, in accordance with the terms of the letter.
- (d) Contractual Problems - Contractual problems, of any nature, that may arise during the life of the task order must be handled in conformance with specific public laws and regulations (i.e. Federal Acquisition Regulation and Agency for International Development Acquisition Regulation). The Contractor and the COTR shall bring all contracting problems to the immediate attention of the Contracting Officer. Only the Contracting Officer is authorized to formally resolve such problems. The Contracting Officer will be responsible for resolving legal issues, determining task order scope and interpreting task order terms and conditions. The Contracting Officer is the sole authority authorized to approve changes in any of the requirements under this task order.

Notwithstanding any clause contained elsewhere in this task order, the said authority remains solely with the Contracting Officer. These changes include, but will not be limited to the following areas: scope of work, price, quantity, technical specifications, delivery schedules, and task order terms and conditions. In the event the Contractor effects any changes at the direction

of any other person other than the Contracting Officer, the change will be considered to have been made without authority.

(e) Failure by the Contractor to report to the Administrative Contracting Office any action by the Government considered to be a change, within the specified number of days contained in FAR 52.243-7 (Notification of Changes), waives the Contractor's right to any claims for equitable adjustments.

(f) In case of a conflict between this task order and the COTR designation letter, the task order prevails.

[END OF SECTION G]

SECTION H – SPECIAL TASK ORDER REQUIREMENTS

H.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

The following contract clauses pertinent to this section are hereby incorporated by reference (by Citation Number, Title, and Date) in accordance with the clause at FAR 1152.252-2 CLAUSES INCORPORATED BY REFERENCE" in Section I of this contract. See FAR 52.252-2 for an internet address (if specified) for electronic access to the full text of a clause.

NUMBER	TITLE	DATE
	FEDERAL ACQUISITION REGULATION (48 CFR Chapter 1) AIDAR 48 CFR Chapter 7	
752.7027	PERSONNEL	DEC 1990
752.225-70	SOURCE, ORIGIN, AND NATIONALITY REQUIREMENTS	FEB 1997

H.2 752.7007 PERSONNEL COMPENSATION (April 2006) (pursuant to class deviation No. OAA-DEV-2006-02c, AAPD 06-03)

- (a) Direct compensation of the Contractor's personnel will be in accordance with the Contractor's established policies, procedures, and practices, and the cost principles applicable to this contract.
- (b) Reimbursement of the employee's base annual salary plus overseas recruitment incentive, if any, which exceed the USAID Contractor Salary Threshold (USAID CST) stated in USAID Automated Directives System (ADS) Chapter 302 USAID Direct Contracting, must be approved in writing by the Contracting Officer, as prescribed in 731.205-6(d) or 731.371(b), as applicable.

H.3 ADDITIONAL REQUIREMENTS FOR PERSONNEL COMPENSATION

(a) Limitations:

- (1) Salaries and wages may not exceed the Contractor's established policy and practice, including the Contractor's established pay scale for equivalent classifications of employees, which shall be certified to by the Contractor. Nor may any individual salary or wage, without approval of the Cognizant Contracting Officer, exceed the employee's current salary or wage, or the highest rate of annual salary or wage received during any full year of the immediately preceding three (3) years.
- (2) In addition, there is a ceiling on the reimbursable base salary or wage paid to personnel under the Contract equivalent to the maximum annual salary rate specified in section H.3 above unless an advance written waiver is granted by the USAID Procurement Executive prior to contract award.

(b) Salaries during Travel

Salaries and wages paid while in travel status will not be reimbursed for a travel period greater than the time required for travel by the most direct and expeditious air route.

(c) Return of Overseas Employees

Salaries and wages paid to an employee serving overseas who is discharged by the Contractor for misconduct, inexcusable nonperformance, or security reasons will in no event be reimbursed for a period which extends beyond the time required to return him promptly to his point of origin by the most direct and expeditious air route.

(d) Annual Salary Increases

One annual salary increase (includes promotional increase) shall be based on the Contractor's established policy and practice. Annual salary increases of any kind exceeding these limitations or exceeding the maximum salary in Section H.3 may be granted only with the advance written approval of the Contracting Officer.

(e) Definitions

As used herein, the terms "Salaries," "Wages," and "Compensation" mean the periodic remuneration received for professional or technical services rendered, exclusive of any of the differentials or allowances defined in the clause of this contract entitled "Differentials and Allowances" (AIDAR 752.7028), unless otherwise stated. The term "compensation" includes payments for personal services (including fees and honoraria). It excludes earnings from sources other than the individual's professional or technical work, overhead, or other charges.

H.4 DEFENSE BASE ACT (DBA) INSURANCE

Pursuant to AIDAR 752.228-3 Worker's Compensation Insurance (Defense Base Act), USAID's DBA insurance carrier is:

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

Points of Contact:

Sara Payne or Diane Proctor
(703) 354-1616

Hours of Operation are: 8 a.m. to 5 p.m. (EST)

Telefax: (703) 354-0370

E-Mail: www.rutherford.com

H.5 752.228-70 Medical Evacuation (MEDEVAC) Services (April 2006)

(a) Contractor must provide MEDEVAC service coverage to all U.S. citizen, U.S. resident alien, and Third Country National employees and their authorized dependents (hereinafter "individual") while overseas under a USAID-financed direct contract. USAID will reimburse

reasonable, allowable, and allocable costs for MEDEVAC service coverage incurred under the contract.

The Contracting Officer will determine the reasonableness, allowability, and allocability of the costs based on the applicable cost principles and in accordance with cost accounting standards.

(b) Exceptions.

(i) The Contractor is not required to provide MEDEVAC insurance to eligible employees and their dependents with a health program that includes sufficient MEDEVAC coverage as approved by the Contracting Officer.

(ii) The Mission Director may make a written determination to waive the requirement for such coverage. The determination must be based on findings that the quality of local medical services or other circumstances obviate the need for such coverage for eligible employees and their dependents located at post.

(c) Contractor must insert a clause similar to this clause in all subcontracts that require performance by contractor employees overseas.

NOTE: USAID does not have a Medevac service provider. Contractors must meet this requirement in the most efficient manner. The following link is provided as a courtesy: http://travel.state.gov/travel/tips/health/health_1185.html.

H.6 AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services (for other than commodity related services) under this RFTOP is 935 (Special Free World). Pursuant to AIDAR clause 752.225-70, "Source Origin and Nationality," The Contractor must comply with the following descending order of preference, regarding the source and origin of such goods or commodities:

a) Order of Preference

Purchases of goods or services (other than commodity-related services) must follow the following descending order of preference:

- 1) The United States (USAID Geographical Code 000);
- 2) The Cooperating Country;
- 3) "Selected Free World" Countries (USAID Geographical Code 941);
- 4) "Special Free World" Countries (USAID Geographical Code 935).

b) Justifications and Documentation Requirements

When the Contractor purchases goods or services (other than commodity-related services) which are not of U.S. source and/or origin and/or from suppliers of non-U.S. nationality, the Contractor must document its files to justify each such instance. The documentation must set forth the circumstances surrounding the purchase, and must be based on one or more of the following reasons, which must be set forth in the Contractor's documentation:

1) The purchase was of an emergency nature, which would not allow for the delay in meeting the U.S. or other source, origin, and/or nationality preferences which are higher than the USAID geographic code applicable to the particular purchase;

2) The price differential for purchase of goods or services (other than commodity-related services) meeting U.S. or other source, origin, and/or nationality preferences which are higher than the USAID geographic code applicable to the particular purchase exceeded by more than 50% or more the delivered price of goods or services (other than commodity-related services) meeting U.S. or higher source, origin, and/or nationality preferences;

3) Compelling local political considerations precluded consideration of goods or services (other than commodity-related services) meeting U.S. or other source, origin, and/or nationality preferences, which are higher than the USAID geographic code applicable to the particular purchase;

4) Goods or services (other than commodity-related services) not meeting U.S. or other source, origin, and/or nationality preferences which are higher than the USAID geographic code applicable to the particular purchase were not available; or

5) Purchase of locally available goods or services (other than commodity-related services) not meeting U.S. or other source, origin, and/or nationality preferences which are higher than the USAID geographic code applicable to the particular purchase, as opposed to purchase of goods or services (other than commodity-related services) which met U.S. or other source, origin, and/or nationality preferences which are higher than the USAID geographic code applicable to the particular purchase, would best promote the objectives of the Foreign Assistance program under the Task Order.

H.7 LANGUAGE REQUIREMENTS

All deliverables shall be produced in English.

H.8 INTERNATIONAL TRAVEL APPROVAL

In accordance with the clearance/approval requirements in paragraph (a) of AIDAR 752.7027 PERSONNEL (DEC 1990) (incorporated by reference above) and AIDAR 752.7032 INTERNATIONAL TRAVEL APPROVAL AND NOTIFICATION REQUIREMENTS (JAN 1990) (incorporated in Section I), the Contracting Officer shall provide prior written approval but the Contractor shall be required to obtain the COTR's written concurrence with the assignment

of individuals outside the United States before the assignment abroad, which must be within the terms of this task order, is subject to availability of funds, and should not be construed as authorization either to increase the estimated cost or to exceed the obligated amount. The Contractor shall retain for audit purposes a copy of each travel concurrence.

H.9 REPORTING OF FOREIGN TAXES

(a) Reports. The Contractor must annually submit an annual report by April 16 of the next year.

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

(1) Contractor name.

(2) Contact name with phone, fax and email.

(3) Agreement number(s).

(4) Amount of foreign taxes assessed by a foreign Government 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.

(5) Only foreign taxes assessed by the foreign government in the country receiving U.S. assistance is to be reported. Foreign taxes by a third party foreign government are not to be reported. For example, if an assistance program for Lesotho involves the purchase of commodities in South Africa using foreign assistance funds, any taxes imposed by South Africa would not be reported in the report for Lesotho (or South Africa).

(6) Any reimbursements received by the Contractor during the period in (iv) regardless of when the foreign tax was assessed plus, any reimbursements on the taxes reported in (iv) received by the Contractor through March 31.

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

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

(c) Definitions. For purposes of this clause:

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

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

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

(4) "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:

USAID/Zambia
Controller's Office
351 Independence Avenue
Lusaka

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

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

H.10 GRANTS UNDER CONTRACT

The Head of the Contracting Activity (HCA) for the ordering activity must provide written approval to allow task orders for a USAID-direct contractor to execute grants up to \$100,000 (unless a deviation is obtained to have this threshold increased) with US organizations (not-for-profits or for-profits), providing conditions in ADS 302.3.4.8 are met. For non-US organizations there is no ceiling unless a fixed obligation grant is executed in which case the ceiling is \$250,000.

If not provided by USAID, the contractor shall develop grants formats and provide a field grant guide that adheres to USAID regulations (including selection criteria, competition, cognizant Contracting Officer approvals, etc.). If the grants formats and field guide are not provided before award to the Contracting Officer, the contractor shall obtain approval from the Contracting Officer within 45 days after award.

The contractor shall comply with all USAID policies, procedures, regulations, and provisions set forth in the contract and ensure

- (1) sufficient time to complete grantee audits,
- (2) sufficient time for the grantee to submit a final report to the contractor, and
- (3) sufficient time for the contractor to complete its review of the grantee and provide a final report to the government before contract or task order close-out.

All grants must be closed out no later than the end date of the task order. Reporting requirements shall be in accordance with Section F.

[END OF SECTION H]

SECTION I – CONTRACT CLAUSES

I.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

Reference: Technical Assistance and Support Contract 3 (TASC 3) IQC

I.2 52.252-2 CLAUSES INCORPORATED BY REFERENCE (FEB 1998)

This task order incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this/these address (es):

<http://arnet.gov/far/>

<http://www.usaid.gov/policy/ads/300/aidar.pdf>

I.3 SPECIAL PROVISIONS

a) Directing and re-directing during implementation

(i). Activities under this Task Order forms part of USG/Zambia program under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the President's Malaria Initiative (PMI) and the forthcoming Global Health Initiative. Funding levels, guidance, priorities and management are evolving and will continue to evolve over the life of the award. The contractor is expected to maintain a degree of flexibility, and to work with USAID in designing, prioritizing, implementing and evaluating these activities.

(ii). USAID/Zambia is required to develop specific activities and funding requests each year for the PEPFAR Country Operational Plan (COP). Once the activities and associated funding levels shown in each fiscal year COP are approved by the Office of the Global AIDS Coordinator (OGAC), the contractor will be required to implement them and this will be reflected as an attachment through subsequent modifications to the Task Order.

[END OF SECTION I]

SECTION J – LIST OF DOCUMENTS EXHIBITS AND OTHER ATTACHEMENTS

Attachment Number	Title
J.1	Additional References
J.2	Acronyms
J.3	Environmental Compliance Guidelines
J.4	USAID FORM 1420-17 Contractor Biographical Data Sheet*

* A hard copy is attached at the end of this document; however, for an electronic version, please locate the form at <http://www.usaid.gov/forms/>. The copy of the form is being provided herewith for reference purpose only.

[END OF SECTION J]

SECTION K – REPRESENTATIONS, CERTIFICATIONS, AND OTHER STATEMENTS

Offerors must certify that the representations and certifications submitted under the basic IQC still apply.

[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 (CPFF) task order as a result of this RFTOP; however, it reserves the right to make multiple awards or no award.

L.2 ACQUISITION SCHEDULE

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

Stage	Date
RFTOP issued	December 03, 2009
Questions due	December 21, 2009
Answers to questions disseminated	December 24, 2009
Proposals due	January 22, 2010
Technical evaluation, negotiations and award documentation completed	April 26, 2010
Clearances and award of task order	April 30, 2010
Debriefings begin (if required)	May 7, 2010
Contractor mobilization and post award meeting	May 27, 2010

All Questions relating to this RFTOP must be submitted to Cecilia Kasoma at oa-solicit-lusaka@usaid.gov via email no later than December 21, 2009 17:00 hours Zambia time.

Unless otherwise notified by an amendment to the RFTOP, no questions will be accepted after this date. Offerors must not submit questions to any other USAID staff, including the technical office for either the Task Order or the basic IQC.

L.3 TECHNICAL PROPOSAL INSTRUCTIONS

Each offeror must submit a full proposal consisting of a technical proposal and a cost proposal. Both proposals must include a table of contents facilitating access to sections and ensuring ease of review.

Offerors must submit their full proposals to the location(s) by the date and time indicated in the cover letter that accompanies this RFTOP. USAID/Zambia will review all proposals received by the deadline for responsiveness to the general, technical, and cost proposal instructions. USAID/Zambia will not review late, incomplete, or faxed proposals.

Each offeror should retain one copy of the full proposal. The individual signing the proposal must initial erasures and/or other changes.

L.3.1 FORMAT

Type the technical proposal in English, with one-inch (2.54 cm) margins on all sides, in a single column. Use Times New Roman (12 points or larger); figures and tables may feature different fonts in smaller font sizes (e.g., Arial, 10 points) but must be easily readable.

The narrative body may include text boxes, but type all text in Times New Roman (12 points or larger) and format these boxes such that they do not interfere with readability.

Do not exceed 45 pages, excluding the cover, table of contents, and attachments. Insert page numbers on all pages. Avoid any excessively elaborate formatting/presentation to facilitate duplication and readability. USAID/Zambia may not review anything over 45 pages.

For the attachments, label each one, list them in the table of contents, and include them at the end of the technical proposal. An English translation must accompany any attachment not originally prepared in English. Do not submit superfluous materials as attachments that will detract from the technical proposal. Insert page numbers on all pages.

Submit the entire technical proposal (including the cover, table of contents, and attachments) both in hard copy and by e-mail.

L.3.2 CONTENT

Offerors should demonstrate their technical expertise and management capabilities to undertake the activities described in the statement of work. Technical proposals must include the following five sections regardless of how they conform to the 45-page limit:

- Executive summary;
- Strategic and technical approach (including the framework/model and plan for developing capacity and building sustainability and response to the case study);
- Performance management and evaluation plan;
- Staffing and key personnel; and,
- Organizational mission, capacity, and past performance.

L.3.3 EXECUTIVE SUMMARY

This section must not exceed three pages and should contain the following information:

- Brief description of the strategic approaches;
- Brief description of the technical approaches, including innovations, public-private partnerships, and gender issues;
- Brief description of approaches to develop capacity and build sustainability;

- Identification of major outcome indicators, specifying end-of-program targets as well as data collection and reporting methods;
- Identification of sub-partners in Zambia, including their names, type of relationship (e.g., sub-contract or strategic/technical collaborator), and level of program funding to be expended;
- Level of USAID funding requested and cost-share amount (if applicable);
- Proposed start and end dates; and,
- Main authors of the application/proposal and responsible representative(s) from the headquarters, regional, and/or in-country office(s).

L.3.4 STRATEGIC AND TECHNICAL APPROACH

Offerors must propose how to carry out the statement of work. They must demonstrate a clear understanding of the work to be undertaken and the responsibilities of all parties involved. Offerors must describe a clear and comprehensive plan and rationale on the technical approaches and activities to complete the tasks in the statement of work. They must depict the linkages between the tasks, activities, and outcomes in a program components flow chart (see annex A for a standard format) as an attachment. Additionally, offerors must submit a work plan matrix for the first year of program implementation as an attachment.

Offerors must describe a clear and comprehensive strategic approach to engage governmental entities, organizational sub-partners, community/faith-based groups, and other stakeholders to complete the tasks in the statement of work. As part of this description, they must discuss the main roles and responsibilities, including the technical approaches/activities, which partners/stakeholders shall undertake as well as a clear plan for selecting the communities/districts in which project activities will be undertaken.

Offerors must describe a clear and comprehensive strategic approach to work with stakeholders in the organization, integration, management, and support of health service delivery that will sustain the positive health impacts (e.g., reductions in morbidities and mortalities associated with early childhood diseases, HIV/AIDS, STIs, and malaria or a reduction in total fertility rate).

Offerors must describe a comprehensive approach to private sector engagement that (a) demonstrates understanding of the need and potential for such engagement, including through GDAs, and how potential partnerships will contribute to project objectives and to the business interests of potential partners; (b) provides an appropriate approach for private sector partner engagement, with a focus on innovative approaches and sustainable development outcomes and a detailed explanation of how partnerships, including leveraged funds, will be solicited, established and managed; and (c) demonstrates how the proposed private sector engagements contribute to improved health outcomes.

As part of the technical approach, offerors must provide a coherent plan, grounded in a sustainability framework or model (with illustrative indicators), which (a) develops local capacity and processes to enable continuity of health benefits, and (b) supports increasing local responsibility and “ownership” for operation of activities. Please refer to Section C.4.5.9 for more details.

Offerors must delineate key gender factors that influence access to and use of health products, services, and information by both male and female clients based on measurable indices, devise specific interventions with which to resolve the issues/problems, and put in place the appropriate means to track and report progress.

Additionally, offerors must demonstrate how the following key principles will be incorporated in the execution of this task order:

- Alignment,
- Partnerships,
- Linkages,
- Innovation,
- Continuity of care,
- Zambian leadership and human resources support,
- Gender integration,
- Attention to the environment
- Sustainability
- Resource integration

Case Study: Offerors’ response to the case study questions should be no more than five pages as part of the 45 page limit.

Choose a district in Zambia which is implementing HIV/AIDS and other health activities, and present the relevant health and family planning data for that district. Identify the two or three major gaps in RH/FP and maternal and child health that the project could target, and design a strategy that will strengthen both the facilities and communities in that district. Illustrate a comprehensive program approach, including activities to strengthen the demand and supply side of RH/FP and MCH, and integrate them with ongoing HIV, malaria and other health activities. Show how you will do monitoring and evaluation to determine effectiveness and progress attributable to project activities.

Offerors are encouraged to propose innovative approaches/activities, as part of a clear and comprehensive plan and rationale, to complete the tasks in the statement of work.

L.3.5 Performance Management and Evaluation Plan

Offerors must describe a plan to manage governmental entities, organizational sub-partners, community/faith-based groups, and other stakeholders to complete the tasks in the statement of work. As part of this description, they must discuss the assignment of management and decision-making authorities to partners/stakeholders and their relationships with the offeror, distinguishing between entities with whom they intend to enter into an implementing agreement

and others with whom they intend to collaborate, but not transfer program funds. Additionally, offerors must discuss how to coordinate and oversee the work of these partnerships, including components to build capacity for program implementation. They must also discuss ways to solicit active involvement by USAID/Zambia, GRZ, and other stakeholders in Zambia who will guide program planning, decision-making, implementation, monitoring, and evaluation.

Offerors must discuss their ability and experience in rapid development of partnerships with governmental entities, organizational sub-partners, and community groups to facilitate uninterrupted delivery of health services in one or more Southern African countries.

Offerors must identify the output and outcome indicators that correspond to the major activities as well as the outcome indicators that correspond to the tasks. This section should specify the end-of-program targets and year-to-year milestones for the output and outcome indicators, including indicators and targets for private sector engagement and/or GDAs. Monitoring and evaluation plans must explicitly consider gender issues. Offerors must ensure that all indicators meet USAID/Zambia's reporting needs for the OP, MOP, PMP, and PEPFAR.

Offerors must identify the information sources, data collection and reporting methods, and assumptions for each output and outcome indicator. This section should: (a) identify the kinds of data collection and reporting systems that already exist; (b) describe how the proposed performance monitoring and evaluation plan will leverage these systems; (c) describe the kinds of assessments, studies, or surveys that the offeror will carry out to complement these systems while meeting the reporting needs for the program and USAID/Zambia.

Offerors must propose a plan to communicate success and share lessons within their organizations and with relevant in-country stakeholders.

L.3.6 Staffing and Key Personnel

Offerors must propose an organizational structure by: identifying the key positions; describing their main technical and/or administrative functions; and specifying their locations, authorities, reporting relationships, and lines of communication within the organization and with sub-partners and stakeholders, as appropriate. Additionally, they must identify headquarters and/or regional staff who will backstop the program. For these staff members, offerors must: (a) specify the percent of effort devoted to the program; (b) describe their roles and responsibilities; and (c) discuss their linkages with in-country program staff. Offerors must depict the organizational structure in an organogram format, showing the program, headquarters, and regional linkages.

Offerors must identify candidates to fill the key positions and include their CVs as attachments. Each CV must detail the requisite qualifications and experience of the candidate. References with contact information are also required. Each CV must not exceed five pages in length. Qualifications, experience, and skills must be placed in chronological order starting with the most recent information.

A list of all proposed key personnel candidates, descriptions of the relevant skills they bring to the performance of this program, their CVs, and letters of commitment must be included as attachments. The signed letters of commitment from each candidate must indicate his/her: (a) availability to serve in the stated position, in regular terms of days after award; (b) intention to serve for a stated term of service; (c) agreement to the compensation levels which corresponds to the levels set forth in the cost proposal; and (d) prior work experience. For each key personnel candidate, the offeror must submit at least three references from professional contacts over the past three years, in addition to each candidate's current and complete contact information (including an e-mail address).

According to USAID Acquisition Regulation 722.170, remuneration for Zambian and third country national (TCN) staff hired to work for the ZISSP in Zambia may not exceed the prevailing compensation paid to Foreign Service National staff [according to the local compensation plan(LCP)] performing comparable work in USAID/Zambia. Zambian and TCN staff may not receive allowances or differentials. However, the Mission Director of USAID/Zambia may waive these regulations in special circumstances. Offerors must provide full and appropriate justification for each proposed Zambian and/or TCN staff member for consideration by the Mission Director for pay above USAID/Zambia LCP.

L.3.7 Organizational Mission, Capacity, and Past Performance

Offerors must state their general purpose and annual budget, including funding sources.

Offerors must discuss their experience in designing, implementing, monitoring, and evaluating similar health programs. Experience building and managing GDAs and/or other public-private partnerships, and the results of such partnerships must be described. As evidence of such experience, at least three references should be included in an attachment. Each reference must describe any contract, cooperative agreement, and/or grant on a similar health program that the offeror has executed over the past three years. As part of the description, each reference must include the following information:

- Name and address of the organization for which the work was performed;
- Name, current telephone number, and current e-mail address of a responsible representative from the organization for which the work was performed;
- Contract/grant name and number (if any);
- Beginning and end dates;
- Total and annual amounts received;
- Brief descriptions of activities; and
- Brief descriptions of results achieved to date.

USAID/Zambia does not require reference letters from the organization(s) for which the offeror performed the work.

USAID/Zambia directs offerors to participate in the mission's "green" initiative to operate and support development programming in environmentally-friendly ways. Offerors must discuss

their organizational commitment and experience to protect the environment. Examples of such commitment and experience include:

- Establishing and enforcing an organization-wide “green” policy and strategy that reflects the International Organization for Standardization (ISO) 14000 standard for environmental management systems and other guidance;
- Purchasing and using “green” products from suppliers (e.g., paper products and shipping materials made from recycled materials, vehicles with fuel-efficient features);
- Reducing waste and recycling and reusing materials at every opportunity;
- Repairing rather than throwing away whenever possible;
- Reducing electrical energy consumption in offices and other facilities (e.g., by installing energy-efficient lighting systems, encouraging employees to turn off lights and computers when they leave their offices);
- Encouraging car pooling and designing travel routes to minimize fuel consumption and promote responsible work-related travel;
- Receiving electronic business documentation from institutional partners whenever possible; and,
- Monitoring compliance with “green” policies and strategies in usage reports and cost savings documentation.

L.3.7 Branding Implementation Plan (BIP) and Marking Plan

The BIP and Marking Plan will be evaluated as outlined in Section D.

L.3.8 Attachments

Offerors must include the following attachments at the end of their technical proposals:

- Work plan matrix for the first year of program implementation;
- Organogram;
- CVs of candidates filling the key positions; and,
- At least three references of previous and/or current experiences in designing, implementing, and evaluating similar health programs over the past three years.

L.4 INSTRUCTIONS FOR THE PREPARATION OF COST PROPOSAL

(a) Offerors shall submit the cost/business management proposal in sealed envelopes clearly marked on the outside with the following information:

"Cost/Business Management Proposal - *ZAMBIA INTEGRATED SYSTEMS STRENGTHENING PROGRAM (ZISSP)*"

(b) Offeror shall submit a budget with one costed option as follows:

Total Base Contract (without option)	\$87m to \$89m
Option	\$9m to \$10m
Total with options	\$96m to \$99m

This task order will receive funding from several different subaccounts, including HIV, RH/FP, MCH and malaria. The following table depicts the illustrative proportion of funding from each of the four major accounts. As strategies evolve, funding proportions may evolve as well. Importantly, the following table is only an estimate of USG resources, and does not include resources leveraged through partnerships, GDAs or other sources.

Offerors should submit a budget not to exceed a total estimated cost of \$99,400,000 (the option budget must be separate) over a period of five years from the date of award. Subject to the availability of funding, USAID/ Zambia plans to initially provide resources of approximately \$10,000,000 in year 1 with the following breakdown/elements:

Task / Subtask	Illustrative Funding Proportion			
	HIV	RH/FP	MCH	Malaria
Task 1: Strengthen the ability of the MOH at the national level to plan, manage, supervise and evaluate delivery of health services nationwide				
1.1 Second personnel to the MOH				
1.1.1 Human Resources for Health	90%	5%	5%	
1.1.2 Family planning		100%		
1.1.3 Emergency Obstetric and Newborn Care	10%	10%	80%	
1.1.4 Child Health and Nutrition			90%	10%
1.2 Strengthen NMCC and MOH for malaria control				100%
1.3 Participate and support TWGs	25%	25%	25%	25%
Task 2: Improve management and technical skills in order to increase use of quality health services within target districts				
2.1 Increase capacity of provincial team	50%	20%	20%	10%
2.2 Increase capacity of district teams	50%	20%	20%	10%
2.3 Implement province and district malaria activities				100%
Task 3: Increase community involvement in the production of health				
3.1 Undertake effective health communication programs	25%	25%	25%	25%
3.2 Support improved community health worker services	25%	25%	25%	25%
3.3 Strengthen involvement of traditional and other leaders	25%	25%	25%	25%
Task 4: Ensure service delivery and other activities are effectively integrated at all appropriate levels of the health system through joint planning with partners, in-kind activities, and appropriate PPPs.		50%	35%	15%

(c) For budgeting purposes salary rates (i.e., the employee's base annual salary plus overseas recruitment incentive, if any) shall not exceed the maximum rate for agencies without a certified

SES performance appraisal system, as published in the Federal Register, for US employees; and the Local Employee Compensation Plan (LECP) for CCN employees.

The basic daily salary/fee rates for each U.S. or expatriate employee shall be escalated at the ceiling rate proposed by the offeror or identified/definite subcontractor(s) but shall not exceed the maximum rate for agencies without a certified SES performance appraisal system, as published in the Federal Register.

The basic daily salary/fee rates for each Cooperating Country National (CCN) employee shall be escalated at not more than 5% per year for estimating purposes. Actual CCN employee salary shall not exceed the following salary range for various CCN staff positions:

<u>CCN Grades</u>	<u>Position</u>
FSN1-FSN5: \$ 4,518 - \$10,664	Clerk, Driver, Janitor
FSN6-FSN8: \$8,497 - \$21,363	Administrative & Support staff
FSN9-FSN10: \$15,520 - \$29,317	Junior Professional staff
FSN11-FSN12 \$27,996 - \$55,025	Senior Professional & Specialist staff
FSN 13 \$42,246 - \$67,593	Exceptional scale for highly compensated staff

For the above salary figures the following exchange rate was used:

Exchange rate used: \$1 = K4, 610 as of November 24, 2009

Please note:

(a) The above exchange rate is NOT to be considered an official rate for purpose of this RFTOP. Offerors are expected to indicate a conservative exchange rate for budget purposes.

(b) Third Country Nationals (TCNs) are subject to the same restrictions as CCN's. Therefore, if offerors propose to hire a TCN at a higher level of skill than CCNs, where proposed salaries and salary escalation is expected to be on the same basis as US employees, the offeror shall seek Mission Director's approval for those TCNs in accordance with USAID policies on compensation as set forth in AIDAR 722.170. Budget approval, in this case, shall not be deemed a sufficient substitute for Mission Director's approval. Therefore, any desired waivers will have to be explicitly approved after award by the Mission Director.

The current Mission policy encourages the hire of local staff. Where it is necessary to employ a TCN, the appointment must be for a limited time not exceeding three 3 years on the contract. Further, salary waivers for local employees will only be granted under very special consideration. Offerors are therefore advised to ensure that salaries are within the salary range provided above for USAID/Zambia.

(c) Offerors must provide their organization salary scale for local employees and ensure that all statutory fringe benefits are incorporated in the budget such as workmen compensation, pension, severance payment/gratuity, etc.

(i) Salary Information

Bio-data sheets and CVs should only be submitted for local and expatriate professional staff.

(ii) Fringe Benefit Information

Unless the offeror's Negotiated Indirect Cost Rate Agreement contains a fringe benefit rate(s), the rate(s)/factor(s) proposed shall be supported by a detailed breakdown comprising each item of fringe benefits (e.g. unemployment insurance, workers compensation, health and life insurance, retirement, severance pay, FICA, etc.) and the costs of each, expressed in U.S. dollars for both US and CCN employees. Each page shall have the prime contractor's (or identified/definite subcontractor's) name clearly marked. A tab or colored divider page shall separate the prime contractor's and each identified/definite subcontractor's fringe benefit information.

(iii) Direct Costs

The proposal shall contain a complete cost breakdown as described below. The costs should be allocated separately, as appropriate, to the offeror (prime contractor) and each identified/definite subcontractor, with each such subcontractor specifically identified. This would include:

(a) Travel, Transportation, and Per Diem

Estimated travel and transportation costs shall be in accordance with the clause entitled "Travel and Transportation" (AIDAR 752.7002) and shall be based on estimated travel and transportation costs, indicated by the number of trips, domestic and international, duration of travel, the number of individuals traveling, mode of transportation, and unit prices, and the subtotal of all travel and transportation costs. Estimated per diem cost must be in accordance with Section 925 of the Standardized Regulations (Government civilians, Foreign Areas). The breakdown of per diem costs will be tied to the travel itinerary and work-days, and must specify, location(s), number of days in each location, the per diem rate for each location, and the subtotal for all per diem costs.

(b) Purchases of Nonexpendable Personal Property

The detailed budget breakdown for purchases of nonexpendable personal property and long-term lease of motor vehicles shall include the types and quantities of nonexpendable personal property to be purchased, the unit prices, and the total costs. The types and quantities of nonexpendable personal property must be consistent with the information provided in the technical proposal.

Equipment that follows under the capitalization threshold of the offeror must be supported with at least three quotations.

(c) Other Direct Costs (ODCs)

The detailed budget breakdown shall present the basis for all other items of direct cost. ODCs include costs such as allowances, communications, passports/visas, medical exams/inoculations (for international travel), DBA insurance, medical evacuation services, purchase of expendable

property), lease/rentals of nonexpendable property, report preparation/reproduction, publications, office rent, etc.

(iv) Indirect Cost Information

The detailed budget breakdown must be structured in such a way as to clearly and easily identify the rate(s) being used, the base(s) to which the rate(s) is (are) applied, and the resulting amount of dollars. The indirect cost rate must be in compliance with ceilings rates set forth in Section B.7 of the basic contract.

(v) Fixed Fee

The detailed budget breakdown must indicate the fixed fee (if applicable) in dollars, and indicate the percentage that the base fee dollars is to the total estimated costs. The fixed fee proposed must be in compliance with the fixed fee limitations (if any) set forth in the Basic Contract.

(vi) In addition the Offeror shall provide the following:

(a) Ceiling Rate on Annual Non-CCN Employee Salary Increases

The offeror shall propose a ceiling rate on annual non-CCN salary increases for its employees and employees of identified/definite subcontractors. The ceiling rates on annual non-CCN employee salary increases must be the same for each year of the task order and must apply to non-CCN employees regardless of whether the non-CCN employee is an employee of the offeror (prime contractor) or an identified/definite subcontractor. Offerors are cautioned against proposing a ceiling rate on annual non-CCN employee salary increases which is too low to attract and retain qualified personnel. Use of "average" ceiling rates, ceilings on non-CCN salary increase dollars, or ceiling rates which vary from year-to-year, are not acceptable.

(b) Purchasing/Leasing Information

The offeror shall include documentation to demonstrate the basis for the unit price(s), such as suppliers' quotes, *pro forma* invoices, catalog excerpts, etc., for all purchases or leases/rentals of nonexpendable personal property to be acquired. The offeror shall also provide a lease vs. purchase analysis for each item of nonexpendable personal property.

(c) Contractor Employee Biographical Data Sheets

The offeror shall submit completed Contractor Employee Biographical Data Sheets for each individual whose salary/consulting fee will be charged as a direct cost to the Task Order. The offeror shall propose which positions/ individuals are considered key/essential to the work to be performed. The form must be signed by the individual and the offeror (or subcontractor) in the appropriate spaces with all blocks completed. Consulting fees must clearly specify the number of days for each consultancy. If the individual is on an appointment of less than 12 months (*e.g.*, an academic year appointment for a university faculty member), the form must indicate the number of months in the appointment period. Use of Biographical Data Sheets which are more than three months old is not acceptable. Biographical Data Sheets must be presented in alphabetical order, by the individual's last name, regardless of whether the individual is to be

furnished by the prime contractor or a subcontractor. The form must reflect the earnings for the three preceding years, and the date when salary increases went into effect must be indicated. If the form reflects only the highest salary of the most recent employer, the date when such salary went into effect must be indicated. If continuation sheets are used, each must contain the individual's name, signature, and date.

(d) If the offeror proposes to purchase any restricted goods AIDAR 752.225.70 under the Task order, the offeror shall identify, for each restricted good, the types of goods, the number of units, the unit price(s), the total costs, and the expected source, origin, and supplier nationality.

(e) The same information must be provided for any subcontractor. A tab or colored divider page shall separate the prime contractor's and each subcontractor's purchasing/leasing information. The offeror's (or subcontractor's) name must be indicated on each page.

(f) Costs of Communications Products

The proposal must, to the maximum practicable extent, include the estimated costs, with a complete cost breakdown, for each communications product for which USAID approval is required.

(g) Evidence of Subcontractors' Agreements

The proposal must include a letter, on subcontractor letterhead, and signed by an authorized representative of each subcontractor, which specifically states the following:

(A) The subcontractor's agreement to be included in the offeror's proposed teaming arrangement;

(B) A discussion and agreement on whether the prime contractor or the subcontractor will finance the subcontractor's performance;

(C) The subcontractor's agreement with the proposed ceiling rate for annual non-CCN salary increase; and

(D) A discussion and agreement on type(s) of subcontract(s) to be used, and applicable terms and conditions, unless the subcontract(s) will be essentially the same as the prime contract (with appropriate alterations to reflect the difference in the parties, and to reflect the fact that USAID will not have privity of contract with any subcontractor). Included in the discussion of applicable terms and conditions shall be the agreed-upon method of resolving any disputes which may arise between the prime contractor and the subcontractor. The clause entitled "Disputes" (FAR 52.233-01) may not be used in subcontracts.

(h) A tab or colored divider page shall separate the prime contractor's and each identified/definite subcontractor's indirect cost information. The offeror's (or

subcontractor's) name must be indicated on each page. For subcontracts not included in the Basic IQC the offeror shall submit the following:

(A) The most current Negotiated Indirect Cost Rate Agreement (NICRA) or other documentation from the subcontractor's cognizant U.S. Government Audit Agency, if any, stating the most recent final indirect cost rates and/or the current provisional or predetermined rates accepted by the cognizant U.S. Government Audit Agency, and the subcontractor's fiscal year (*e.g.*, October 1 through September 30).

(B) Each subcontractor's representations and certifications, as required.

(C) Evidence regarding responsibility of the subcontractor. Each subcontractor must be responsible in order to receive a subcontract.

(i) U.S. Small Business Subcontracting Plan

The proposal must include a U.S. small business subcontracting plan as required by the clause of the contract entitled "Small Business Subcontracting Plan". The plans are required even if the offeror does not plan to subcontract any performance, and the subcontracting goals would then be nil. The plans must follow the format and contain all of the information required by paragraph (d) of said clause. If any subcontractor will perform under the Task Order and the subcontract will exceed US\$500,000, and was not identified in the basic IQC, the subcontractor, if it is a U.S. organization and is not a U.S. small business, must submit a U.S. small business subcontracting plan.

[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.

M.2 TECHNICAL PROPOSAL EVALUATION CRITERIA

The evaluation criteria establish the standards against which all technical proposals will be assessed. The percentage of total points indicates the relative importance of the criterion. To facilitate the review of proposals, offerors should develop the narrative body with the same sections in the same order as specified in the content section of the technical proposal instructions. While close adherence to these guidelines are necessary, it does not guarantee a successful review.

The specific evaluation criteria are as follows:

Technical Evaluation Criteria	Weight
Strategic and Technical Approach ¹⁹	35 points
Overall Strategic and Technical Approach	
Response to Case Study Questions	
Framework/model and plan for developing capacity and building sustainability	
Innovation	10 points
Performance Management and Evaluation Plan	15 points
Staffing and Key Personnel	25 points
Organization, capacity and past performance	15 points
Total Possible Technical Evaluation Points	100

[END OF SECTION M]

^{2:1} The sub-factors are ranked in order of highest points

ATTACHMENTS (REFERENCE SECTION J)

ATTACHMENT J.1 – ADDITIONAL REFERENCES

Offerors may wish to refer to the following resources;

Available on the PMI website (www.pmi.gov)

- Malaria operational plans for the 15 focus countries

Available on the MOH website (www.moh.gov.zm):

- Selected national health policies, protocols, and guidelines, including the NHSP

Available on the National Malaria Control Center (www.nmcc.org.zm/)

- Selected strategies, plans, guidelines, surveys including the Malaria Indicator Survey of 2008

Available on the NAC website (www.nac.org.zm/resources.php):

- Selected national HIV/AIDS policies, protocols, and guidelines, including the NASF

Available on the Environmental Council of Zambia website (www.necz.org.zm):

- Environmental protection policies and guidelines

[End of Attachment J.1]

ATTACHMENT J.2 - ACRONYMS

ACT	Artemisinin-based Combination Therapy
ADS	Automated Directives System
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal care
APR	Annual Progress Report
ART	Antiretroviral treatment
BEO	Bureau Environmental Officer
CCP	Central Contraceptive Procurement Project
CDC	U.S. Centers for Disease Control and Prevention
CFR	Code of Federal Regulations
CoC	Continuum of care
COP	Country Operational Plan
COTR	Contracting Officer's Technical Representative
CP	Cooperating Partner
CT	Counseling and testing
CV	Curriculum vitae
DATF	District AIDS Task Force
DHMT	District Health Management Team
DHR&A	Directorate of Human Resources and Administration
EA	Environmental Assessment
EC	European Commission
EmONC	Emergency Obstetric and Neonatal Care
FAR	Federal Acquisition Regulations
FP/RH	Family planning/reproductive health
GDA	Global Development Alliance
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Hospital Management Team
HRHSP	Human Resources for Health Strategic Plan
IEE	Initial Environmental Examination
IMCI	Integrated Management of Childhood Illnesses
ITN	Insecticide-treated bednet
IPTp	Intermittent preventive treatment of pregnant women
IP	Implementing partner
IQC	Indefinite quantity contract
IRS	Indoor residual spraying
IUD	Intrauterine device
JICA	Japan International Cooperation Agency
M&E	Management/monitoring and evaluation
M&M	Mitigation and monitoring
MC	Male circumcision
MDG	Millennium Development Goal

MDR	Maternal Death Review
MOH	Ministry of Health
MSL	Medical Stores Limited
MTR	Mid-term Review of National Health Strategic Plan
NAC	National HIV/AIDS/STI/TB Council
NASF	National HIV/AIDS Strategic Framework
NGO	Non-governmental organization
NHSP	National Health Strategic Plan
NMCC	National Malaria Control Center
OI	Opportunistic infection
ORT	Oral rehydration therapy
PATF	Provincial AIDS Task Force
PEPFAR	President's Emergency Plan for AIDS Relief
PHN	Population, Health, and Nutrition
PHO	Provincial Health Office
PLWHA	People living with HIV/AIDS
PMI	President's Malaria Initiative
PMP	Performance Management Plan
SWAp	Sector Wide Approach
TASC 3	Technical Assistance and Support Contract 3
TFR	Total Fertility Rate
TWG	Technical Working Group
ZHWRS	Zambia Health Workers' Retention Scheme
ZISSP	Zambia Integrated Systems Strengthening Program

[End of Attachment J.2]

ATTACHMENT J.3 - ENVIRONMENTAL PROTECTION GUIDELINES

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Title 22 of the Code of Federal Regulations, Part 216 (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 201.5.10g and 204, which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. The offeror's environmental compliance obligations under these regulations and procedures are specified in the following paragraphs of this Request for Task Order Proposals (RFTOP).

In addition, the offeror must comply with Zambia's environmental policies, regulations, protocols, and guidelines unless otherwise directed in writing by USAID. These include the Technical Guidelines on Sound Management of Health Care Waste, issued by the Environmental Council of Zambia in 2007, which call for improvements in occupational health and safety for workers and clients in the health system. Such improvements include minimization of client contact with infectious waste and environmentally sound treatment of waste generated by health workers. In case of conflict between Zambian and USAID regulations, the latter shall govern.

No activity funded under this RFTOP will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in a Request for Categorical Exclusion (RCE), Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO).

The IEE covers activities expected to be implemented under this RFTOP. USAID has determined that a Negative Determination with conditions applies to one or more of the proposed activities. This indicates that if these activities are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The offeror shall be responsible for implementing all IEE conditions pertaining to tasks to be funded under this RFTOP. Additionally, before the expiration of the current IEE, the offeror will assist the PHN Office to develop a new version that will ensure environmental compliance for the program described in this RFTOP.

As part of its initial Work Plan, and all Annual Work Plans thereafter, the contractor, in collaboration with the Contracting Officer's Technical Representative (COTR) and Mission Environmental Officer or BEO, as appropriate, shall review all ongoing and planned activities under this RFTOP to determine if they are within the scope of the approved IEE. If the contractor plans any new activities outside the scope of the approved IEE, it shall prepare an amendment for USAID review and approval. No such new activities shall be undertaken prior to receiving written USAID approval of environmental documentation amendments. Any ongoing activities found to be outside the scope of the approved IEE shall be halted until an amendment is submitted and written approval is received from USAID.

Because the approved IEE contains one or more Negative Determinations with conditions applying to one or more of the proposed activities in the program described in this RFTOP, the contractor shall:

- Prepare a project mitigation and monitoring (M&M) plan describing how the contractor will, in specific terms, implement all IEE conditions that apply to proposed program activities within the scope of the award. The M&M Plan shall include monitoring the implementation of the conditions and their effectiveness.
- Integrate a completed M&M Plan into the initial Work Plan.
- Integrate the M&M Plan into subsequent Annual Work Plans, making any necessary adjustments to activity implementation in order to minimize adverse impacts to the environment.

A provision for sub-grants is included under this award; therefore, the contractor will be required to use an Environmental Review Form (ERF) or Environmental Review (ER) checklist using impact assessment tools to screen grant proposals to ensure the funded proposals will result in no adverse environmental impact, to develop mitigation measures, as necessary, and to specify monitoring and reporting. Use of the ERF or ER checklist is called for when the nature of the grant proposals to be funded is not well enough known to make an informed decision about their potential environmental impacts, yet due to the type and extent of activities to be funded, any adverse impacts are expected to be easily mitigated. Implementation of sub-grant activities cannot go forward until the ERF or ER checklist is completed and approved by USAID. The contractor is responsible for ensuring that mitigation measures specified by the ERF or ER checklist process are implemented. The contractor is also responsible for periodic reporting to the COTR regarding environmental compliance in subgrantee activities.

22 CFR 216 also applies to all GDA programs, exemplified by task 4 in this RFTOP. Before entering into a GDA partnership, the contractor shall assist the PHN Office in conducting a due diligence investigation of the private sector entity. Such an investigation will determine whether the prospective partner meets the “triple bottom line” – i.e., socially responsible, environmentally acceptable, and financially sound. The PHN Office will develop criteria in assessing the prospective partner’s operational practices, such as commitment to human rights, provision of decent work conditions, involvement in communities, in addition to environmental protection.

USAID anticipates that environmental compliance and achieving optimal development outcomes for the proposed activities will require environmental management expertise. Offerors should therefore include, as part of their proposal, their approach to achieving environmental compliance and management, to include:

- The offeror’s approach to developing and implementing the approved IEE through an M&M Plan;

- The offeror's approach to providing necessary environmental management expertise, including examples of past experience of environmental management of similar activities; and,
- The offeror's illustrative budget for implementing the environmental compliance activities (for the purposes of this RFTOP, offerors should reflect illustrative costs for environmental compliance implementation and monitoring in their cost proposal).

[End of Attachment J.3]

ATTACHMENT J.4 – USAID FORM 1420-17 - CONTRACTOR BIOGRAPHICAL DATA SHEET

CONTRACTOR EMPLOYEE BIOGRAPHICAL DATA SHEET						
1. Name (Last, First, Middle)			2. Contractor's Name			
3. Employee's Address (include ZIP code)			4. Contract Number		5. Position Under Contract	
			6. Proposed Salary		7. Duration of Assignment	
8. Telephone Number (include area code)		9. Place of Birth		10. Citizenship (If non-U.S. citizen, give visa status)		
11. Names, Ages, and Relationship of Dependents to Accompany Individual to Country of Assignment						
12. EDUCATION (include all college or university degrees)				13. LANGUAGE PROFICIENCY (see Instruction on Page 2)		
NAME AND LOCATION OF INSTITUTION	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading
14. EMPLOYMENT HISTORY						
1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.						
2. Salary definition – basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, commissions, consultant fees, extra or overtime work payments, overseas differential or quarters, cost of living or dependent education allowances.						
POSITION TITLE	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (M/D/Y)		Annual Salary		
		From	To	Dollars		
15. SPECIFIC CONSULTANT SERVICES (give last three (3) years)						
SERVICES PERFORMED	EMPLOYER'S NAME AND ADDRESS POINT OF CONTACT & TELEPHONE #	Dates of Employment (M/D/Y)		Days at Rate	Daily Rate	
		From	To		In Dollars	
16. CERTIFICATION: To the best of my knowledge, the above facts as stated are true and correct.						
Signature of Employee					Date	
17. CONTRACTOR'S CERTIFICATION (To be signed by responsible representative of Contractor)						
Contractor certifies in submitting this form that it has taken reasonable steps (in accordance with sound business practices) to verify the information contained in this form. Contractor understands that USAID may rely on the accuracy of such information in negotiating and reimbursing personnel under this contract. The making of certifications that are false, fictitious, or fraudulent, or that are based on inadequately verified information, may result in appropriate remedial action by USAID, taking into consideration all of the pertinent facts and circumstances, ranging from refund claims to criminal prosecution.						
Signature of Contractor's Representative					Date	

[END OF RFTOP]