



USAID | RWANDA

FROM THE AMERICAN PEOPLE

May 13, 2009

1. John Snow, Inc. (JSI)
44 Farnsworth Street
Boston, MA , 02210

Contract Number: GHS-I-00-07-00002-00

Points of Contact: Kenneth Olivola & Abul Hashem

Email address: TASC3@JSI.com

Phone Number: 617-482-9485

Fax Number: 617-482-0617

2. Abt Associates
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814

Contract Number: GHS-I-00-07-00003-00

Points of Contact: Nancy Pielemeier; Jennifer Bowman

Email address: TASC3@abtassoc.com

Phone Number: 301-913-0500

Fax Number: 301-652-3618

3. Chemonics International
1133 20th Street, NW
Washington, DC 20036

Contract Number: GHS-I-00-07-00004-00

Points of Contact: Richard Dreiman

Email address: TASC3@Chemonics.com

Phone Number: 202-955-3300

Fax Number: 202-955-3400

4. Research Triangle Institute International (RTI)
1615 M Street, NW
Washington, DC 20036

Contract Number: GHS-I-00-07-00005-00

Points of Contact: Amy Doherty & Mary Linehan

Email address: TASC3@rti.org

Phone Number: 202-728-2041

Fax Number: 202-974-7818

5. Management Sciences for Health (MSH)
784 Memorial Drive
Cambridge, MA 02139

Contract Number: GHS-I-00-07-00006-00

Points of Contact: Sharon Moerloos & Derek Reynolds

Email address: TASC3@msh.org

Phone Number: 617-250-9500

Fax Number: 617-250-9090

6. Family Health International (FHI)
Street Address: 2101 Wilson Blvd., Suite 700
City & State: Arlington, VA 22201

Contract Number: GHS-I-00-07-00007-00

Points of Contact: David Mein & Ed Scholl

Email address: TASC3@fhi.org

Phone Number: 703-516-9779

Fax Number: 703-516-9718

7. Academy for Educational Development (AED)
1825 Connecticut Avenue, NW
Washington, DC 20009

Contract Number: GHS-I-00-07-00008-00

Points of Contact: Petra Reyes & Miriam Schreier

Email address: TASC3@aed.org

Phone Number: 202-884-8000

Fax Number: 202-884-8491

8. Program for Appropriate Technologies in Health (PATH)
1455 New Leary Way

Seattle, WA 98107-5136

Contract Number: GHS-I-00-07-00009-00

Points of Contact: Suzanne Rexing & Eric Walker
Email address: TASC3@path.org

Phone Number: 206-285-3500
Fax Number: 206-285-6619

9. University Research Co., LLC (URC)
7200 Wisconsin Avenue
Bethesda, MD 20814

Contract Number: GHS-I-00-07-00010-00

Points of Contact: Tisna Velduyzen van Zanten & Stacy Kancijanac
Email address: TASC3@urc-chs.com

Phone Number: 202-728-2041
Fax Number: 202-974-7818

10. Population Council
One Dag Hammarskjold Plaza
New York, NY 10017

Contract Number: GHS-I-00-07-00011-00

Points of Contact: Alan Ring & Dr. Johannes Van dam
Email address: TASC3@popcouncil.org

Phone Number: 212-339-0500
Fax Number: 212-755-6052

11. The Manoff Group, Inc.
2001 S Street, NW
Washington, DC 20009

Contract Number: GHS-I-00-07-00012-00

Points of Contact: Marcia Griffitts & Laurie Krieger
Email address: TASC3@manoffgroup.com

Phone Number: 202-265-7469
Fax Number: 202-745-1961

12. Initiatives, Inc.
376 Boylston Street, Suite 4C
Boston, MA 02116

Contract Number: GHS-I-00-07-00013-00

Points of Contact: Joyce Lyons & Nicole Dupre
Email address: TASC3@initiativesinc.com

Phone Number: 617-262-02930
Fax Number: 617-262-2514

13. Medical Services Corporation International (MSCI)
1716 Wilson Blvd.
Arlington, VA 22209

Contract Number: GHS-I-00-07-00014-00

Points of Contact: George Contis & Cynthia Turner
Email address: TASC3@mscionline.com

Phone Number: 703-276-3000

14. CAMRIS International
1801 Rockville Pike, Suite 410
Rockville, MD 20852

Contract Number: GHS-I-00-07-00015-00

Points of Contact: Dr. Lawrance Day & Michele Teitelbaum
Email address: TASC3@CAMRISinternational.com

Phone Number: 301-770-6000
Fax Number: 301-770-6030

15. Emerging Markets Group (EMG)
2107 Wilson Blvd., Suite 800
Arlington, VA 22201

Contract Number: GHS-I-00-07-00016-00

Points of Contact: Margaret Dijkerman & Jill Mathis
Email address for RFTOPs: TASC3@emergingmarketsgroup.com

Phone Number: 703-373-7600

SUBJECT: Request for Task Order Proposal (RFTOP) No. 696-09-005 for Integrated Health Systems Strengthening Project – USAID/Rwanda

**REFERENCE: Technical Assistance and Support Contract, Three (TASC3)
Global Health IQC**

Dear Sirs/Madams:

Attached is a statement of work for a proposed task order not to exceed \$35,000,000 under the subject contract (Attachment 1). Please submit your technical and cost proposals for accomplishing the work requested in the Statement of Work attached via email to Marcus A. Johnson, Jr. at marcusjohnson@usaid.gov with a copy to Aster Kebede at askebede@usaid.gov no later than **June 15, 2009 at 3:00 p.m. Kigali, Rwanda Time.**

The Government intends to issue a Cost-Plus Fixed Fee Task Order for this request. The period of performance to accomplish all work requirements under this task shall not exceed a total of five (5) years. The proposal shall include the following:

1. Your technical proposal with your proposed approach to accomplish the work requirements, deliverables, key personnel, and/ or a pool of short term expatriate and/or cooperating country national specialists who may be called upon to perform work under the resultant task order, the availability of personnel to complete the work and a proposed time schedule for the work. The technical proposal shall be concise, no more than 25 pages – excluding the cover page and required attachments.
2. Your cost proposal for labor and "Other Direct Costs", such as travel, transportation, per diem, overseas allowances, in country training, non-expendable property, etc, including a detailed level of effort cost estimate. Please provide detailed level of effort information with a separate line item for each proposed individual and identify each by name and provide his/her resume. In the event that a specialist is not identifiable at the time of submission of the proposal, the offeror may show this as "TBD" (To Be Determined) but prior approvals shall be required before an individual commences working.

You must include a detailed narrative explanation of the basis of estimate for each proposed item. This explanation must identify the factors upon which the proposed costs were derived and show the arithmetic in reaching the cost figure. The information provided shall be sufficient enough so that a determination of its allocability, allowability, and reasonableness can be made by the Contracting Officer. All proposed personnel and/or consultant(s) rates shall be negotiated between the Contractor and the Contracting Officer.

3. Biographical Data for any proposed personnel and/or consultant which provides sufficient details to determine his/her suitability for the work to be performed and salaries (see Attachment 2 for a copy of AID Form 1420-17). This form can also be downloaded from the link below for USAID Forms.

4. A statement as to the relationship of the proposed individual(s) to the Contractor (e.g. employee, consultant, subcontractor employee).
5. A certification that no USAID employee has recommended an individual for use under the proposed task order who was not initially located and identified by your organization.
6. Lobbying Certification (Attachment 3).
7. Complete the attached Certificate of Current Cost or Pricing Data (Attachment 4).
8. Complete the Certification Regarding Responsibility Matters as required by FAR 52.209-5 (Attachment 5).
9. A certification regarding compliance with the anti-kickback procedures as required by FAR 52.203-7. (Attachment 6).

NOTE: Offerors are requested to guarantee that the key personnel included in their proposals will maintain their availability for the specific positions for a period of not less than, and preferably more than, 120 days from the time of submission of the Offer. Should the key personnel not be available for the position before the time limit has expired the offeror may no longer be considered for award.

Ensure that all enclosures are properly completed and signed. Should you have any questions, you may contact Marcus A. Johnson, Jr., e-mail: marcusjohnson@usaid.gov with a copy to Aster Kebede, e-mail: askebede@usaid.gov.

Please note that this does not constitute any guarantee that a task order will be awarded nor does it constitute any authorization by USAID to reimburse costs incurred in the preparation of a proposal.

Sincerely,

Marcus A. Johnson, Jr.
Regional Contracting Officer
USAID/East Africa

STATEMENT OF WORK

List of Acronyms

BCC	Behavior Change Communication
BTC	Belgian Technical Cooperation
CDC	Centers for Disease Control and Prevention
CHP	Community Health Policy
CHW	Community Health Worker
CIDC/TRAC+	Center for Infectious Disease Control
CNLS	National AIDS Control Center
COP	Country Operational Plan
c-PBF	Community Performance Based Financing
COTR	Contracting Officer Technical Representative
CSH	Child Survival and Health
CSO	Civil Society Organization
DIF	District Incentive Funds
DOD	Department of Defense
EDPRS	Economic Development and Poverty Reduction Strategy
FP	Family Planning
GOR	Government of Rwanda
HMIS	Health Management Information Systems
HRH	Human Resources for Health
HRMIS	Human Resources Management Information Systems
HSSP	Health Sector Strategic Plan
IGA	Income Generating Activities
IMCI	Integrated Management of Childhood Illnesses
LG	Local Government
LLIN	Long Lasting Insecticide- treated Net
LMIS	Logistics Management Information Systems
M&E	Monitoring and Evaluation
MCC	Millennium Challenge Corporation
MCH	Maternal and Child Health
MOH	Ministry of Health
MOP	Malaria Operational Plan
NHA	National Health Accounts
OVC	Orphans and Vulnerable Children
OP	Operational Plan
PBF	Performance Based Financing
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHA	People Living with HIV/AIDS
PMI	Presidents Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategic Plan
QI	Quality Improvement
RWF	Rwanda Francs

SMDP	Sustainable Management Development Program
SO	Strategic Objective
TWG	Technical Working Group
USAID	United States Agency for International Development
USG	United States Government

A. STATEMENT OF WORK

Title: Integrated Health System Strengthening Project

- I. Purpose:** The objective of this project is to strengthen the Government of Rwanda (GOR)'s capacity to provide high quality, client-oriented health and social services to all Rwandans in a sustainable manner. The project builds upon several years of U.S. Government (USG) support to the GOR in health system strengthening, health financing, health information systems, human resources for health (HRH), management, leadership and governance in support of delivery of quality health services. An efficient health system is one that relies on leadership, governance and accountability structures, policy frameworks, the right mix and deployment of staff, infrastructure and medical commodities, reliable and timely data; and one that mobilizes and allocates adequate financial resources towards healthcare delivery. Because these inputs into the health system are interconnected, this project will provide support to these various aspects of the health system. This project will support the overall health system to promote effective, safe and quality health services, with minimum waste of resources.
- II. Period of Performance and Funding Levels:** The period of performance for this task order is 5 years from an estimated award on or about August 31, 2009. To minimize implementation gaps, it is expected that the Contractor demonstrate the ability for a fast start up of country operations upon receipt of award. It is anticipated that the level of funding available for this five-year task order will not exceed \$35 million of which approximately 50% will be HIV/AIDS funds, 40% will be family planning/reproductive health (FP/RH) and maternal and child health (MCH) funds, and 10% will be from other programs (malaria, Democracy & Governance). In addition, this task order will collaborate with the Millennium Challenge Corporation (MCC) grants in civil society participation. The time period, annual funding levels, level of effort and primary focus areas are all subject to the availability of funding.

While an integrated approach is expected, the Contractor must maintain the ability to report separately on the use of each stream of funding, abiding by restrictions in the Foreign Appropriations Act (FAA) and other relevant requirements.

III. Background

A. Rwanda Country and Health Context

Rwanda is among the least developed countries in the world, ranking 161 out of 177 according to the 2008 Human Development Index. Home to 10.1 million people¹, it is the most densely populated country in sub-Saharan Africa. 60%² of the population lives below the poverty line. Significant gains have been made in reducing infant mortality (down from 86 to 62 deaths per 1,000 live births) as well as in modern contraceptive use which has increased from 10% to 27% over three years³. The country has made important progress since the 1994 genocide, but much remains to be accomplished if sustainable social and economic development is to take place.

¹ Rwanda National Institute of Statistics 2009

² United Nations Human Development Report 2007/2008

³ Interim Demographic and Health Survey 2007

Rwanda's economic development and poverty reduction strategy (EDPRS) provides a medium-term framework for achieving the country's long-term development aspirations. The strategy builds on strong achievements in human capital development and promotes three flagship programs: sustainable growth for jobs and exports; governance and vision 2020 umurenge⁴ - the GOR's framework for Rwanda's development. The emphasis on health in the EDPRS is to maximize high impact preventative health measures and build the capacity to have high quality and accessible health care services for the entire population in order to reduce malnutrition, infant, child and maternal mortality, fertility, as well as control communicable diseases. The capacity building includes strengthening institutional capacity, increasing the quantity and quality of human resources, ensuring that health care is accessible to the population, increasing geographical accessibility. Further information on the strategy can be found at http://www.rada.gov.rw/img/pdf/edprs_version_july_9th.pdf

B. The Health System in Rwanda

The Rwandan health sector operates under the core values of a sector-wide approach (SWAP). The three 'ones': one national framework, one national plan and one monitoring and evaluation system are the main principles of the SWAP. The USG is a signatory to the SWAP but does not provide direct funding.

Health services and delivery in Rwanda have their foundation in the GOR's recently revised Health Sector Strategic Plan II (HSSP II) (2009-2013). This strategic plan, based on the goals of Vision 2020 and EDPRS 2008-12, provides the focus of all activities in the health sector, supported by both GOR and other development partners. The HSSP II is aligned with sub-sector strategic plans, e.g. the HIV Strategic Plan 2009-13; the National Strategic Plan for the Control and Prevention of Malaria 2008-12; and the Human Resources Strategic Plan 2009-13. Input into policy and guideline development and implementation of the HSSP II is provided through technical working groups (TWG), chaired by the Government of Rwanda and co-chaired by development partners. The TWGs are a formal component of the SWAP process and report directly to the Health Sector Cluster Group.

The HSSP II is the most recent comprehensive document of all policies to date related to health. It supports major strengthening of interventions categorized along three strategic objectives: 1) Maternal and child health, family planning, reproductive health and nutrition; 2) prevention of diseases and promotion of health; and 3) treatment and control of diseases. The HSSP II describes seven strategic programs across these three objectives:

1. Institutional Capacity: to strengthen the sector's institutional capacity
2. Human Resources for Health (HRH): to increase the availability and quality of human resources (including basic and in-service training)
3. Health Sector Financing: to ensure financial accessibility to health services for all and sustainable and equitable financing of the health sector
4. Geographic Accessibility: to ensure geographical accessibility to health services for all
5. Drugs, Vaccines, and Consumables: to ensure the (universal) availability and rational use at all levels of quality drugs, vaccines and consumables
6. Quality Assurance: to ensure the highest attainable quality of health services at all levels

⁴ <http://www.moh.gov.rw/docs/VISION2020.doc>

7. Specialized Services, National Referral Hospitals and Research Capacity: to strengthen the specialized services, national referral hospitals and research capacity

All interventions in the HSSP II are divided into three service delivery modes: family oriented community based services (including household behavior change activities, CHW services), population oriented services (including outreach and campaigns), and individual oriented clinical services (including diagnosis and treatment). The HSSP II also incorporates the following key GOR initiatives: performance-based financing, community-based health insurance, accreditation of quality of services, health education, quality emergency transportation, development of the SWaP, and decentralization.

The intention of the *Integrated Health Systems Strengthening* Task Order is to specifically address the first three objectives: institutional capacity, HRH, and health sector financing.

Decentralization:

The Government of Rwanda (GOR) adopted its National Decentralization Policy in May 2000, as a mechanism to achieve three main goals: the promotion of good governance; the achievement of poverty reduction; and the efficient, effective and accountable delivery of services. The Decentralization Policy seeks to establish and empower decentralized administration in the areas of devolution, delegation and deconcentration. The overall strategic objectives of the policy include:

- Enabling local participation of communities in affairs that directly affect them;
- Strengthening the accountability and transparency of leaders in Rwanda;
- Developing sustainable economic planning and management capacity at local levels of administration;
- Enhancing the efficiency, effectiveness and monitoring of services delivered at local levels by local authorities; and
- Creating a responsive local administration which can plan, finance and manage service provision in response to local needs.

Decentralization is being rolled out by the GOR in three phases:

- *The first phase (2001-2006)* established democratic and community development structures and attempted to build their capacities. To facilitate the functioning of these structures, a number of legal, institutional and policy reforms were undertaken during this period, covering the roles and responsibilities of central and decentralized structures, the financing of services, and the mechanisms to ensure accountability.
- *The second phase (2006-2011)* further decentralizes government and strengthens the districts as core local authorities, supporting them to delegate responsibility to (administrative) sectors which are the focus of local service deliveries. Cells act as centers for information and community mobilization and *Imidugudu* (villages) are areas of participatory democracy and sustainable community development. The central government mainly retains the responsibility of policy and regulatory frameworks, while facilitating capacity building for local governance and monitoring and evaluating the decentralization process. The current phase aims to deepen the decentralization process in line with the Local Administration Reform Policy adopted in 2005.

- *The third phase (2011-2016)* will be a continuous process of improving, supporting and sustaining the achievements of the first two phases.

According to the Rwanda Decentralization Implementation Program 2008 –2012 (DIP), the specific objectives of the current phase of decentralization are:

- To promote and enhance effectiveness in service delivery by making the Sector a truly service delivery focal point with adequate human, material and financial capacity, and to improve collection of data and information at this level;
- To streamline and strengthen the coordination of “public services” and local economic development at District Level by availing more technically competent personnel as well as financial resources to the District in order to ensure sustainability of decentralized fiscal regimes;
- To streamline and strengthen the coordination of development at provincial level; and
- To establish and strengthen coherent monitoring and evaluation systems as well as institutionalize accountability tools and systems.

This shift in authority for budgeting, reporting and managing to decentralized levels has important implications for the health system and health governance in Rwanda and requires capacity building for the MOH and other stakeholders at all levels to maintain or improve the level of performance of the health system.

Community Health:

In 2007, the Community Health Desk of the MOH finalized the National Community Health Policy (CHP)⁵ and is currently finalizing the community health strategy, guidelines and operational procedures. The policy defines three types of volunteer community health workers (CHWs) – *Agent de Sante Binome* (male and female community health workers), *Animatrice de Sante Maternelle* (maternal community health worker), and *Agent de Sante Communautaire* (HIV/AIDS and palliative care community health worker). The CHP proposes to have 60,000 community health workers across all 30 districts in place by the end of March 2009. There will be five CHWs per village- the Binome couple, the maternal CHW, the palliative care CHW and one supervisor CHW. The CHWs will cover a wide range of health issues: integrated management of childhood illnesses (IMCI); tuberculosis (TB); HIV/AIDS; malaria; immunization; nutrition; environmental health; reproductive health/family planning; care and support for OVC; home-based palliative care; and a range of behavior change communication (BCC) activities. The CHW will all directly be linked to and support the 416 existing health facilities. They will serve as the entry point for communities into the health system and will relieve much of the burden of services at the health facility by offering basic preventative and curative services at the community level.

Catered for under the National Community Health Policy and the National Policy on Cooperatives⁶ is the plan for association of CHWs to transition into Cooperatives. The Government of Rwanda views cooperatives as a potential vehicle through which the cooperatives members could create employment and expand access to income-generating activities, develop their business potential, including entrepreneurial and managerial capacities through education and training; increase savings and investment, and improve social well-being with special emphasis on gender equality, housing,

⁵ http://www.moh.gov.rw/docs/pdf/Community_Health_policy_English_Janvier_2009final.pdf

⁶ <http://www.minicom.gov.rw/spip.php?article39>

education, health care and community development. It is expected that incentives and sustainability for CHWs will be enhanced through the establishment of Cooperatives.

The GOR is planning to roll out community health performance based financing (c-PBF), which will serve as the incentive structure for community health workers. The proposed remuneration for CHW will be as follows:

- Local associations of CHW will be expected to transition to Cooperatives - at least one per health facility, for an expected total of 416. To date, only 50 Cooperatives have been formed. These Cooperatives are expected to implement income generating activities to sustain the members therein.
- The GOR, through c-PBF, will provide a quarterly grant to each of the Cooperatives based upon their timely, accurate and quality submission of their service delivery reports. The grant amount issued to the Cooperative will depend on how well the CHWs performed.
- The oversight of c-PBF will be by a Sector Steering Committee which will not only have direct links to the health facility from where supervision of CHW will take place but will also have a direct performance contract with the Cooperative linked to that health facility.

Potential challenges with the scale up of community health PBF include concern that the CHW Cooperatives might lose focus of their purpose and focus their efforts on business opportunities rather than health service delivery or that they may rely completely on the grant that is issued at the end of each quarter that they might not focus on business development. It will be imperative to help these CHW Cooperatives develop sound business plans and continue to effectively deliver quality health services in the community.

Given the changes in decentralized administrative functions and responsibilities, and the new intensive focus on community health, it is a critical moment for USG and other donors to assess their contribution to the health sector and determine strategic steps forward.

While there is strong political will and commitment to health system strengthening, more than half of Rwandans live below the poverty line. The doctor/patient ratio is stands at 1: 33,000 while that of nurses/patient stands at 1:1700⁷, suggesting that the development and rational use of human resources for health will continue to be a priority area. The private sector is weak and public resource allocation to the health sector is below the standards set by the World Health Organization (WHO). The cost of health interventions is also beyond the GOR's capacity to fund. The fundamental challenge for US government support is how to ensure that government meets its vision 2020 objectives in light of these limitations.

C. United States Government Investment in Health:

The United States Government (USG) is represented in Rwanda by 5 agencies- United States Agency for International Development (USAID), US Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), Peace Corps and the State Department. USAID's overall strategy in health focuses on increasing use of community health services including HIV/AIDS, with an underlying framework captured by the following intermediate results:

- 1) Reinforced capacity for implementation of the decentralization policy in target health districts

⁷ Rwanda Health Sector Strategic Plan HSSP I, 2005-2009, Evaluation Report. July 2008

- 2) Increased access to selected essential health commodities and community health services
- 3) Improved quality of community health services
- 4) Improved community level responses to health issues

USAID's health portfolio includes 5 priority areas: HIV/AIDS (prevention, care and treatment); maternal and child health; malaria; family planning; health decentralization and systems strengthening. The USG also supports a variety of 'wrap around activities', which link together health and other sectors to provide comprehensive program support and improve overall quality of life. Wraparounds leverage resources, both human and financial, from entities with different funding sources in order to maximize the effectiveness of programs. Wraparound activities include other programs funded by the USG (e.g., economic growth and strengthening, democracy and governance etc.). As an example, a current five year \$5m program to promote dairy competitiveness in Rwanda will work primarily on improving milk quality and the marketing aspects of the dairy sector with a special objective to improve the livelihoods of people living with HIV/AIDS by involving them in the growing dairy sector.

HIV/AIDS: Rwanda is one of 15 focus countries under the President's Emergency plan for AIDS Relief (PEPFAR), supported by USAID, US Centers for Disease Control and Prevention (CDC), the Department of Defense (DOD), Peace Corps and the State Department. Through PEPFAR, the USG supports the GOR to minimize the impact of HIV/AIDS by supporting prevention, basic care and treatment services, as well as systems strengthening and strategic information. The current programs focus on increasing access to prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT), behavior change communication and social marketing, provision of ARV services and capacity development of health care workers through curriculum development and task shifting. Other services focus on impact mitigation for orphans and vulnerable children.

Maternal and Child Health (MCH): Rwanda was recently identified by USAID/Washington as a high priority country for child survival resources to enable the scale up of maternal and child health programming. USAID supports activities that improve on the quality and availability of key MCH services to reduce the burden of diseases such as diarrhea, acute respiratory infections, and pregnancy/childbirth complications, which are the principal killers of mothers and children in Rwanda.

Malaria: Rwanda is a priority country under the President's Malaria Initiative (PMI). Through PMI, the USG supports the National Malaria Control Program to further expand the implementation of home-based management of fever; indoor residual spraying; provide and promote the use of long lasting insecticide treated bed nets (LLITNs); strengthen the epidemic surveillance and response, and provide technical assistance for key policy decisions. The number of malaria illnesses seen at health facilities has declined significantly and malaria is no longer the leading cause of death among children under five, largely due to expansion of home-based management of fever and increased use of LLITNs.

Family Planning: The Government of Rwanda has made family planning a major priority, both to improve the health of women and children, as well as to sustain gains made in the economy. USAID supports training for doctors and nurses in family planning methods, including long term and permanent methods; training for community health workers to provide injectable contraceptives at the

community-level; social marketing of family planning products; promotion of condoms for dual protection and male involvement in family planning and maternal health. USAID has been supporting long-term improvement of quality MCH and family planning services through support to post-graduate education in public health; post graduate training for clinicians and the introduction of family medicine at the National University School of Medicine.

Health decentralization/systems strengthening: USG currently supports a range of health systems strengthening/health decentralization activities, including performance based financing (PBF); national health accounts (NHA); capacity development through the National University of Rwanda's School of Public Health, training at all levels of the health system; as well as support to central government to improve monitoring and evaluation (M&E); health management information systems (HMIS); logistics management information systems (LMIS) and other information systems used to inform decision making and policy development.

USG will continue to provide national level support to logistics procurement and distribution through existing programs. The Partnership for Supply Chain Management Systems (SCMS) is the prime partner for the procurement of all HIV/AIDS commodities including ARV medication, lab reagents and supplies, test kits and other medical consumables; while the USAID Deliver project is responsible for the procurement of all MCH/FP commodities including contraceptives, condoms, and anti-malarial drugs, and both organizations support the Rwandan National Medical Stores (CAMERWA) with warehousing and active distribution to the district pharmacies and beyond.

D. Linkage to Other U.S. Government Priorities and USAID Strategy:

USAID/Rwanda focuses on health, economic growth, and democracy and governance. The economic growth and democracy and governance programs are briefly summarized below.

Promoting Rural Economic Growth: USAID/Rwanda's economic growth program expands agribusiness opportunities in the specialty coffee and the dairy sectors; supports biodiversity and ecotourism and provides economic opportunities to most vulnerable populations. For example, in 2000 no specialty coffee was exported from Rwanda; in 2007, annual export revenue from this sub-sector has grown from zero dollars to \$8 million. Rwandan specialty coffee has been featured by Starbucks and Green Mountain Coffee as their "best of the best." In the dairy sector, USAID/Rwanda provides technical assistance to the Rwandan dairy industry to enhance its competitiveness through increased efficient and profitable flow of quality milk, dairy products and related inputs and services through the dairy value chain. In addition, the program seeks to expand access to economic opportunities for vulnerable populations through integrating people living with HIV/AIDS, orphans and other vulnerable children into dairy-related income-generating activities. USAID/Rwanda also supports eco-tourism in Nyungwe National Park working to increase the number of visitors to the park, conserve the biodiversity, and improve the livelihoods of Rwandans surrounding the park.

USAID/Rwanda also provides food assistance to food insecure households. The assistance provides a safety net to HIV/AIDS-infected people, orphans and other vulnerable people. Food aid activities contribute to employment, improved agricultural technologies, agri-business development, incomes, and food security. To date, over 850,000 Rwandans have benefited from the U.S. food assistance.

Democracy and Governance: USAID/Rwanda's democracy and government program focuses on justice sector strengthening, conflict mitigation and reconciliation, political party strengthening, and, in close collaboration with the health team, health decentralization. In addition, the democracy and governance program is supporting a cross-cutting Rwanda youth skills project.

In July 2008, the U.S. Millennium Challenge Corporation (MCC) Board approved Rwanda's Threshold Country Plan, which was developed to address Rwanda's MCC ruling justly indicators; specifically political rights, civil liberties, and voice and accountability. The program will focus on strengthening the capacity and independence of the judiciary, strengthening opportunities for civic participation, building the capacity of civil society organizations, increasing the professionalism of the media, and supporting efforts by the Rwanda National Police to monitor and improved internal police performance.

E. Support of GOR and Other Donors in Health:

According to the 2008 National Health Accounts, GOR spending on health increased in absolute terms from 2003 to 2006, although its relative share has declined. Although Rwanda is a signatory to the Abuja Declaration which commits countries to increase the share of the budget going to health to 15% by 2015, government expenditure on health as a percentage of total government expenditure dropped between 2003 and 2006, from 9% to 7%. Several Ministries, such as Defense, Finance, Education, Justice and Internal Revenues, in addition to the MOH contribute to the health sector in Rwanda. In 2008, other Ministries contributed a total of 1.5 billion Rwf (\$2.8 million USD) to meeting objectives in healthcare delivery and support services. This support is expected to be maintained or to increase over the next five years.

PEPFAR and the Global Fund are the largest donors in health. Other donors and multilateral institutions contributing to the Rwanda health sector include: the Belgium Technical Cooperation (BTC); European Union; German society for technical cooperation (GTZ); Embassy of France; Netherlands Embassy; Lux-Development; Swedish International Development Agency (SIDA); United Kingdom Department For International Development (DFID); Canadian Embassy; Embassy of China; and the United Nations organizations, including the United Nations Development Program (UNDP), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), United Nations Children's Fund (UNICEF), Joint United Nations Program on HIV/AIDS (UNAIDS), World Food Programme (WFP), and the World Health Organization (WHO). A number of these development partners provide general budget support to Rwanda through the Ministry of Finance while others channel funds into the health sector through the process of sector budget support. These processes are evaluated through the Joint Health Sector Review conducted annually.

In 2008, total basket funding for the health sector was 12.4 billion Rwf (\$22.8 million USD) out of a total of 63.9 billion Rwf (\$117 million USD) in health sector support. Currently, the GOR uses the majority of direct budget support in the health sector to combat HIV/AIDS (51% according to the Public Expenditure Review). In the next five years, the GOR is expected to increase its support to the health sector from its ordinary budget.

F. Geographical Focus:

The *Integrated Health System Strengthening Project* will ultimately support activities at a national level. While some activities might have a specific and limited district focus (ex. direct financial support to district administration), majority of other activities will occur across all districts (ex. support to district supervisors for quality improvement and capacity building in management). USAID will reserve the right to change the geographical coverage of the project to accommodate GOR requests and USG priorities.

IV. Task Order Activity Objective and Results:

The activity objective (purpose) of this project is to support the effective and efficient use of scarce health system resources to provide sustainable high quality, client- oriented health and social services to all Rwandans. The Contractor under the task order will provide the necessary technical assistance and support to improve the capacity of the various Government of Rwanda units and structures. The Contractor's activities are expected to strongly link and complement those under the rest of the USG portfolio. Given the ongoing legacy of the 1994 genocide in Rwanda, the Contractor will be expected to incorporate a conflict-sensitive approach to development into project planning and implementation.

The activity objective will be accomplished through the achievement of the five major result and sub-result areas listed below:

1. Improved utilization of data for decision-making and policy formulation across all levels of the health sector.**Context:**

The MOH has made data the cornerstone of its efforts to improve the management of the health system and has made a strong commitment to define and harmonize a core set of indicators needed for decision making at different levels of the health system. A multiplicity of reporting systems and indicators exist, ranging from those collected by the Center for Infectious Diseases (TRAC+) and performance based financing (PBF) to those collected in disease specific areas. The MOH has been trying to establish a health management information system (HMIS) for the last three years. According to the 2008 review of HSSP I this progress has been slow.

In the context of decentralization, the need for information flow regarding policies, norms and guidelines from the central level to the community is as crucial as that from the community back up through the districts to the national level. There is anecdotal evidence to suggest that this does not always happen, or when it does, is not particularly efficient. Availability of high quality data at each level of the health system (national, districts, sector and communities) is essential for efficient implementation of decentralized programs. Human resources and financial planning are captured in separate information systems, but core indicators ought to be included in HMIS.

This project will support policy-makers and health managers to use data for decision-making by enhancing the capacity of policy-makers to use feedback from the district and community level to revise and update policies, norms, and guidelines. This will be critical to ensure: 1) a reduction in data collection time; 2) data flow (particularly from the districts to the national level); and 3) the

availability of a comprehensive and quality data. This project will also support the MOH to strengthen data use through a variety of mechanisms including the communication of performance expectations, the close monitoring of health facility performance and the provision of feedback to health facilities, performance based financing (PBF) and the facilitation of a performance improvement process at health facility level. The project will also support the implementation of health management information systems at all levels through technical assistance to the roll out/ implementation of the HMIS national strategy.

Clarifying and strengthening the planning functions of the MOH planning department in relation to the decentralization will also be part of the support provided by this project.

Building on the work of the GOR and USG partners, this project will help MOH implement a harmonized and simplified system. The project will help support coordination to ensure that all partners involved in capacity building for data analysis and use are operating cohesively.

1.1 Improved capacity of key health managers and providers to use data for decision making.

The project will help the key managers at all levels in the use of data for making decisions on allocation and use of resources, in formulating plans, policies, strategies and in assessing program performance.

Expected Outcomes:

1. Strengthened MOH capacity to produce evidence-based strategic plans and policies.
2. Enhanced capacity of national policy-makers to use feedback from the community and districts to revise and update policies, norms, and guidelines.

Illustrative Activities

- Strengthening the M&E units at district hospitals.
- Supporting periodic data analysis at the all levels of the health system.
- Training of health managers in data analysis and use at decentralized levels.
- Supporting systematic reviews of key program elements all levels of the health system.

1.2 Strengthen HMIS to provide reliable and timely data:

The project will strengthen the M&E unit of the MOH, which is responsible for the formulation of national M&E policies and strategies and for overseeing their implementation at decentralized levels. It will also support the roll out of the new HMIS strategy at national, district and community levels.

Expected Outcomes:

1. Improved M&E systems in place.
2. Streamlined HMIS through the implementation of HMIS strategy.

Illustrative Activities:

- Develop and update norms, guidelines and data collection tools for the HMIS.
- Conduct routine data audits to assess data requirements, utilization and quality and determine how to improve quality and relevance of data.
- Produce and update a meta-data dictionary for MOH indicators containing definitions of core and other indicators.

- Supporting coordination within the MOH M&E Unit for updating the set of national indicators.

2. Strengthened health financing mechanisms and financial planning and management for sustainability.

Context:

Rwanda has rapidly decentralized its governance structures, including those for health. Strengthened financial management and evidence-based planning for long-term sustainability remains crucial. Several noteworthy initiatives (e.g. community health insurance plan (mutuelles) and performance-based financing (PBF)) have been launched which all rely heavily on external financial resources. There are several partners (USG, World Bank, BTC etc) involved in various health financing initiatives, all of which bear heavily on the MOH in its leadership and coordination role.

Mutuelles des santé were introduced in Rwanda in 1999 as a pilot project in three districts. The objective of the initiative was to provide financial access to healthcare the majority of the Rwandan population who were not formally employed and could not afford to pay for healthcare. In 2007, enrollment to the mutuelles was made mandatory but not enforced by law. Over half the enrolment costs for mutuelles memberships are subsidized by government, with households paying RwF 1000 (approximately \$2US) per person per year. This contribution covers the costs of a basic health package including consultations, antenatal care, family planning, normal deliveries, and laboratory analysis and treatment expenses. Mutuelle membership for the poor is completely paid for by government and/or development partners.

National Coverage (2003-2008)

2003	2004	2005	2006	2007	2008
7%	27%	44.1%	73%	74%	83%

The GOR plans to achieve 100% coverage by 2010.

Performance-based financing is a mechanism that seeks to motivate health providers to provide quality health services and to increase coverage of health services through incentive payments to health. Facility PBF was scaled up nationwide, however, to date the GOR has not seen consistent performance improvements across all 30 districts. The GOR is planning to roll out community health performance-based financing (c-PBF) as part of the incentive structure and quality improvement in community health.

As decentralization expands, districts are expected to increase their ability to generate, raise and budget funds in support of district wide activities. District incentive funds (DIF), launched in 2006 were one such mechanism designed to provide financial support to districts to strengthen health service delivery and to allow districts the flexibility to define their own health priorities and improve their sense of ownership for their programs. IntraHealth International through the Twubakane project is currently supporting the implementation of DIF grants in 12 districts, and will perform a program evaluation to document lessons learned through the DIF mechanism.

The role of the private sector in health care delivery remains fairly weak and needs additional analysis to determine its potential additional role. The MOH needs additional data (costing analyses,

expenditure and revenue data) to improve financial management and develop informed options for setting tariffs, especially considering ability to pay, in order to maximize the impact of scarce national financial resources and move towards decreasing reliance on external finances for health.

Building on the work of the GOR and USG partners, the project will help MOH and the districts strengthen their financial systems, including raising funds, improved planning, budgeting and equitable, efficient use of financial resources. The project will also provide support to the MOH to increase its capacity in technical areas related to health financing.

2.1 Strengthened financial systems for the rational use of available health resources.

The project will be guided by the GOR's HSSPII and Imihigo performance-based contracting approach to further expand financial management for district teams and health providers. Imihigo is a concept used in Rwanda to designate a performance management contract signed between the President of the republic and the district mayors on behalf of their constituents. The engagement is recorded publicly in a written contract that presents a set of development targets backed by specific performance indicators over a period of one year. Imihigo is now adapted to focus on results at the district level.

Expected Outcomes:

1. Improved and innovative mechanisms for districts to generate, plan, manage and be accountable for funds.
2. Facility and community performance-based financing systems are fully established and efficiently functioning to improve quality of health services.
3. Established incentive structure (potentially PBF) for OVC volunteers.
4. Increased facility and community health worker performance.
5. Budgets, financial reports including requisite audits of districts available in good time to national and local government officials, the public, media, and civil society organizations.

Illustrative Activities:

- Support for financial management of national and district management teams, including strengthening the capacity of districts to raise funds and improving the financial management of *mutuelles*.
- Providing technical support to the PBF unit for both f-PBF and c-PBF.

2.2 Strengthened MOH capacity for cost reduction, revenue generation, and cost-sharing for services

Expected Outcomes:

1. Increased GOR capacity to conduct and use analysis on cost reduction, revenue generation and cost-sharing for planning.
2. Cost analysis study on cost reduction strategies.
3. Increased GOR capacity to mobilize additional resources for health and to implement a plan to reduce external funding for health.
4. Assessment of the private sector to determine its ability to contribute to health care financing.

Illustrative Activities

- Provide technical assistance to the GOR to carry out studies and analyses.

- Implement cost effectiveness, impact and sustainability analyses of health and social services.

2.3 Increased MOH technical capacity, especially in economics and financial management.

Expected Outcomes:

1. Reduced reliance on international technical expertise in health economics and financial management.
2. Strengthened capacity of MOH to plan, manage, and mobilize country resources for health.
3. Key individuals receive USG-assisted training, including management skills and fiscal management to strengthen local government and/or decentralization

Illustrative Activities:

- Building partnerships with educational institutions and existing mechanisms such as the Young Professionals Program, local and regional training institutions to support the strengthening of health economics and management expertise.

3. Improved management, quality, and productivity of human resources for health and related social services.

Context:

The GOR's Human Resources for Health Strategic Plan (2006-2010) indicates severe shortages of all categories of human resources for health (HRH). Human resources are a major challenge on the delivery of high quality health services including the 2006 GOR decision to limit the number of budgeted staff and profiles of positions at the Ministry of Health to 35⁸. This decision did not take into account the workload. The Government of Rwanda is highly committed to ensuring the availability of adequate and quality staff at all levels. A health human resources strategic plan (2006-2010) exists with 5 strategic objectives: 1) improve policy, regulation and planning; 2) improve management and performance; 3) stabilize the labor market; 4) strengthen education, training and research and 5) establish a HR management information system. The HR strategy touches on important elements such as training and skill development, workload, career plan and salaries.

The GOR has taken several measures to improve the availability, utilization, retention and recruitment of human resources for health, such as:

- Introducing PBF for doctors and nurses;
- Planning for the scale up of community health through the deployment of 75,000 community health workers;
- Establishing HRMIS to inform the revision of its HRH Strategic Plan, as well as overall HR planning.

Despite the strategy, there are several shortcomings in the management of human resources for health in Rwanda, including the lack of job descriptions, norms, performance expectations and review processes for the different cadres. The implementation of policies regarding recruitment, deployment, continuing education requirements and retention plans for health workers is generally weak.

⁸ Human Resources for Health Strategic Plan, 2006-2010

3.1 Implemented and evaluated long term HRH strategic plan and Community Health Worker (CHW) policy.

The project will support the GOR's implementation, management and evaluation of its human resources strategy. In addition, the project will strengthen the Ministry of Health (MOH)'s capacity to update and disseminate human resource norms and guidelines. The project will also support the Community Health Desk in the roll out of the community health policy and provide support to coordinate the development of the comprehensive training package for CHW.

Expected Outcomes:

1. Development of an evidence-based long term strategic plan and policies for HRH beyond 2012.
2. Established mechanism for coordination of HRH strategies and plans and their implementation with other relevant ministries such as local government, education, public service and planning and finance.
3. The community health worker policy will be implemented.

Illustrative Activities:

- Support to the HRH technical working group in the review and production of the new strategic plan.
- Technical assistance to the Community Health Desk in the roll out of the community health worker strategy.

3.2 Improved capacity of MOH to use HRMIS to update and disseminate HR norms and guidelines

The project will support the MOH use the human resource management information system (HRMIS) for improving management of human resources in the health sector.

Expected Outcomes:

1. Support the ongoing development of the HRMIS.
2. Enhanced capacity of HR managers to use HRMIS for improving the decision making for staff recruitment, deployment, performance assessment and utilization of workers and to use HRMIS
3. Planning tools (especially projections) to inform training of different cadres of health professionals.

Illustrative Activities:

- The project will collaborate with the Capacity Development Pooled Secretariat which is charged with planning and coordinating in-service training of different levels of workers in the healthcare sector.

3.3 Improved and strengthened MOH capacity to manage human resources for health (HRH).

Expected Outcomes:

1. Analysis of current policies and programs to improve staff retention and deployment.
2. Job descriptions for the different categories of health professionals in place.
3. Standards for job performance/expectations of different cadres of health professionals in place.

4. A review of productivity of the different cadres of health workers at health facilities and community.
5. Study of the health worker labor market in the public and private sector to determine the demands and supply of labor.

Illustrative Activities:

1. Conduct labor market studies.

4. Improved quality of health services through implementation of a standardized approach to quality improvement (QI).**Context:**

In 2008, the Ministry of Health adopted a National Policy for Quality of Healthcare and a five-year National Strategy for Quality Management, both of which emphasize the role of supervision in achieving a sustainable culture of quality in the healthcare system. Furthermore, the Ministry of Health is in the process of developing national frameworks for QI measurement and integrated formative supervision. This new model of supervision emerges from the HSSP II framework, and is based on the premise that the health system should be designed to deliver the highest quality health services possible to those in need of such services.

Supervision has long been regarded as a key element for delivering high quality health services; however, the nature of supervision must change from an activity focused exclusively on verification and quality control to a collaborative process between the supervisor and health facility staff which allows for the identification of strengths and weaknesses, and uses a problem-solving approach that results in the continuous improvement of quality at the facility level. Thus, the GOR is supporting a team-based approach to QI at the health facility level. The project will support the MOH at the national and district level to implement the newly developed approach for QI, complementing performance-based financing, integrated formative supervision, as well as exploring additional evidence-based approaches to improve the quality of essential health services.

While the government is in the process of developing national supervisory and QI measurement frameworks, including standardized tools, indicators and QI approaches, a key challenge that remains is ensuring the decentralized implementation of these measures across the different levels including the allocation of resources and availability of logistics support for supervision. The current shortage of supervisors also poses a tremendous burden on supervisors and jeopardizes the quality of services. This necessitates a close linkage with HR planning, and requires that training activities be conducted for central-level and district-level personnel who will be tasked with supervisory and on-site mentoring responsibilities to assist health facility staff.

4.1 National supervision framework implemented, strengthening linkages between and within MOH and district health and management teams.

The project will support the MOH to implement the supervision framework and the QI oversight structure. The quality improvement process occurs across the health system- from the community level up through national referral hospitals. A key element in the quality improvement process is the use of data to improve processes and outcomes. The data manager at the health facility level will be

responsible for providing accurate data to the QI team to enable problem identification and monitoring of progress towards the agreed targets, a process which will be formalized upon completion of the QI measurement framework. The supervisor will oversee this process, and ensure that appropriate reporting to central-level occurs, which will allow necessary actions to be taken and required resources to be mobilized to improve the quality of services across all levels.

Expected Outcomes:

1. MOH national supervision framework implemented at national, district and health center levels.
2. Strengthened coordination between the planning and M&E unit to ensure access to timely and valid information, which is compiled and analyzed in order to improve the quality of services.
3. Data managers implementing the national QI measurement framework in conjunction with HMIS data collection systems, which must be harmonized to prevent duplication of efforts.
4. QI and supervisory frameworks harmonized with the existing performance-based financing mechanism, ensuring inclusion of quality improvement indicators in PBF and supervisor participation during PBF quarterly evaluations.
5. QI modules incorporated into pre-service training for appropriate cadres of health provider.
6. Team building skills (including conflict management) skills integrated into Quality Improvement modules.

Illustrative Activities

- Training of health management teams in the new supervisory and QI measurement frameworks, working in collaboration with other QI initiatives.
- Collaborating with the Ministry of Education to incorporate QI modules into pre-service curriculum and ensure incorporation of the national QI approach.
- Coordinating with the PBF unit to ensure harmony across indicators and evaluation periods.

4.2 Districts management teams implement quality improvement mechanisms including regular supervision of health facilities and providers, performance-based contracts, and on-site mentoring at health centers to ensure implementation of QI projects.

The project will support the MOH to ensure that quality improvement mechanisms are harmonized and utilized across district management teams. In particular, it will be important to provide orientation sessions for both the director of health at the district administrative unit and the district hospital directors to ensure proper understanding among all members of the district management team. Furthermore, health center staff must be mentored by district-level supervisors and assisted with problem identification and implementation of activities to improve the quality of services.

Expected Outcomes:

1. Consistent improvement in quality of services at all levels.
2. District management teams take a lead in multi-facility coordination and team problem-solving around QI, conducting peer workshops to share successes, challenges, and lessons learned.
3. Health providers at all levels utilize team-based approaches for QI.
4. Health providers at all levels receive regular support in line with the framework.

Illustrative Activities:

- Working with the MOH to increase the number of newly trained central-level supervisors, who

will then train district-level supervisors.

- Coordinate with the MOH to ensure mentoring of health facility staff by district-level supervisors is ongoing, working in collaboration with other partners.

5. Extended decentralized health and social services to the district level and below.

Context:

The current phase of decentralization (2006-2011) aims to further devolve service delivery from the district level to that of the sector, with coordination at the district level. The GOR recently conducted an assessment of the capacity of districts to undertake the roles and responsibilities allocated to them as per the national standards and identified several challenges in the system. These included: lack of knowledge and understanding of the legal framework of decentralization, service delivery and monitoring hampered by lack of access to transport, weak financial management and budget execution, and limited consultation of national level institutions in policy elaboration. The gaps will be addressed through targeted training and support to the decentralization process. The project will support the necessary capacity building in time and resource management that are required as increased responsibilities are decentralized.

The project will focus on strengthening the capacity at each level of the health system to support the decentralization process. The support will include strengthening coordination capacity, both vertically among the different decentralized levels, and horizontally among ministries, implementing partners, development partners, and civil society.

This project will collaborate with MCC efforts to support existing or alternative models of enhanced community involvement in monitoring health service delivery and influencing community health priorities. It will also help improve collaboration between local government representatives and CSOs.

5.1 Management capacity at decentralized levels improved and extended to all levels, including local communities.

Expected outcomes:

1. Improved capacity of district, sector and community health workers in implementation and management of decentralized health service delivery.
2. Staff at the district level and below able to fill their roles and responsibilities as individuals and as part of a team.
3. Involvement of key CSOs and other stakeholders when possible and appropriate.

Illustrative Activities:

- Training programs developed and implemented for all cadres of health.

5.2 Strengthened capacity of local CSOs and individual community members to influence health sector priorities and services, along with other cross-cutting development priorities that impact the health sector.

Expected outcomes:

1. Enhanced community participation in service delivery for health.
2. Increased capacity of CSOs and community members to advocate for health priorities.
3. Increased number of major local government decisions in which input from participation mechanisms taken into account

Illustrative Activities:

- Coordination of community meetings involving all stakeholders.
- Support the roll out of models for community participation.

B. REPORTING REQUIREMENTS

The Contractor will adhere to all reporting requirements listed below.

1) Performance Monitoring and Reporting

The Contractor will submit reports to the USAID Contracting Officer Technical Representative (COTR) as described below. The exact format for preparation of and timing for submission of all reports will be determined in collaboration with the COTR. The exact format for preparation of reports will be jointly determined between the Contractor and the Contracting Officer's Technical Representative (COTR). In addition, the Contract shall provide timely responses to any requests pertaining to the annual country operational plan (COP), malaria operational plan (MOP) and operational plan (OP) and subsequent semi-annual reports.

a) Annual Work Plan

The Contractor will prepare annual work plans for the award on schedule and according to a format established and agreed upon by both USAID and the MOH. These work plans are to be submitted to the SO6 COTR for approval with subsequent approval from the MOH. The first work plan will be due within 60 days of the award and will include a description of the planned activities. The selection of the districts will be in consultation with USAID and the GOR.

b) Performance Monitoring Report

The Contractor shall submit an original copy of their performance reports to the COTR. The performance reports are required to be submitted quarterly and shall contain the following information on activities in the selected districts: 1) explanation of quantifiable output of the programs or projects; 2) reasons why established goals were not met, if appropriate; and 3) analysis and explanation of cost overruns or high unit costs (the Contractor must immediately notify USAID of developments that have a significant impact on Task Order-supported activities). Further, notification must be given in the case of problems, delays or adverse conditions which materially impair the ability to meet the objectives of the award. These notifications must include a statement of the action taken or contemplated and any assistance needed to resolve the situation.

c) Annual and Semi-Annual Reporting

The Contractor will be expected to report semi-annually and/or annually on selected indicators, as required by the funding source for project activities. Malaria activities may be required to report on a quarterly basis. The Contractor will be asked to submit these selected results into a web-based partner

reporting system used by USAID/Rwanda on which training will be provided. This does not supersede regular performance reports as required by this agreement.

d) Final Report

The Contractor shall submit two copies of the final performance report- one copy to the COTR and one copy to USAID Development Experience Clearinghouse, ATTN: Document Acquisitions, 1611 N. Kent Street, Suite 200, Arlington, VA 22209-2111 (or email: docsubmit@dec.cdie.org). The report should be submitted two months prior to the end date of the award.

The final performance report shall include an executive summary of the Contractor's accomplishments in achieving results and conclusions about areas in need of future assistance; an overall description of the Contractor's activities and attainment of results by country or region, as appropriate during the life of the Task Order; an assessment of the progress made toward accomplishing the objective and expected results; significance of these activities; important research findings, comments and recommendations; and a fiscal report that describes how the Contractor's funds were used.

2) Management Reviews and Evaluations

The Annual Work Plan will form the basis for a joint management review by USAID and program staff to review program directions, achievement of the prior year work plan objectives, and major management and implementation issues, and to make recommendations for any changes as appropriate. A semi-annual management review will also be held to review progress.

At any time during program implementation, USAID may conduct one or more evaluations to review overall progress, assess the continuing appropriateness of the project design, and identify any factors impeding effective implementation. USAID will utilize the results of the evaluations to recommend any needed mid-course changes in strategy and to help determine appropriate future directions. Site visits may occur at any time.

C. TASK ORDER PROPOSAL AND SUBMISSION INSTRUCTIONS

The technical proposal shall be concise, no more than 25 pages – excluding the cover page and required attachments – and give a clear and measurable description of what the applicant organization proposes to achieve as well as where, why, and how. **Any page over 25 will not be evaluated.** The technical proposal format shall follow the following format:

1. Cover Page (not included in the page limit):

- Name of organization(s) submitting proposal
- Name and title of contact person
- Telephone and fax numbers
- Postal and physical addresses
- E-mail address

2. Executive Summary (not to exceed **two** pages) - Briefly describe the proposed activities, goals, purposes, and anticipated results. Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed.
3. Body of the Technical Proposal (not to exceed **25** pages) - Succinctly describe the proposed activities, goals, purposes, and anticipated results. Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed. The proposal's structure should reflect the evaluation criteria listed in Section C. Pages exceeding the 25-page limit will not be read or evaluated. Offerors shall not include proposal material by referencing the annexes in an attempt to circumvent the 25 page limit.
4. Qualifications of Proposed Key Personnel not to exceed **three** positions (maximum two page CVs per position) – Briefly describe the technical background and qualifications of the proposed Key Personnel, using the criteria articulated below:
 - a) Academic and technical background and qualifications (including English) language ability relevant to this Statement of Work;
 - b) Successful experience in providing technical assistance in developing countries and in areas relevant to this Statement of Work; and
 - c) Demonstrated interpersonal skills and managerial/technical abilities.
 - d) Provided full contact information of the two most recent immediate supervisors of each individual proposed for a key personnel position.

USAID may use this information to contact technical representatives on prior contracts, subcontracts, cooperative agreements or grants to obtain information on performance. If the Offeror encountered problems in carrying out any of these contracts, etc., it should provide an explanation of the problem encountered and describe any corrective action taken.

5. Past performance will be evaluated as a means of predicting how the Offeror will likely perform. The following considerations will be examined:

- Quality of Services: How well the Offeror complied with Task Order requirements;
- Timeliness of Performance: How well the Offeror adhered to Task Order schedules and its responsiveness to technical direction;
- Business Practices and Customer Satisfaction: How well the Offeror worked with the Task Order Contracting Officer (TOCO) and his or her technical representative(s). Customer satisfaction also measures the interface with the ultimate end-user of the services;
- Key Personnel: How well the principal individuals elected performed in carrying out the activities called for under the contracts, subcontracts, cooperative agreements or grants; and
- Cost Control: Whether the Offeror operated at or below budget, submitted reasonable price change proposals and provided current, accurate and complete billings.

6. Page Limit: The above page limitations of the body of the proposal exclude the cover page, the executive summary, the authorized attachments, resumes and the statement of corporate capability and past performance. Applicants should retain for their records one copy of the proposal and all enclosures that accompany their proposal. Erasures or other changes must be initialed by the person signing the proposal.

The authorized attachments specified below shall not be counted towards the technical proposal page limit; however, any attachments other than those specified below shall not be read

Authorized attachments:

- Draft first year work plan (in table format)
- Organizational chart and resumes or curriculum vitae of key personnel
- Draft monitoring and evaluation plan
- Description of management systems and procedures required for successful contract administration
- Corporate capability statements
- Offeror NIH CPS Past Performance Reports

INSTRUCTIONS FOR PREPARATION OF THE COST/BUSINESS PROPOSAL

1. Cost/Business Proposal

This will be a five year task order with an estimated dollar value of \$35 million over the life of the Task Order. This range is provided to give Offerors the relative order of magnitude of the anticipated project and should not be used as a target. Each offer will be evaluated for cost reasonableness and realism. The contractor will not be paid any sum in excess of the Task Order ceiling price or current obligated amount. The Offeror is expected to propose a realistic budget to support the expected results described in Section A of this RFTOP. Offerors are reminded that the resulting Task Order will be partially funded through the various USAID funding sources and it is expected that the Successful Offeror will report expenditures and results achieved according to these funding sources.

The cost proposal should include a detailed budget for the five year period including explanatory notes. All schedules necessary to support and explain proposed costs with breakdowns on direct labor, fringe benefits, supplies and equipment, travel and per diem amounts, including international travel should be identified separately and broken down by destination, number of trips, and number of travelers. Include other direct costs, and indirect costs; personnel costs, allowances and benefits, such as costs associated with resident and short-term personnel; travel and transportation costs, including airfares (destinations and number of trips), per diems amounts, taxis, and car rentals; rent, equipment, supplies, domestic, and international communications; and indirect costs supported with a Negotiated Indirect Cost Rate Agreement (NICRA) from the cognizant Federal agency subject to Section B6 and B7 of the Basic IQC.

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

The Offerors budget should include the following information:

- a) The costs associated with home office, expatriate, and local in-country labor, i.e. identification of positions, daily or hourly compensation, hours/days to be worked, etc.
- b) Proposed fringe benefits and allowances for all staff- expatriate and local staff.

- c) Details of travel, per diem and other transportation expenses to include number of international trips, expected itineraries, cost of travel, number of per diem days and per diem rates.
- d) A breakdown of all other direct costs to include cost elements (communications, office supplies, printer, vehicle, and office rent), unit of measure (monthly estimate, cost per unit), number of units, basis of the estimate and programmatic need for the expenditure.
- e) The breakdown of all costs according to each partner organization (or sub-awardee) involved in the program, in the format described herein.
- f) Copies of your organization's most recent Negotiated Indirect Cost Rate Agreement (NICRA) issued by your organization's cognizant audit agency or information to support any non-direct costs recovered by a percentage method.
- g) Contributions offered by or expected to be sought from other sources should be noted.

AUTHORITY TO OBLIGATE THE GOVERNMENT

The Task Order Contracting Officer (TOCO) is the only individual who may legally commit the U.S. Government to the expenditure of public funds. No costs chargeable to the proposal may be incurred before receipt of either a contract signed by the TOCO or a specific, written authorization from the Task Order Contracting Officer.

D. EVALUATION CRITERIA AND SELECTION PROCESS

Each proposal will be scored by the technical evaluation committee under the direction of the Regional Contracting officer using the criteria shown in this section. The significant Technical factors, when combined, are significantly more important than the cost/price factor.

The "Proposed Technical Approach" factor is the most important factor. The subfactors under it are listed in relative order of importance with the subfactor "The description of how the Scope of Work will be accomplished..." being the most important subfactor. "Proposed Key Personnel" is the second most important factor. While not weighted, "Past Performance" is an essential element of the Government's evaluation and award selection.

I. TECHNICAL PROPOSAL

A. Proposed Technical Approach: Methodology and Content

The evaluation of the Offerors technical approach will focus on the following:

- The description of how the Scope of Work will be accomplished is clear, practical, and results-oriented, and it adequately addresses all of the technical requirements specified by USAID/Rwanda in the SOW. Proposals with activities that reflect realistic, imaginative and innovative approaches to achieving the objectives are encouraged in addition to addressing gender.
- The proposed work plan and timeline clearly describe how the activities will be conducted.
- The proposal expresses a clear understanding of the purpose of the activity
- The proposal reflects a clear understanding of the development context in Rwanda, including as related to health sector activities

B. Proposed Key Personnel

Academic qualifications and professional experience of individuals proposed for specific key personnel positions.

C. Past Performance

Past performance sub-factors include quality, cost control, timeliness, and business relations. In evaluating past performance, the Offerors past performance in using small business concerns under previous contracts will be taken into consideration. The Offeror shall identify five past contracts (within the last three years) or current contracts for efforts similar to the requirement and include contact information as well as information pertaining to problems encountered on the identified contracts and the Offerors corrective action. "Similar" in this context means in relation to size, scope, and complexity, as well as to a specific subject matter.

In evaluating past performance, USAID shall consider the information provided by the Offeror, as well as information obtained from other sources. Furthermore, USAID shall determine the relevance of similar past performance information.

The past performance references required by this section shall be provided as an attachment to the Technical Proposal.

COST PROPOSAL

Although the cost proposal will not be numerically scored, in instances where technical proposals are considered essentially equal, cost may be the determining factor. The overall standard for judging cost will be whether the cost proposal presents the best value to the US Government in relationship to the estimated costs. The cost proposal will be judged on: (i) whether it is realistic and consistent with the technical proposal; (ii) overall cost control (avoidance of excessive salaries, excessive home office visits, and other costs in excess of reasonable requirements); and (iii) amount of proposed fee.

The cost proposal should include a detailed budget for the three year period including explanatory notes. All schedules necessary to support and explain proposed costs with breakdowns on direct labor, fringe benefits, supplies and equipment, travel and per diem amounts, other direct costs, and indirect costs; personnel costs, allowances and benefits, such as costs associated with resident and short-term personnel; travel and transportation costs, including airfares (destinations and number of trips), per diems amounts, taxis, and car rentals; other direct costs such as rent, equipment, supplies, domestic, and international communications; and indirect costs supported with a Negotiated Indirect Cost Rate Agreement (NICRA) from the cognizant agency, if available. International travel should be identified separately and broken down by destination, number of trips, and number of travelers

REFERENCES

Government of Rwanda:

www.gov.rw

Government of Rwanda Ministry of Health

<http://www.moh.gov.rw/>

Government of Rwanda Ministry of Local Government

<http://www.minaloc.gov.rw/>

Government of Rwanda Ministry of Finance and Economic Planning

<http://www.minecofin.gov.rw/>

Performance Based Financing

<http://www.pbfrwanda.org.rw/>

Economic Development and Poverty Reduction Strategy (EDPRS)

www.rada.gov.rw/img/pdr/edprs_version_july_9th.pdf

Government of Rwanda National Decentralization Policy (May 2000):

http://www.minaloc.gov.rw/IMG/doc/decentr/dec_pol_uk2.pdf

Rwanda Decentralization Implementation Program 2008–2012:

http://www.minaloc.gov.rw/IMG/pdf_DIP_final_DRAFT_-_12.02.08.pdf

Government of Rwanda National Community Health Policy:

www.moh.gov.rw/docs/pdf/Community_Health_policy_English_Janvier_2009final.pdf

Government of Rwanda National Policy on Cooperatives: www.minicom.gov.rw/spip.php?article39

USAID

www.usaid.gov

USAID/Rwanda

<http://www.usaid.gov/missions/rw/>

USAID Forms:

<http://www.usaid.gov/forms/>

Activity Objective: Effective and efficient use of scarce health system resources to provide sustainable high quality, client- oriented health and social services to all Rwandans.

Results

1: Planning & M/E:

Improved utilization of data for decision-making and policy formulation.

2: Health Financing:

Strengthened health financing mechanisms and financial planning and management for sustainability.

3: Human Resources:

Improved management, quality, and productivity of human resources for health and related social services.

4: Continuous Quality Improvement:

Improved quality of services.

5: Institutional Strengthening:

Extended decentralized health and social services systems to the community level.

Sub-results

1.1 Improved capacity of program managers to use data for decision-making.

2.1 Strengthened financial system for the rational use of available health resources.

3.1 Implemented and evaluated long term HRH strategic plan and CHW policy.

4.1 National supervision framework implemented, strengthening linkages between and within MOH and district health and management teams.

5.1 Management capacity at decentralized levels improved and extended to all levels including community.

1.2 Strengthen HMIS to provide reliable and timely data.

2.2 Strengthened MOH capacity for cost reduction, revenue generation, and cost-sharing for services.

3.2 Improved capacity of MOH to use HRMIS to update and disseminate HR norms and guidelines.

4.2 Districts management teams implement quality improvement mechanisms through regular supervision of health facilities and providers, performance-based contracts, and on-site mentoring

5.2 Strengthened capacity of local community to influence health sector priorities and services

2.3 Increased MOH technical capacity, especially in economics and financial management.

3.3 Improved and strengthened MOH capacity to manage human resources for health (HRH).

CONTRACTOR EMPLOYEE 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 Instructions on Reverse)		
NAME AND LOCATION OF INSTITUTE	MAJOR	DEGREE	DATE	LANGUAGE	Proficiency Speaking	Proficiency Reading

14. EMPLOYMENT HISTORY

1. Give last three (3) years. List salaries separate for each year. Continue on separate sheet of paper if required to list all employment related to duties of proposed assignment.
2. Salary definition - basic periodic payment for services rendered. Exclude bonuses, profit-sharing arrangements, or dependent education allowances.

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

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

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

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

Signature of Employee	Date
-----------------------	------

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

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

Signature of Contractor's Representative	Date
--	------

INSTRUCTION

Indicate your language proficiency in block 13 using the following numeric Interagency Language Roundtable levels (Foreign Service Institute Levels). Also, the following provides brief descriptions of proficiency levels 2, 3, 4, and 5. 'S' indicates speaking ability and 'R' indicates reading ability. For more indepth description of the levels refer to USAID Handbook 28.

2. Limited working proficiency

S Able to satisfy routine special demands and limited work requirements

R Sufficient comprehension to read simple, authentic written material in a form equivalent to usual printing or typescript on familiar subjects.

3. General professional proficiency

S Able to speak the Language with sufficient structural accuracy and vocabulary to participate effectively in most formal and informal conversations.

R Able to read within a normal range of speed and with almost complete comprehension.

4. Advanced professional proficiency

S Able to use the language fluently and accurately on all levels.

R Nearly native ability to read and understand extremely difficult or abstract prose, colloquialisms and slang.

5. Functional native proficiency

S Speaking proficiency is functionally equivalent to that of a highly articulate well-educated native speaker.

R Reading proficiency is functionally equivalent to that of the well-educated native reader.

PAPERWORK REDUCTION ACT INFORMATION

The information requested by this form is necessary for prudent management and administration of public funds under USAID contracts. The information helps USAID estimate overseas logistic support and allowances, the educational information provides an indication of qualifications, the salary information is used as a means of cost monitoring and to help determine reasonableness of proposed salary.

PAPERWORK REDUCTION ACT NOTICE

Public reporting burden for this collection of information is estimated to average thirty minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of informatoin. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to:

United States Agency for International Development
Procurement Policy Division (M/OP/P)
Washington, DC 20523-1435,
and
Office of Management and Budget
Paperwork Reduction Project (0412-0520)
Washington, DC 20503

DISCLOSURE OF LOBBYING ACTIVITIES

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation of receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in Item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET**

Approved by OMB
0348-0046

Reporting Entity: _____ Page _____ of _____

Authorized for Local Reproduction
Standard Form - LLL-A

CERTIFICATE OF CURRENT COST OR PRICING DATA

CERTIFICATE OF CURRENT COST OR PRICING DATA

This is to certify that, to the best of my knowledge and belief, cost or pricing data (as defined in section 2.101 of the Federal Acquisition Regulation (FAR) and required under FAR subsection 15.403-4) submitted, either actually or by specific identification in writing, to the Contracting Officer or to the Contracting Officer's representative in support of _____* are accurate, complete, and current as of _____**. This certification includes the cost or pricing data supporting any advance agreements and forward pricing rate agreements between the offeror and the Government that are part of the proposal.

FIRM _____

SIGNATURE _____

NAME _____

TITLE _____

DATE OF EXECUTION*** _____

* Identify the proposal, request for price adjustment, or other submission involved, giving the appropriate identifying number (e.g., RFP No.).

** Insert the day, month, and year when price negotiations were concluded and price agreement was reached or, if applicable, an earlier date agreed upon between the parties that is as close as practicable to the date of agreement on price.

*** Insert the day, month, and year of signing, which should be as close as practicable to the date when price negotiations were concluded and the contract price was agreed to.

**FAR 52.209-5 CERTIFICATION REGARDING RESPONSIBILITY MATTERS
(DEC 2008)**

(a)(1) The Offeror certifies, to the best of its knowledge and belief, that—

(i) The Offeror and/or any of its Principals—

(A) Are or are not presently debarred, suspended, proposed for debarment, or declared ineligible for the award of contracts by any Federal agency;

(B) Have or have not, within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, state, or local) contract or subcontract; violation of Federal or state antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, violating Federal criminal tax laws, or receiving stolen property;

(C) Are or are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with, commission of any of the offenses enumerated in paragraph (a)(1)(i)(B) of this provision;

(D) Have, have not, within a three-year period preceding this offer, been notified of any delinquent Federal taxes in an amount that exceeds \$3,000 for which the liability remains unsatisfied.

(1) Federal taxes are considered delinquent if both of the following criteria apply:

(i) *The tax liability is finally determined.* The liability is finally determined if it has been assessed. A liability is not finally determined if there is a pending administrative or judicial challenge. In the case of a judicial challenge to the liability, the liability is not finally determined until all judicial appeal rights have been exhausted.

(ii) *The taxpayer is delinquent in making payment.* A taxpayer is delinquent if the taxpayer has failed to pay the tax liability when full payment was due and required. A taxpayer is not delinquent in cases where enforced collection action is precluded.

(2) *Examples.*

(i) The taxpayer has received a statutory notice of deficiency, under I.R.C. § 6212, which entitles the taxpayer to seek Tax Court review of a proposed tax deficiency. This is not a delinquent tax because it is not a final tax liability. Should the taxpayer seek Tax Court review, this will not be a final tax liability until the taxpayer has exercised all judicial appeal rights.

(ii) The IRS has filed a notice of Federal tax lien with respect to an assessed tax liability, and the taxpayer has been issued a notice under I.R.C. § 6320 entitling the taxpayer to request a hearing with the IRS Office of Appeals contesting the lien filing, and to further appeal to the Tax Court if the IRS determines to sustain the lien filing. In the course of the hearing, the taxpayer is entitled to contest the underlying tax liability because the taxpayer has had no prior opportunity to contest the liability. This is not a delinquent tax because it is not a final tax liability. Should the taxpayer seek tax court review, this will not be a final tax liability until the taxpayer has exercised all judicial appeal rights.

(iii) The taxpayer has entered into an installment agreement pursuant to I.R.C. § 6159. The taxpayer is making timely payments and is in full compliance with the agreement terms. The taxpayer is not delinquent because the taxpayer is not currently required to make full payment.

(iv) The taxpayer has filed for bankruptcy protection. The taxpayer is not delinquent because enforced collection action is stayed under 11 U.S.C. 362 (the Bankruptcy Code).

(ii) The Offeror has or has not, within a three-year period preceding this offer, had one or more contracts terminated for default by any Federal agency.

(2) "Principal," for the purposes of this certification, means an officer, director, owner, partner, or a person having primary management or supervisory responsibilities within a business entity (*e.g.*, general manager; plant manager; head of a subsidiary, division, or business segment; and similar positions).

This Certification Concerns a Matter Within the Jurisdiction of an Agency of the United States and the Making of a False, Fictitious, or Fraudulent Certification May Render the Maker Subject to Prosecution Under Section 1001, Title 18, United States Code.

(b) The Offeror shall provide immediate written notice to the Contracting Officer if, at any time prior to contract award, the Offeror learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

(c) A certification that any of the items in paragraph (a) of this provision exists will not necessarily result in withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Offeror's responsibility. Failure of the Offeror to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Offeror nonresponsible.

(d) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of an Offeror is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(e) The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Offeror knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the contract resulting from this solicitation for default.

FAR 52.203-7 ANTI-KICKBACK PROCEDURES (JUL 1995)*(a) Definitions.*

“Kickback,” as used in this clause, means any money, fee, commission, credit, gift, gratuity, thing of value, or compensation of any kind which is provided, directly or indirectly, to any prime Contractor, prime Contractor employee, subcontractor, or subcontractor employee for the purpose of improperly obtaining or rewarding favorable treatment in connection with a prime contract or in connection with a subcontract relating to a prime contract.

“Person,” as used in this clause, means a corporation, partnership, business association of any kind, trust, joint-stock company, or individual.

“Prime contract,” as used in this clause, means a contract or contractual action entered into by the United States for the purpose of obtaining supplies, materials, equipment, or services of any kind.

“Prime Contractor” as used in this clause, means a person who has entered into a prime contract with the United States.

“Prime Contractor employee,” as used in this clause, means any officer, partner, employee, or agent of a prime Contractor.

“Subcontract,” as used in this clause, means a contract or contractual action entered into by a prime Contractor or subcontractor for the purpose of obtaining supplies, materials, equipment, or services of any kind under a prime contract.

“Subcontractor,” as used in this clause, (1) means any person, other than the prime Contractor, who offers to furnish or furnishes any supplies, materials, equipment, or services of any kind under a prime contract or a subcontract entered into in connection with such prime contract, and (2) includes any person who offers to furnish or furnishes general supplies to the prime Contractor or a higher tier subcontractor.

“Subcontractor employee,” as used in this clause, means any officer, partner, employee, or agent of a subcontractor.

(b) The Anti-Kickback Act of 1986 ([41 U.S.C. 51-58](#)) (the Act), prohibits any person from—

- (1) Providing or attempting to provide or offering to provide any kickback;
- (2) Soliciting, accepting, or attempting to accept any kickback; or
- (3) Including, directly or indirectly, the amount of any kickback in the contract price charged by a prime Contractor to the United States or in the contract price charged by a subcontractor to a prime Contractor or higher tier subcontractor.

(c)(1) The Contractor shall have in place and follow reasonable procedures designed to prevent and detect possible violations described in paragraph (b) of this clause in its own operations and direct business relationships.

(2) When the Contractor has reasonable grounds to believe that a violation described in paragraph (b) of this clause may have occurred, the Contractor shall promptly report in writing the possible violation. Such reports shall be made to the inspector general of the contracting agency, the head of the contracting agency if the agency does not have an inspector general, or the Department of Justice.

(3) The Contractor shall cooperate fully with any Federal agency investigating a possible violation described in paragraph (b) of this clause.

(4) The Contracting Officer may (i) offset the amount of the kickback against any monies owed by the United States under the prime contract and/or (ii) direct that the Prime Contractor withhold from sums owed a subcontractor under the prime contract the amount of the kickback.

The Contracting Officer may order that monies withheld under subdivision (c)(4)(ii) of this clause be paid over to the Government unless the Government has already offset those monies under subdivision (c)(4)(i) of this clause. In either case, the Prime Contractor shall notify the Contracting Officer when the monies are withheld.

(5) The Contractor agrees to incorporate the substance of this clause, including paragraph (c)(5) but excepting paragraph (c)(1), in all subcontracts under this contract which exceed \$100,000.

SPECIAL PROVISION**USAID Disability Policy - Acquisition (December 2004)**

(a) The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations an

d other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website:

<http://www.usaid.gov/about/disability/DISABPOL.FIN.html>.

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