

SECTION C: STATEMENT OF WORK

C.1 PURPOSE OF THIS TASK ORDER

The purpose of this Task Order (T.O.) is to provide assistance to the Ministry of Health (MOH) to improve policies, strategies, guidelines and protocols on:

- A) Maternal and Child Health (MCH);
- B) Reproductive Health (RH);
- C) Malaria;
- D) Nutrition;
- E) Emergency preparedness; and
- F) Systems that support the delivery of these services.

Activities under this TO will include technical assistance (TA), training and limited commodity support to the MOH in the priority areas of system strengthening for MCH/RH services, malaria, nutrition and emergency preparedness. Technical advisors will work primarily with MOH officials from the *Departamento da Saúde da Comunidade* (which encompasses MCH, and IEC/BCC), the *Departamento de Epidemias e Endemias* (encompassing the National Malaria Control Program, Epidemiology and emergency preparedness), and the *Direcção de Planificação e Cooperação* (which focuses on leadership and management and health information system).

This task order will contribute to the achievement of USAID/Mozambique's Strategic Objective Number 8: Increased use of child survival and reproductive health services in target areas by directly strengthening and supporting health systems at the central level and lower levels. In addition to this TO, USAID is also providing direct support for service delivery in four key provinces of Zambezia, Nampula, Gaza and Maputo.

This TO will particularly focus on USAID's intermediate result no. 3 (IR.3) for more accountable policy and management. The TO will also assist in creating an enabling environment under which the MOH and other implementing organizations can effectively increase access and demand for these critical health services.

The aim of the USAID Health Program is to improve the health status of the population of Mozambique by strengthening critical health services through:

Maternal and Child Health services include antenatal care (including intermittent preventive therapy for malaria (IPT)); safe delivery; post-natal maternal and neonatal care; maternal and infant nutrition; breastfeeding; Vitamin A; immunizations; integrated management of childhood illness (IMCI) and linkages for the prevention of mother to child transmission of HIV (PMTCT).

Malaria activities that reinforce the National Malaria Control Program will include prevention with insecticide treated materials (ITM); environmental control; detection; laboratory services and treatment including revised drug policies as part of the Rollback Malaria Initiative (RBM).

Reproductive Health services include family planning; STI prevention; detection and treatment (including HIV); post-abortion care; youth friendly services and contraceptive procurement and distribution.

Emergency preparedness includes support to the MOH and other GRM and NGO partners to monitor and respond to epidemics and natural disasters such as cholera outbreaks; meningitis and diseases that occur as a result of floods and droughts.

Systems that support the delivery of MCH, RH and other health services include planning; budgeting; logistics and management information systems; information and communication technology (ICT); behavior change communication (BCC); training; supervision; quality control; monitoring and surveillance.

C.2 BACKGROUND

C.2.1 Current health status

The health status of Mozambique is very low due to a variety of factors including food insecurity (demonstrated by the fact that 41% of under-fives are chronically malnourished), lack of quality data on immunization, high burden of malaria, high maternal mortality and a poor infrastructure. The 1997 and 2003 Demographic Health Surveys (DHS) reported relatively high ANC attendance for at least one visit, but less than half of all deliveries were assisted by a trained health worker.

In spite of recent improvements, the health infrastructure and delivery of services remain extremely weak. Communicable infectious diseases and parasites (namely malaria, diarrhea, tuberculosis, respiratory infections) and the rapid spread of HIV/AIDS dominate the country's epidemiological profile. In addition, Mozambique suffers from regular epidemics of cholera and meningitis in many districts. Early pregnancies, low contraceptive prevalence and short birth spacing further compound these problems.

The health services network has not developed sufficiently since the end of the civil war, thus failing to address the health needs of the dispersed population. The government is committed to building an equitable health system that is affordable and sustainable – a daunting task given that the combined resources of the state and external donors do not meet the country's estimated total needs for adequate health service delivery.

The severity of poverty is reflected in widespread morbidity and mortality – 41% of children under the age of five are chronically malnourished and 4% are acutely malnourished (DHS, 2003 Preliminary Data). Malaria accounts for roughly 15% of the country's total disease burden and is the primary killer.

Mozambican women suffer from some of the highest rates of maternal mortality in the world, ranging between 400 and 1,100 deaths per 100,000 live births. Both infant mortality and under five mortality are high compared to other African countries at 101 and 151 deaths per 1,000 live births, respectively (DHS 2003 Preliminary Data).

C.2.2 Constraints in the health sector

Profound reform of the health sector is just beginning and will seek to address some of the most important constraints to improving health status. These constraints, identified and described in Strategic Plan for the Health Sector (PESS) 2001 – 2005 – (2010) in addition to those previously mentioned, include:

- i) The population's **low level of education** in general and of women in particular, with markedly lower rates in the countryside than in the cities
 - ii) **Deficient nutrition**, above all chronic malnutrition and deficiencies in micronutrients (particularly iodine, vitamin A and iron).
 - iii) **Regional disparities** in access and consumption of health care.
 - iv) **Inequalities between health teams**, particularly the poor qualifications of professionals working in the most remote regions;
 - v) Continual and chronic **lowering of employees' morale**, motivation and professional ethics, as a result of difficult working and living conditions and low salaries;
 - vi) **Inadequate supervision** by higher levels;
 - vii) **Users' perceptions** that health care is of poor quality.
 - viii) The quality and quantity of acting **Community Health Agents (ACs)** is unknown. It is estimated that some of these agents are in some way linked to the SNS and others to NGOs. They are not always recognised by SNS because of their different levels of training, because they are not certified and/or because of the services they provide.
- Existing systems do not promote effective management of public health resources, do not exploit opportunities to outsource services to the private sector and do not allow for accountable decentralization of financial management, service delivery and quality assurance;
 - Roles and responsibilities of various entities involved in health service delivery are imperfectly defined and health sector staff are inadequately trained to fulfill them;
 - Service delivery resources are used inefficiently and inconsistently leading to poor service quality, low client confidence and reduced use of basic services at primary facilities;
 - HIV/AIDS is a severe burden on the system in terms of increased demand for services and reduced capacity and might increase existing inequalities since prevention and particularly treatment activities are benefiting more urban than rural populations, for a set of reasons (socio-economical, cultural, logistics, ...);
 - There is a chronic shortage of technically trained health workers and ;
 - The capacity to develop or improve community participation and ownership in public health services is lacking.

C.2.3 The Ministry of Health (MOH)

The Mozambique MOH is charged with protecting the health of the population estimated at 20 million people in 2004, where 54% of adults are illiterate (73% are women), 78% of people live on less than \$2 per day and 21% of the labor force is unemployed. In such circumstances, health is understandably not the first or only priority for the population. This makes efforts to increase the use of priority health services particularly challenging. In addition, 1.4 million Mozambicans including 68,000 children under the age of five have HIV or AIDS, and malaria-carrying mosquitoes produce 18 cases of malaria for every 100 people each year. The MOH must also respond to the health dimensions of Mozambique's frequent crises including floods, cyclones and droughts.

Essential interventions in Mozambique's Health Sector Strategic Plan ("PESS" in Portuguese) 2001-2005 reflect the goals of the National Poverty Reduction Strategy (PARPA) to improve both the well being of the poor and the quality of human capital. The PESS will contribute to the PARPA goals in three priority areas:

- **Health care provision:** MOH program priorities will focus on primary health care to reduce the burden of disease on families, including prevention and treatment of malaria, tuberculosis, diarrhea, acute respiratory infections and vaccine-preventable diseases.
- **Capacity building:** MOH will strengthen efficiency through skills training of its personnel, update and streamline organizational structures for key functions and decentralize management capacity and information management systems.
- **Health advocacy:** MOH will increase the roles of individuals and communities in health promotion through improving people's knowledge and information about health issues and healthier lifestyles. Advocacy includes interventions to influence and improve services and environmental changes outside the direct control of the MOH such as improving household sanitation and water supply, nutrition, female education and the status of women in society.

Organization of the government health sector: The MOH has three levels of administration: central agencies, Provincial Directorates of Health (DPS) and District Directorates of Health (DDS). The central agencies consist of the Ministry's national directorates (Health, Human Resources, Administration and Management, and Planning and Cooperation), subordinated central institutions and Maputo Central Hospital. These agencies are responsible for defining the strategies and objectives of the sector, budgeting and allocation of resources to Provinces and Maputo Central Hospital, logistics and maintenance of equipment, procurement and distribution of drugs and medical supplies, and service supervision.

The DPS constitutes the second level of administration and the DDS the lowest. The DPS is responsible for the administration of the decentralized component of the budget, funds personnel costs and other recurrent expenditures as well as for maintenance of DPS and DDS operations, both general and provincial hospitals in the provinces. The DDS is in charge of the management of resources allocated by the DPS. The DDS is responsible for the delivery of primary health care services at the district level through health centers and health posts and for rural or district hospitals where applicable.

The MOH must carry out its enormous mission with only 11,020 health providers, of whom only 477 are medical doctors (with a ratio of approx. 1/37,000 population). Of the remaining nearly 10,543 staff, 2,720 are middle level (health technicians), 6,060 are basic level (auxiliary nurses), and 1,710 are elementary personnel (nurse aides). The central Ministry of Health operates with 629 staff, 60 of them being medical doctors.

The Ministry runs 44 hospitals with a combined total of 16,513 beds, 685 health centers and 510 health posts. The service delivery system is de-concentrated and organized into 11 Provincial Health Directorates and 140 district health departments. Facilities are distributed in four levels of attention: primary, secondary, tertiary and quaternary.

Communications between the central and provincial levels are fluid and include telephone, internet and e-mail. Communications between the provinces and districts are more problematic, as internet connections and e-mail are limited. Severe limitations on the availability of landlines further curtail communications.

C.2.4 Donors and Other Support to the Ministry of Health

According to an informal survey conducted by the USAID Health Team in October 2003, there were at least 24 bilateral and multilateral cooperation agencies working in the health sector. A large number of donors (15) provide direct budgetary support to the MOH through the Common Funds¹—one of the main components of the Sector-wide Approach (SWAP).

Donors work together closely and consistently to expand and accelerate the implementation of the MOH's development strategy. Donor support is detailed in the MOH's Annual Operational Plan (POA) which identifies all activities funded directly by the MOH, by the Common Funds provided by budgetary support donors and by other bilateral and multilateral funds including those of USAID. The GRM is currently initiating large programs for HIV/AIDS, tuberculosis and malaria including three grants from the Global Fund for AIDS, TB and Malaria and the new World Bank grants to accelerate treatment of HIV/AIDS (TAP). In addition, as a focus country for the USG Presidential Emergency Plan for HIV/AIDS, the MOH receives substantial support from CDC and USAID.

C.2.5 USAID/Mozambique's support to the health sector

Although USAID does not contribute to the Common Funds, the Health Team has supported the MOH to strengthen management and effectiveness of its pooled funds under its previous strategy and will continue to build on that work and strengthen program coordination to leverage additional resources and derive maximum benefit from those resources.

USAID has gained extensive experience in providing significant support to Mozambique's public health system by working with U.S, third-country and Mozambican organizations to provide assistance to the MOH to strengthen its health policy and financial management capacity.

¹ There are currently three Common Funds : PROSAUDE (Main Common Fund), Provincial Common Fund Common Fund for Drugs and Medical Supplies

The result of USAID's capacity building efforts with the MOH has been the creation of cadres of master trainers to continue developing and implementing the Ministry's ongoing staff development program. USAID support in these areas closed the gap in the Ministry's ability to manage its staff improvements in the areas of MCH/RH, essential obstetric care and communication approaches.

C.3 DESCRIPTION OF SO8's HEALTH PROGRAM

C.3.1. Strategic Objective and Intermediate Results

The purpose of Health SO 8 is to improve the health of Mozambican families so that they become more productive, less vulnerable to disease and more effective participants in community health and development. The Strategic Objective statement and its three intermediate results (IR) are as follows:

SO8: Increased use of child survival and reproductive health (CS/RH) services in target areas.

- **IR1: Increased access to quality MCH/RH services in target areas;**
- **IR2: Increased demand at community level for MCH/RH services in target areas; and**
- **IR3: More accountable policy and management.**

The health SO will include a combination of national and community-level interventions designed to strengthen the policy and management environment, increase access to proven and effective primary health services, and increase community-level demand for these services by strengthening community² participation in managing or influencing the quality of health care services, and in providing appropriate services in the community itself. These three key intervention areas will lead to healthier families that are more productive, less vulnerable to disease and contribute more effectively to their economic status.

SO 8 will focus interventions on those health problems responsible for the largest number of child and maternal deaths: malaria, pregnancy and peri-natal complications, vaccine-preventable diseases, and diarrheal diseases. The expected resource level for this program will oblige USAID and the MOH to make choices about priority interventions that will generate the greatest impact in the selected areas.

- **IR1: Increased access to quality MCH/RH services in target areas**

PVOs implementing Provincial Projects will be the main actors leading to the achievement of this IR. In order to increase access to primary health care, this IR will focus on improving the quality and efficiency of existing MOH service delivery sites and strengthening networks of

² For service delivery, "community" will refer to the catchment population of a specific type of service or facility. For local participation, "community" will refer to some appropriate civil society or local governance entity made up of local residents and organized for their common good.

community-based health agents. The IR will focus on formal and informal maternal and child health and reproductive health interventions for those illnesses most responsible for the largest number of child and maternal deaths in Mozambique. Strengthening specific service delivery and quality improvements for family planning, assisted deliveries and peri-natal care and other services are critical elements of the new program. The program envisions following the approach of strengthening the health system to be fully functional in specific services and requiring outreach services or fixed facilities to meet minimum standards before they can be considered fully functional. The program will also seek to strengthen community-based care and link it to MOH facilities for referrals and technical guidance.

- **IR2: Increased demand at community level for MCH/RH services in target areas**

PVOs implementing Provincial Projects will be the main actors leading to the achievement of this IR which focuses on improving accountability for health services by stimulating participation of local, provincial and national leadership in advocacy for and management of health resources. Communities will participate in local decisions pertaining to their own health services and demands. Communities will also support improvements in quality through more direct accountability. Leadership and advocacy are critical elements in the process of changing community beliefs and encouraging community participation in their own health services. USAID partner NGOs have supported the creation and empowerment of community leadership councils that focus on local health improvements and community responsibility. Prominent people from all levels of society will provide leadership and advocate for increasing client involvement in primary health services, both at public health facilities and in the community.

- **IR3: More accountable policy and management**

IR 3 will be the key focus for this Task Order. This IR focus on improving the efficient and transparent management of scarce health resources to enable Mozambique's health sector to derive maximum benefit from all available support. The program will strengthen critical systems within the MOH for planning of health services and monitoring program performance. The IR will also focus on improving MOH policies, guidelines and protocols related to maternal and child health technical areas, malaria, epidemic response, advocacy and monitoring and evaluation.

Activities under this IR will strengthen and expand priority, interrelated management systems that will improve the MOH's effectiveness in managing scarce health resources. Strengthened planning and management systems will allow the MOH to more effectively utilize financial, human, and other resources available. Improved systems and procedures will allow for more comprehensive coordination of internal programs and outsourcing of cost-effective services to the NGO or private sector. The program will assist the MOH to better define the roles and responsibilities of their operating units and ensure that staff is adequately trained. It is crucial not only to assist the MOH in increasing the effectiveness of allocating human resources, but also ensuring that management systems, monitoring and related interventions are consistent with the increased involvement of stakeholders. TA will be provided to the MOH to strengthen policy, program and communications and management at central and provincial levels.

C.3.2 Level of Focus and Geographic Area

This Task Order will focus on IR3 (described above) and will assist the MOH at the central level and support national programs that are responsible for providing proven MCH/RH, Malaria and Nutrition services.

USAID also expects the TO contractor to coordinate and collaborate with other USAID-funded partners working in health, including four separately awarded Cooperative Agreements with PVOs, more focused on IR1 and IR2 (described above) that will strengthen service delivery and use in select districts within the four provinces of Zambezia, Nampula, Gaza and Maputo.

In addition, SO 8 finances a separate contractor who is working with the central level MOH to strengthen the logistics management system especially related to essential medicines, and contraceptives. In the coming months, this scope of work could be expanded to include anti-retro viral drugs in collaboration with the USG support for HIV/AIDS. Collaboration with this contractor is also expected.

SO8, in collaboration with the MOH has defined the mechanisms of coordination and the roles and responsibilities of the different parties involved (MOH, USAID and the implementing organizations) that will guide the implementation of all SO8 funded activities (refer to Task 5).

C.3.3 Illustrative Level of Effort

It is anticipated that priorities and levels of effort will shift during the life of this award. In order to provide illustrative guidance on the level of effort versus resources the MOH currently estimates will be required to complete the below tasks we recommend proposal are addressed to cover:

| | MOH Sector | Tasks | Level of effort |
|---------------------------|------------|----------|-----------------|
| Family Health * | DSC | 1 & 3 | 40 % |
| Long Term Training | DSC | 6 | 5 % |
| Malaria | Epidemio | 1 & 3 | 25% |
| Epidemic surveillance | Epidemio | 3. (3.8) | 5 % |
| Health Information System | DPC | 2 | 10 % |
| M&L | DPC | 4 | 10% |
| Coordination | All | 5 | 5 % |
| Total | | | 100 % |

* Family Health includes : Maternal and Child Nutrition, Community participation in support of health, Behaviour Change and Communication, Family Planning, Safe Motherhood, Neonatal, infant and child health.

C.4 CONTRACTOR SCOPE OF WORK

The aim of this five-year activity is to assist the central MOH to improve MCH/RH, malaria and nutrition policies and implementation to improve quality and efficiency of services to improve health status. In addition, because Mozambique is especially vulnerable to epidemics such as cholera and meningitis the other focus of this TO is emergency preparedness. A wide variety of activities are anticipated including TA, training, ICT support, provision of equipment, supplies and materials, capacity building, policy dialogue, monitoring and evaluation, development of tools and job aids, BCC/Community Participation strategies, and operational research. The aim is to strengthen MOH and PVO/NGO partners' capacities to increase utilization of, access to, demand for, and management of MCH/RH services at provincial, district and community levels.

C.4.1. Priority setting with MOH and USAID

USAID recognizes the uncertain nature of future priorities and needs for technical assistance to the Ministry of Health. This is because of the level of development of Mozambique's health sector, the major challenges it faces, and the evolving nature of other sources of technical assistance including the SWAp Monitoring Groups. Thus, although this scope of work sets forth specific tasks and preliminary performance standards, USAID does not expect that the Contractor will be able to make equal progress on all fronts. However, nutrition has been appointed as a priority. To account for these circumstances the Contractor will develop with USAID and the MOH a Five-Year Strategic Plan and rolling plans of technical assistance for one year at a time for approval by USAID (see below). USAID will review these plans after each year of implementation and agree with the Contractor on any changes needed for the following year of implementation.

C.4.2. Data collection

The Contractor will assist the MOH collect monitoring data for its annual report and be responsible for the collection and analysis of all data needed for the monitoring of USAID's Performance Monitoring Plan and Annual Report. While the contractor's responsibility will be to consolidate the collection of data in a timely manor from the PVOs for IR.1 and IR.2, in their geographic areas of activity, the contractor will be responsible for indicators yet to be defined under IR.3.

C.4.3. Illustrative IR.3 Indicators

- # of targeted policies in MCH/RH, malaria and nutrition drafted and approved.
- # of targeted policies in MCH/RH, malaria and nutrition operationalized.
- % of districts preparing annual operational plans.

The Contractor, in close collaboration with the MOH and USAID, shall finalize performance indicators which will allow monitoring of activities and progress towards achieving results under IR.3 which will be integrated into the Performance Management Plan. The Contractor's performance will be assessed against results expressed through the to-be-finalized IR3 indicators.

C.4.4. Specific Tasks of the Contractor

The Contractor will provide long-term advisors and an administrative support team that will manage the delivery of short-term technical assistance, home office support, training, development of learning materials, equipment and supplies related to technical support and other related systems support as stated in Section C.5 below. The Contractor may execute sub-contracts and/or sub-grants as necessary to meet the requirements of this Task Order.

The contractor shall undertake the following tasks over the life of the contract focusing on interventions either at the central or provincial levels of the MOH or both Central and Provincial levels depending on the task:

Task 1: Improve capacity of the MOH (Departments of Community Health, Planning & Cooperation, Epidemiology) in data collection, analysis and documentation

One of the key issues in the health sector seems to be the lack of data and the analytical capacity to use data in effectively addressing challenges in maternal and child health, reproductive health, malaria and nutrition. The Contractor will approach each of the tasks described in this task order with this in mind in order to assist the MOH to make evidence-based decisions.

In this respect, the Contractor shall strengthen MOH capacity to collect, analyze and document data as follows:

- 1.1 Develop MOH capacity for evidence-based solutions to technical issues in MCH, FP, malaria and nutrition through data analysis and documentation including sentinel surveys on selected health issues and the mitigation of epidemics.
- 1.2 Develop MOH capacity for effective monitoring and evaluation of program implementation and for decision making towards achievement of planned results.
- 1.3 Improve MOH capacity to use evidence-based data to address equity issues ranging from staffing criteria/patterns to other resource allocations and management in order to improve quality and efficiency.
- 1.4 Improve the capacity of the Epidemiology Department to analyze data and publish quarterly Epidemiological Bulletins including national and provincial disease prevalence data.
- 1.5 Assist MOH with the elaboration of an Operational Research Plan with themes relevant to this Task Order. The costs of implementation are not covered under this Task Order.

| Preliminary performance standards: | PMP indicator link |
|---|--|
| Data/vital statistics on MCH, RH, malaria, nutrition and quality of care are readily available. | <i>Link baseline data with SO level Indicators on vitamin A, immunization rates, CPR, ITN use and assisted deliveries.</i> |
| MOH publishes periodic (bi-annual) M&E reports demonstrating progress against key indicators in MCH, FP, nutrition and Malaria. | <i>Bi-annual reports will address SO level indicators</i> |
| Data on staffing patterns, prescription practices, and financial disbursements is readily available. | <i>Link baseline data to IR 8.3 and 8.1 indicators.</i> |
| Behavior change learning materials relevant to local region available. | <i>Link baseline data to IR 8.2 indicators.</i> |
| Data on patterns of epidemics outbreaks is available. | |
| Quarterly Epidemiological Bulletin are published and used by health staff at all levels to monitor health care services | <i>Link baseline data to IR. 8.1 indicators.</i> |
| Improvements in district health returns to provincial and central MOH offices. | <i>Link baseline data to SO level indicator.</i> |
| MOH staff can articulate health priorities to communities and motivate communities to use limited health resources efficiently at facility and community level. | <i>Link baseline data to IR. 8.1 and 8.2 indicators</i> |

Due to the broad range of data requirements this component is best implemented through short-term consultants who will be hired for a specific sub-task under the coordination of the Senior Technical Advisor. Technical support can also be sort from Global Health, REDSO (and its partners) etc.

Task 2: Assist MOH improve Information and Communication Technology (ICT) systems

The Contractor will assist the Ministry of Health to assess the current ICT systems and how these meet current ICT needs for advocacy, decision-making and communications.

- 2.1 Support MOH to more effectively use available health information for decision-making at all levels and to communicate within different departments in the MOH and at all levels.
- 2.2 Support MOH to streamline routine operational tasks, training and reassigning human resources to focus on health sector information analysis and application.
- 2.3 Assist the MOH to improve the quality and use of information collected routinely or through operations research and testing of new technologies and through participation on the HIS working group.
- 2.4 Assist MOH to use ICT to enhance information sharing.

| Preliminary performance standards: | PMP Indicator link |
|---|---|
| Forecast data on potential epidemics readily available. | <i>Baseline data needs to be linked to an indicator on epidemic outbreaks</i> |
| Health Information System is assessed according to World Health Organization and World Bank's promoted Health Metrics Network methodology to monitor the performance of the Health Information System . Challenges/weakness of current information are system are documented. Priority corrective/improvement actions are defined with MoH and are implemented to the extend of possible within budget limits.. | <i>Link baseline data to IR 8.3 indicators</i> |
| CS and MCH data are available on MoH webpage, updated regularly. Users (MoH Central Level, DPS and partners) have been made aware of the availability of those data and are consulting regularly the website. | <i>Link baseline data to IR 8.3 indicators</i> |

ICT expertise necessary and again participation in regional forums on ICT practices would be useful.

Task 3: Assist MOH to develop Policies, Strategies, Guidelines and Capacity on MCH, RH, Nutrition and Malaria

The Contractor shall provide technical support to MOH to develop, update and disseminate policies, strategic plans, guidelines and protocols and enhance the capacity to deliver MCH, RH, Nutrition and Malaria services. Areas that should be addressed include:

- 3.1 Maternal and child nutrition
- 3.2 Community participation in support of health
- 3.3 Behavior change communication
- 3.4 Family planning and child spacing services
- 3.5 Safe Motherhood including IPT, syphilis screening, lifesaving skills
- 3.6 Neonatal, infant and child health including exclusive breastfeeding, immunization, kangaroo mother method, infant and young child feeding, micronutrient supplementation, IMCI
- 3.7 Fostering public-private partnerships
- 3.8 Epidemic surveillance, epidemic response and notification of diseases protocols like cholera, measles, meningitis and malaria
- 3.9 Identify, make arrangements and/or organize related training activities in Mozambique

The contractor shall promote and facilitate cross-sector ownership and contribution to policies within MoH.

| Preliminary performance standards | PMP Indicator link |
|--|---|
| MOH has documented policies, strategies and guidelines on MCH, RH, Malaria, Nutrition and epidemic response. | <i>Link baseline data to IR 8.3 indicators.</i> |
| MOH policies demonstrate participatory approach and greater incorporation of partners, communities and private sector. | <i>Link baseline data to IR 8.3 indicators.</i> |
| MOH multiyear strategic plan and annual operating plan include effective approaches for mitigating disaster impacts on the health of the affected population | <i>Link baseline data to IR 8.3 indicators</i> |
| Epidemic response unit is in place with budgetary resources to respond to emergencies | <i>Link baseline data to IR 8.3 indicators</i> |
| MOH services demonstrate improvements in preventing infections and proper waste disposal. | <i>Link baseline data to IR 8.1.</i> |
| The MOH policies and strategic plans on MCH, RH, nutrition and malaria include aspects of HIV/AIDS integration | <i>Link baseline data to IR 8.3 indicators</i> |
| MOH policies on Community participation include drug availability component at the community level (Community Based Distribution Scheme) | <i>Link baseline data to IR 8.3 indicators</i> |
| <i>The Chief of Party will only lead in coordinating TA needs with MOH. There will be need for external short term TA and possibly a short-term resident Advisor at MOH to help move activities.</i> | |

Task 4: Assist MOH to strengthen staff Management and Leadership skills

The Contractor will assist the MOH to develop capacity in management and leadership at the central level and in Nampula, Zambezia, Gaza and Maputo Provinces to sustain effective health service delivery as follows:

- 4.1 Assist MOH to develop a training curriculum based on a review of key management and leadership issues negatively impacting on service delivery.
- 4.2 Assist MOH to train core teams at central and provincial level that will implement the management, leadership and participatory supervision programs. These teams will be encouraged to seek other resources to develop cascade training system to reach basic health units in the country.
- 4.3 Assist MOH to train core teams at central and provincial level that will sustain the promotion of quality assurance.
- 4.4 Assist the MOH to institutionalize quality and efficiency of service delivery as a key tenet of its MCH, RH, nutrition and malaria services.
- 4.5 Assist the MOH to perform multi-year strategic planning

| Preliminary performance standards: | PMP Indicator link |
|---|--|
| Data/information on key management and leadership challenges is documented. | <i>Link baseline data to IR 8.3 indicators</i> |
| Management and leadership training curricula adapted to local circumstances documented. | <i>Link baseline data across the 3 IRs key indicators</i> |
| Facility and community health workers are able to resolve basic problems through problem solving techniques. | <i>Link baseline data to SO level and to IR 8.3 indicators</i> |
| Health facility managers better qualified to plan, organize, implement, monitor and evaluate quality improving activities. | <i>Link baseline data to SO level and IR 8.3 indicators.</i> |
| Capacity of MOH to identify and implement the necessary improvements in Human Resource Management and to provide support to provincial HR divisions improved. | <i>Link baseline data to IR 8.3 indicators</i> |
| Performance Improvement introduced in in-service training curricula. | <i>Link baseline data to IR 8.1 indicators</i> |

Training skills will be necessary. Expertise with Mozambique management culture will be useful. There is a need to expose key managers and leaders to other countries in the region but with a clear scope of work before any tours take place and will be conditional on implanting a learned practice on their return.

Task 5: Improve coordination and monitoring of USAID health funded activities and linkages with the MOH

USAID/Mozambique’s assistance to GRM in the health sector involves implementation in different technical areas by a variety of implementing partners. MOH also receives support from other donors contributing to the Common Funds mechanisms created in the context of ProSaúde. This represents a challenge in terms of coordinating all partners and ensuring that the intended results, as defined by MOH, are achieved.

In this context it is envisioned that the Contractor shall have a major role in coordinating and monitoring all USAID-funded health (SO8) activities, both at central level as well as at the provincial level. The Contractor shall:

- 5.1. Work closely with the MOH and USAID to select final indicators, establish baseline data and performance targets for each indicators and finalize the Performance Monitoring Plan accordingly.
- 5.2 Assist the MOH to review and monitor all USAID-funded health activities on a regular basis and collect monitoring data for MOH annual report and USAID Performance Monitoring Plan and annual report.
- 5.3 In accordance with the official agreement between USAID and the MOH, organize semi-annual conferences to report on and review progress, address issues, make recommendations and outline objectives for the next six months. These meetings will include representatives of USAID/ Mozambique, MOH (central/ provincial), USAID implementing partners and other partners. The contractor shall not finance the participation of other implementing partners.
- 5.4 The Contractor shall facilitate communication and collaboration between the MOH and USAID on SWAP activities.
- 5.5. Assist the Ministry of Health to identify and respond effectively to new opportunities that emerge to attract additional resources to improve maternal and child health, reproductive health, nutrition, malaria and emergency preparedness.

| Preliminary performance standards: | PMP Indicator link |
|--|---|
| Ministry of Health officials indicate that their work has benefited from the Contractor’s participation as a technical resource. | <i>Link baseline data to IR 8.3 and 8.3.1 indicators.</i> |
| MOH annual operational plans (POA) for 2006 to 2008 include USAID-funded priority MCH, RH, nutrition and malaria activities. | <i>Link baseline data to SO level and to IR 8.3 indicators.</i> |
| USAID Health Team receives reliable and timely data for annual reports. | <i>All IRs.</i> |
| <i>The Contractor will identify and facilitate monitoring activities for USAID and the MOH including organizing partner meetings, maintaining a website, disseminating reports, etc. The USAID/ Mozambique Health Team Leader will facilitate communication between the contractor and other USAID implementing partners who need to collect and report on data.</i> | |

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| <u>Task 6: Provide post-graduation academic training</u> | |
| Once the MOH has identified candidates and potential sites, the Contractor shall : | |
| 6.1. Identify and make arrangements for post-graduation training in Mozambique a/o abroad in the fields of Public Health, Epidemiology, MCH and other related to the activities described in this Task Order. | |
| 6.2 Be responsible for full registration process, transportation, logistics and payments. | |
| Preliminary performance standards: | PMP Indicator link |
| MOH managers better qualified to plan, develop and implement policies and to strengthen health systems | <i>Link baseline data to IR 8.3 indicators</i> |

C.5 GENDER

Key health sector donors such as USAID and the World Bank support gender equality as a core development issue and objective. Overall, research demonstrates that there are widespread gender gaps in access to and control of resources, economic opportunities, power and political voice. These gender inequalities impose costs on the health and well-being of men, women and children by directly influencing health outcomes in terms of the supply of and demand for services, service utilization and desirable health practices, e.g. gender inequality diminishes the likelihood that women will visit health services or undertake healthy behaviors because they lack knowledge of healthy practices and access to sources of service, have limited access to resources, including nutrition and health care, and lack control over decision-making as it relates to number of children, protection from sexually transmitted infections and related topics.

The focus of the planned health program on expanding health service coverage through strengthening health systems and service quality and increasing community participation in health activities requires that activity planning must take into account the influence of gender on the demand for, access to and utilization of services, on health behaviors and on community level participation in health activities.

Capacity building/training support activities planned under this intervention must address gender issues paying particular attention to cultural practices. Many customary practices give rise to and entrench women's subordinate social and economic status in Mozambique including: the perpetual minority status for adult women; wife inheritance; polygamy; virginity testing; and the position of women in society as child bearers, primary caregivers to children and men and taking responsibility for issues relating to sexual and reproductive health yet without having decision-making power over when and how they fulfill these roles. These critical issues and practices compromise a women's right to bodily integrity and autonomy and impact negatively on her ability to negotiate safe sex and proper care for her children in turn negatively affecting her and her family's health status.

In developing the initial program implementation plan and Performance Monitoring Plan, the contractor shall ensure that it incorporates gender issues as appropriate and should refer to the Gender Analysis and Action Plan for Mozambique 2004-2010.

C.6 CAPACITY BUILDING

Programs should strengthen in-country capacity and foster collaboration as in-country capacity is the foundation for long-term success. Sustainable health systems and services at the national and local level depend critically on the engagement and commitment of key stakeholders - local people, government, civil society, enterprises, NGOs and donor institutions. In addition, good cooperation and coordination among USAID implementing partners and other donors is necessary.

C.7 REPORTING, DELIVERABLES AND ADMINISTRATIVE REQUIREMENTS

The following sub-sections describe the nature and content of plans and reports required for planning, implementation and monitoring of the Task Order. Most of these deliverables are interrelated. The format of all of the different plans and reports should be compatible with MOH and USAID plans and designed to allow analysis among the completed activities, expenditures, and results for each year of the program. Because of the interrelationships, the timing of the delivery of these documents should also be coordinated, i.e. the year 1 Performance Monitoring Report and Financial Status Report should be available before the year 2 Action Plan is completed so that rate of expenditure and progress in each area can be taken into account in the preparation of year 2's Action Plan and in assessing its feasibility. The specific timing for delivery of the Annual Action Plans, the Annual Financial Status Reports, and the Annual Performance Monitoring Reports will be mutually agreed upon once the Contractor's TA team is actively involved in implementing the Scope of Work.

C.7.1 ACTION PLANS

C.7.1.1 Five-Year Strategic Plan

The contractor will submit a "draft" five-year strategic plan that encompasses the activities required to achieve results, the corresponding time frames, and an estimated budget required to achieve the six tasks. In contrast to the Annual Action Plans (described in c.5.1.2 below), the five-year strategic Plan will focus on the five-year chain of actions needed to achieve the targeted end results of SO8 and IR3 in particular. The Contractor will work closely with the MOH and other stake holders in developing the final plan. This five-year Strategic Plan will be submitted in a format mutually agreed among the MOH, the Contractor and USAID/Mozambique.

C.7.1.2 Annual Action Plans

Within the first 90 days after the arrival of the first long-term TA team member in Mozambique, the Contractor will submit an Annual Action Plan for Year 1, designed with input from MOH and USAID. This Annual Action Plan, and Annual Action Plans for

subsequent years, will describe the activities and interventions to be carried out and the corresponding time frames. The Annual Action Plans will include as an integral component of the Annual Capacity Building/Training Plan (described in c.5.1.2.1 below). The Annual Action Plan will also incorporate a Financial Report. The Annual Action Plans will provide information in a format mutually agreed with the MOH and USAID/Mozambique.

The Contractor will develop plans in collaboration with the MOH and USAID/Mozambique Health Team. The plans are subject to the approval of the USAID/Mozambique CTO for the TASC2 Task Order. The CTO, in consultation with MOH, will review and approve plans to ensure that they are within the TASC2 Scope of Work and contribute to the USAID/Mozambique Health results framework.

C.7.1.2.1 Annual Capacity Building/Training Plans

As part of the Annual Action Plan submissions, the Contractor will submit an Annual Capacity Building/Training Plan for all Contract-funded training activities. The plan will be based on the Annual Action Plan and consist of on-the-job or more formal training designed to support achievement of MOH PESS and SO8. The timing of actions will be shown in the Annual Action Plan. The separate Capacity Building/Training plan will be used to meet USAID review and reporting requirements. The plan will include a brief description of the relationship to the MOH PESS and Human Resource Development Plan, SO8 framework, types of capacity building/training proposed by category (international, national or provincial); expected cost; source of training; and proposed timing. The Annual Capacity Building/Training Plans will provide information in a format mutually agreed with the MOH and USAID/Mozambique, and will be included in the USAID Tracking System for training in accordance with ADS.

C.7.2 MONITORING AND EVALUATION

C.7.2.1 Performance Monitoring Plan

Expected program results with illustrative indicators are provided in this document. However, during the initial program planning period and within the first 90 days after the arrival of the first long-term TA team member in Mozambique, the contractor shall work closely with the MOH and USAID to select final indicators, establish baseline data and performance targets for each indicator, and finalize a Performance Monitoring Plan (PMP) which monitors progress towards achieving results. The PMP will be developed in accordance with USAID guidelines. To the extent it is possible, performance-monitoring systems will be integrated into, and will enhance existing MOH management information systems.

USAID/Mozambique, the MOH and the contractor will conduct monthly meetings to monitor the progress of work and identify and resolve constraints. There will also be bi-annual performance reviews involving USAID/Mozambique, the MOH, the contractor and all USAID partners to monitor the achievement of results based on the targets specified in the PMP and MOH expected results.

C.7.2.2 Six-month Performance Monitoring Reports

All Performance Monitoring Reporting will be in a format compatible with USAID's format of the Mission's Annual Performance Report to USAID/Washington. The report shall discuss

progress against the Performance Monitoring Plan, results achieved, constraints affecting implementation and proposed solutions.

Performance monitoring reports will include program outcomes, and results based on the five-year strategic plan, annual action plans, and the indicators and targets in the SO8 Performance Monitoring Plan. As specified in these plans, the data for performance monitoring may be from a variety of sources, including: (i) the MOH HIS; (ii) KAP surveys; (iii) facility and community level assessments; (iv) field visits; (v) other relevant analyses and reports; and (vi) the Contractor's primary monitoring and reporting system for this Task Order. Each six months the contractor shall report against appropriate indicators included in the PMP.

The Performance Monitoring Report format should contain at a minimum the following information:

- Activities and interventions implemented in last six months;
- Reported Results;
- Planned activities and interventions for next six months;
- Expected future results;
- Performance;
- Compelling individual-level success stories; and
- Documentation of better practices that can be replicated or taken to scale.

C.7.2.3 Monthly Performance Reports

The Monthly Performance Reports shall discuss progress against the Annual Action Plan (C.5.1.2), results achieved, constraints affecting implementation and proposed solutions. The report shall also address whether and how constraints reported in previous reports have been addressed and resolved and shall also include discussion of activities and events planned for the next month.

Monthly Performance Reports will include program activities, outcomes, and results based on the five-year strategic plan, annual action plans, and the indicators and targets in the SO8 Performance Monitoring Plan.

The Monthly Performance Report format should contain at a minimum the following information:

- Progress (achievements) since the last report;
- Problems described in previous report solved or still outstanding and intentions to address outstanding problems;
- New problems encountered since previous report;
- Proposed solutions to outstanding and new problems;
- Plan for next month;

C.7.3 FINANCIAL REPORTING

Financial Status Report information will be provided in a functional format to allow an examination of the cost of carrying out major action plan activities rather than simply providing conventional “budget categories” for major expenditures. The Financial Report will also provide meaningful information comparing the life-of-contract budget, expenditures to date, summary of estimated requirements for the next year, and a pipeline analysis of Task Order funds.

15 days before the end of each calendar quarter, the contractor shall submit a detailed quarterly financial report with separate line items illustrating all vouchered and accrued monthly expenses. The report should contain at a minimum the following information:

- Total life-of contract budget;
- Total funds committed to date;
- Total funds expended by the Applicant to date, including direct and indirect administrative costs;
- Total estimated accrued expenditures this reporting quarter;
- Total expended (actual plus accrued)
- Duration of contract time remaining (in months and percentage)
- Pipeline (committed funds minus expended funds);
- Estimated expenditures for remainder of year; and
- Pipeline (committed funds less total expenditures).

C.7.4 MISCELLANEOUS REPORTING REQUIREMENTS

- Implementation problems: The Contractor shall immediately report to the USAID Contracting Officer and the Cognizant Technical Officer any implementation problems affecting work quality, price or delivery schedules.
- Document specifications: All plans, reports and other documentation prepared under this Task Order shall be provided in English as a finished document both in hard copy and electronically. Documents will be prepared in Microsoft Word, Microsoft Excel and/or Microsoft PowerPoint. All project planning will be done with Microsoft Project Planning.
- Report of USAID-funded property: In accordance with USAID acquisition regulations, the Contractor is required to submit Annual Inventory Reports of all non-expendable, USAID-funded property in the Contractor’s custody (based on the calendar year). Copies will be submitted to USAID/Mozambique.

C.7.5 ADMINISTRATION

Offerors should make the following assumptions in planning their proposals for program, office and logistical support:

The MOH will provide office space for two key personnel staff of the contractor only. The contractor will need to provide and budget for offices premises for the remainder of their staff .

The contactor shall fulfill the following administrative requirements:

- Equip and staff a small office within the MOH in Maputo. The office will house the contractor's Chief of Party and Senior Technical Officer.
- Provide and equip an office to accommodate all remaining staff and short-term consultants;
- Recruit and field local and international consultants and experts as needed. Where feasible, the contractor shall make maximum use of available local expertise for short-term assignments. In fielding all short-term experts but particularly with expatriate short-term expertise, the contractor shall ensure continuity of technical assistance by utilizing a limited pool of specialists who make repeated visits to work on continuing activities;
- Organize in-country logistics and travel for meetings, site visits and other activities outlined in the approved program implementation plan;
- Ensure compliance with all applicable USAID rules and regulations. Funds for this five-year program come from the Child Survival and Health (CSH) Program Fund earmark. The contractor shall manage funds ensuring strict adherence to all USAID funding guidelines and regulations for CSH funds.

Program support provided through the Contractor for its own tasks and other CAs is intended to support training, technical assistance, assessment, and follow-up rather than to replace MOH and other donor support for operating costs.

Based on the availability of funding, particularly for infectious diseases and malaria, USAID may amend the Task Order to increase the total ceiling price to provide additional support to these program areas without further competition. In the case of additional funding of this Task Order, the Contractor shall be prepared to submit revised action plans and budgets to reflect the change in the actual ceiling price.

C.8 CONTRACTOR PERSONNEL

Personnel capacity and experience is a critical evaluation criterion (weight = 35%) for award of this Task Order.

Scoring for personnel capacity and experience will be based on: 1) qualifications and experience of named individuals for 2 positions identified as key personnel; 2) a proposed staffing plan for a Maputo based team, and; 3) the qualifications and experience of proposed staff resources to provide short-term technical assistance.

USAID/Mozambique envisions the need for a small but effective team based in Maputo. A Chief of Party and a Senior Technical Officer who may/will be recruited internationally will lead the team and will be considered as key personnel. It is expected that all other team members will be recruited locally following award of the Task Order and agreement on a staffing plan with USAID/Mozambique. It is also anticipated that short-term technical

assistance will be used to complement the skills of the in-country team. To the extent feasible, qualified consultants should be recruited locally or from other countries in the region.

During the initial detailed program implementation planning process, the contractor will review staffing needs and submit, along with the implementation plan, a proposed staffing plan for a limited number of local professional and administrative/support staff. Once USAID/Mozambique approves this plan, the contractor shall recruit staffing.

C.8.1 Key Personnel

For Key Personnel offerors should submit a summary of qualifications and demonstrated experience as well as a letter of commitment from proposed candidates.

Chief of Party

The Chief of Party (COP) will be responsible for overall planning and management of activities under this Task Order. The COP is primarily responsible for facilitating senior level policy and technical dialogue with the MOH, other GRM Ministries and International Partners. The COP will assist the MOH to work more effectively both internally and with external partners. Specifically, s/he will assist the MOH in working: 1) across operational units at the central level through the implementation of new policy, planning and management processes, 2) between the central level and the Provincial/District levels to enhance information flows and facilitate implementation of programs, 3) with other Ministries to facilitate implementation of MOH priorities, and 4) with international partners to insure coordination through strong leadership by the MOH.

The COP will also assist USAID/Mozambique with effective use and coordination of SO8 resources awarded through cooperative agreement(s) for support of IR1 and IR2 at Provincial and District levels.

Additional Terms of Reference:

- Graduate level training in public health management, public administration, health finance, health economics or related discipline.
- Excellent communications skills, both oral and written in English and preferably in Portuguese. For candidates not fluent in Portuguese, please provide information on other language skills and a plan for Portuguese language training.
- Demonstrated success at providing technical assistance to a developing country Ministry of Health. (Please provide references of Ministry of Health counterparts.) Preference in descending order for experience in Mozambique, southern Africa, low-income country, other developing country.
- Recent prior experience overseeing a long-term health technical assistance program of similar nature and scope, including negotiating work plans, interfacing with donors, Ministry, other development partners; developing terms of reference, identifying technical assistance sources, and ensuring high quality.
- Demonstrated excellent interpersonal and cross-cultural skills.

- Skills and experience anticipated in some combination of the following: negotiation, advocacy, health policy development and strategic planning, information management, health human resources, decentralization of health systems and local health planning, managing community participation, health care quality improvement, and technical areas of maternal, reproductive and child health, nutrition, malaria.

Senior Technical Officer

The work of the COP will be facilitated by another senior level position. The Senior Technical Officer (STO) is responsible for the technically focused work associated with activities under this Task Order including the content of advocacy messages and the evidence base for policies and strategies developed through dialogue with the MOH, other GRM Ministries and International Partners. The STO will also provide guidance and oversight to the technical members of the local team and short-term technical consultants. The STO provides assistance to the MOH in translating national policy into practical guidance to support implementation of the Provincial and District levels and, when required, in developing technical proposals for funding health sector activity. The STO also plays a role in ensuring the technical quality of SO8 activities implemented through cooperative agreement(s) for support of IR1 and IR2 at the Provincial and District levels.

Additional Terms of Reference:

- Graduate training in public health or related discipline, preferably at the doctoral level (MD with MPH, Ph.D. or equivalent in qualifications or experience).
- Excellent communications skills, both oral and written in English and preferably Portuguese. For candidates not fluent in Portuguese, please provide information on other language skills and a plan for Portuguese language training.
- Minimum of 10 years experience implementing and evaluating large-scale public health programs in Africa..
- An excellent understanding of the full array of health and health related issues facing women and young children in Mozambique.
- Demonstrated capacity to advise the Chief of Party on technical issues related to health policies and strategies, health interventions, innovations and health information.
- Demonstrated capacity to compile, evaluate and maintain the evidence base to support advocacy, policy dialogue and planning with the Central MOH, Provincial and District Health Teams and implementing partners.
- Demonstrated experience in providing oversight and guidance to technical staff and short term consultants concerning the focus and timely completion of their work.
- Provides assistance to the MOH in translating policy into implementation guidelines for use at the Provincial and District levels.
- On technical issues, serves as the primary point of contact for USAID cooperating agencies working at the Provincial and District levels.
- Responsible for collecting and maintaining information required for quarterly and annual reporting to USAID.

C.8.2 Staffing Plan

The staffing plan for a small Maputo-based team will be finalized following award of the Task Order and consultations with USAID/Mozambique and the MOH. The team should be recruited locally to optimize use of Mozambican resources.

For the purposes of this application, offerors should propose a draft staffing plan for the Maputo-based team that takes into consideration the purpose and scope of the Task Order, the roles and skills of named key staff and the complementary array of local and short-term assistance that will be available.

Local technical assistance

The Maputo based team should be small but have the necessary managerial and technical skills required 'on site'. The draft staffing plan should include a description of the key roles and responsibilities as well as the minimum qualifications and experience required for each proposed position. It is not necessary to identify named candidates, although offerors are encouraged to describe their proposed approach to recruitment of local staff.

Short-term technical assistance

USAID/Mozambique recognizes the need for short-term technical assistant to complement the skills and enhance the work of Maputo-based staff.

It is the preference of USAID/Mozambique that, to the extent possible, offerors utilize short-term technical assistance resources available locally (in Mozambique and the Africa Region) and actively promote South-South technical assistance to foster South-South exchange and minimize travel costs. When developed country technical assistance is the most appropriate option consultants should be encouraged to transfer skills to local counterparts.

Offerors are encouraged to demonstrate their capacity to meet the short-term technical assistance needs associated with the Task Order. It is suggested that short-term technical assistance resources be sorted into categories. The number and definition of categories is at the discretion of the offeror, however the Task Order will require the availability of skills/competencies in the following areas:

- Child Survival (including IMCI, ARI, Nutrition, Immunization, Diarrheal Control);
- Maternal and Neonatal Health;
- Reproductive Health;
- Malaria;
- Epidemics and Emergency Response;
- Behaviour Change and Communication;
- Monitoring and Evaluation;
- Information Systems and Information Management;
- Health Systems, Management and Policy;
- Health Financing; and
- Human Resource Development.

Continuity is an important aspect of short-term technical assistance and offerors are encouraged to identify consultants in each technical assistance category who will be able make repeated visits to Mozambique and develop highly functional working relationships with Maputo-based staff and country counterparts. To this end, for each category of technical assistance, offerors are encouraged to: 1) identify a focal point and alternate who are committed to providing ongoing assistance. The qualifications, skills, experience and minimum availability of each focal point and alternate should be provided; and 2) provide information on additional technical assistance resources that can be mobilized by the offeror.

It is anticipated that short-term technical assistance will be used to complement a small in-country team. Using the program description, the contractor shall include in its proposal to USAID a roster of short-term technical specialists to implement activities outlined in this task order. It is critical that the contractor identify specialist who are able to make repeated visits to Maputo to work on ongoing activities. Short-term technical assistance plans will be finalized during the implementation planning process. In finalizing these plans, the contractor shall, where feasible, make maximum use of local consultants.

C.9 EVALUATION CRITERIA

Technical proposal will be scored by the Technical Evaluation Committee using the criteria listed below. The criteria below reflects the requirements of this particular solicitation. Offerors should note that these criteria (1) serve as the standard against which all proposals will be evaluated, and (2) serve to identify the significant matters which Offerors should address in their proposals.

Technical proposal should, at a minimum, include the following: (a) Cover Page; (b) Executive Summary; (c) Narrative; (d) Annexes, consisting of, at a minimum, information on Offeror's Team, Institutional Capacity and Past Performance References and a proposed Monitoring and Evaluation Plan. Page limitations are specified below for each section; applications must be on 8-1/2 by 11 inch (210mm by 297mm paper) or A4 paper, single spaced, 10 pitch type or larger, and have at least one inch margins on the top, bottom and both sides.

The technical approach must set forth the conceptual approach, methodology and results to be achieved by the Offeror's program. The rationale for the appropriateness of the suggested approach should be explicit.

- **Cover Page:** A single page with the names of the organizations/institutions involved in the proposed application. Proposed subcontract (hereafter referred to as the subs) should be listed separately, including a brief narrative describing the unique capacities/skills being brought to the program by each sub. In addition, the Cover Page should include information about a contact person for the prime Offeror, including this individual's name (both typed and his/her signature), title or position with the organization/institution, address and telephone and fax numbers. Also state whether the contact person is the person with authority to contract for the Offeror, and if not, that person should also be listed.

- **Executive Summary:** The Executive Summary shall not exceed two pages and should summarize the key elements of the Offeror's strategy, approach, expected results, and implementation plan. The Executive Summary must be concise and accurate.

- **Narrative:** In thirty (30) pages or less please describe your proposed strategy and approach. The narrative should be brief, concise and provide a clear description of what the Offeror proposes to do, why, and with whom and how the Offeror will effectively assess the achievement of program objectives. The Offeror should be able to demonstrate, with sufficient evidence, the merits of the proposed approach and its wider application based upon lessons learned and past experiences.

- **Offeror's Team (Resumes, Letters of Commitment, and References):** Offerors should provide summary job descriptions and qualifications of the two key professional staff, local and/or expatriate, to be funded under the contract. Resumes/CVs for these staff, not to exceed 3 pages, should be provided, including the developing-country experience of expatriate staff and recent references from persons familiar with the individual's work. Proposals should include copies of letters from the two key professional staff to the effect that they will accept the position in question for the entire period of the contract, should the Offeror receive an award.

- **Offeror's Past Performance Data:** The quality of an Offerors' past performance on similar programs is a factor in consideration of award. The Offeror should furnish information on all U.S. Government contracts, grants, or cooperative agreements involving similar or related programs over the past three years in which your organization has been involved. The information should include (at a minimum) the following for each program:
 - Name and address of funding organization;
 - Name, address and phone number, if possible, of the individual from the funding agency's number assigned to the contract, grant or cooperative agreement;
 - A brief description of the program;
 - Start and end dates, or projected end date of the Offeror's involvement with the program; and
 - Provide independently verifiable evidence on past performance.

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| TECHNICAL APPROACH | 30 points |
| a. Is complete and responsive to the USAID/Mozambique health program objectives, level of focus and efforts; | 10 points |
| b. Demonstrates an understanding of health sector issues in Mozambique; | 5 points |
| c. Integrates sustainable capacity building as a core principle in each of the actions proposed | 5 points |
| d. Offers a realistic proposal to strengthen and expand priority, interrelated management systems that will improve the MOH's effectiveness in managing scarce health resources without USAID assistance by the end of the Task Order. | 10 points |
| PERSONNEL CAPACITY AND EXPERIENCE | 45 points |
| a. Appropriateness and rationale of the proposed Personnel Structure (long- and short-term) to the proposed technical approach. | 5 points |
| b. Expertise of Key Personnel in a range of comprehensive services required to improve the efficient and transparent management of scarce health resources, especially strengthening critical systems within the MOH for planning of health services and monitoring program performance. | 30 points |
| c. Capacity to meet short-term technical assistance needs associated with the Task Order and using resources available locally. | 5 points |
| d. Capacity to recruit local technical assistance and to foster South-South exchanges | 5 points |
| INSTITUTIONAL CAPACITY AND PAST PERFORMANCE | 25 points |
| a. Past performance on and demonstrated capability to plan, implement and monitor similar programs; | 5 points |
| b. Capability and past performance in starting program activities rapidly; | 5 points |
| c. Capability to support personnel and field operations; | 5 points |
| d. Past performance in meeting USAID reporting and accountability requirements; and | 5 points |
| e. Success in forming alliances with other organizations and/or donors. | 5 points |

C.10 PERIOD OF PERFORMANCE

Subject to the availability of funds the period of performance is from the effective date of the Task Order Agreement until August, 30, 2010.

C.11 APPLICABLE DOCUMENTS

Applications must be consistent with USAID/Mozambique's Health Strategic Objective and can be located at the following selected list of background materials can be accessed at the following website: <http://www.usaid.gov/mz/>

1. USAID/Mozambique Country Strategic Plan 2004-2010
2. SO 8 Strategic Framework
3. MOH Strategic Plan for the Health Sector (PESS) 2001 – 2005 – (2010)
4. MOH Plano Operacional 2005
5. Performance Monitoring Plan
6. MOH Strategy on Community Participation – October 2004

Other relevant documents are :

1. Health system metrics. Monitoring the health system in developing countries October 6-7 2004, Glion, Switzerland . WHO and World Bank:
www.who.int/hiv/pub/en/Report_Health_System_Metrics_meeting.pdf

C.12 LIST OF KEY STAKEHOLDERS AND PARTNERS

1. **Ministry of Health**
Dr. Gertrudes Machatine,
National Director for Planning & Cooperation
Av. Eduardo Mondlane 1008
5th Floor
Maputo
Telephone: +258-1-303.039 or 321.095
Email: mgertrudes@tropical.co.mz
2. **JSI/Deliver** (Drug Logistics: Central & Provincial / Injection Safety & Waste Disposal: Central, Provincial & Health Facilities level)
Richard Ainsworth
Coordinator for Country Programs
Telephone: (703) 528-7474
Fax: (703) 528-7480
Email: richard_ainsworth@jsi.com

3. **Save the Children U.S.** (Community Outreach Activity – Nampula Province)
Dr. Mark Fritzler
Country Director
Av. Tomas Nduda, # 1489
Maputo
Cellphone: +258-82-313.6820
Direct Line: +258-1-493.156
Fax Line: +258-1-493.121
Email: mfritzler@savechildren.org

4. **World Vision** (Community Outreach Activity – Zambezia Province)
Dr. Omo Olorum Olupona
Director
Agostinho Neto, #620
Maputo
Telephone.: +258-1-350.600
Fax No: +258-1-350.619
Email: OmoOlorum_Olupona@wvi.org

5. **Pathfinder** (Community Outreach Activity – Maputo Province)
Dr. Julio Pacca
Representative
c/o UNFPA Office
Av. do Zimbabwe, 830/824
Maputo
Mozambique
Cellphone: +258-82-313.0830
Tel/Fax: +258-1-485.473
Email: jpacc@pathfind.org

6. **Project Hope** (Community Outreach Activity – Gaza Province)
Kevin Bernarde Novatny
Representative
Av. Emilia Dausse, #83
Maputo
Telephone: +258-1-314.700
Direct line: +258-1-314.814
Fax No: +258-1-314.813
Email: projhope@tvcabo.co.mz

TASC2: MONTHLY PERFORMANCE REPORT

| | |
|-------------------------|--------------------------|
| Contractor: | |
| Contract Number: | Reporting Period: |
| | From: To: |

SECTION I. CONTRACTOR'S REPORT

1. Progress: *achievements since the last report.*

2. Previous Problems: *problems described in previous reports solved or still outstanding and intentions to address outstanding problems.*

3. New Problems: *problems encountered during this reporting period.*

4. Proposed Solutions: *to outstanding (previous) and new problems.*

5. Plan for next month: *describe briefly each of the major activities in process during the next period as found in the Annual Action Plan and/or Task Order.*

Note: Not to exceed two (2) pages

TASC2: SIX-MONTHLY PERFORMANCE MONITORING REPORT

| | |
|-------------------------|--------------------------|
| Contractor: | |
| Contract Number: | Reporting Period: |
| | From: To: |

SECTION I. CONTRACTOR'S REPORT

1. Activities and Interventions: *summarize activities and interventions carried out in the last six months which were previously reported as "planned activities"*

2. Reported Results: *summarize the tangible results.*

3. Planned Activities and Interventions: *list future activities and interventions planned to be implemented within the next six months.*

4. Expected Future Results: *summarize the tangible results expected at conclusion of next 6 month period and whether this expectation is still reasonable.*

5. Performance: *for each of the activities described in number 1 and 4 above, state whether on-target or not, and comment, particularly in terms of meeting benchmarks, or other requirements established for the period and explain reasons why benchmarks or requirements were not met, as appropriate.*

6. Compelling individual-level success stories: *short paragraph (optional).*

7. Documentation of better practices that can be replicated or taken to scale: *activities that have worked well in USAID/Mozambique's geographic focus area that can be replicated in other provinces..*

Note: Not to exceed ten (10) pages.

SECTION II. CTO'S COMMENTS

The Cognizant Technical Officer (CTO), whether in USAID/Washington or in the field, will complete Section II and pass his/her comments on to the Contracting Officer for possible further comment. The CTO will obtain input from counterparts or others, as appropriate, prior to completing this section.

1) Comment on Contractor's technical performance (quality of technical assistance, professional services, etc.) and provide examples, if appropriate.

2) Comment on Contractor's administrative performance (timeliness in meeting schedules and/or delivering materials/products) during the quarter and give examples, if appropriate.

3) Comment on Contractor's management (cost-effectiveness, quality of communication with staff and with USAID) for the quarter and provide examples as appropriate.

4) React to Contractor's assessment of performance regarding any of the activities/Benchmarks described in section IA. above.

5) Note areas for potential Contractor improvement regarding achievement of Benchmarks and Tangible Results or any of the items covered

CTO/OFFICE SYMBOL:

DATE:

SECTION III - CONTRACTING OFFICE'S COMMENT (OPTIONAL)

The Contracting Officer may, if he or she wishes, add comments on any areas of concern in regard to Sections I and II above or identify actions to support, correct, or improve Contractor's performance.

The CTO will provide timely feedback to the Contractor relative to Section II and Section III (optional) comments

CO/OFFICE SYMBOL:

DATE:

TASC2: QUARTERLY FINANCIAL REPORTING

SAMPLE

| Task Order Financial Information | US\$ | % |
|--|-------------|--------------|
| Total life of contract budget | 1,000 | 100.0% |
| Committed to date | 200 | 20.0% |
| Uncommitted | 800 | 80.0% |
| | | |
| Total funds expended to date | 25 | 2.5% |
| Total <i>estimated accrued</i> expenditures for this quarter | 5 | 0.5% |
| Total Expended | 30 | 3.0% |
| Estimated expenditures for remainder of year | 100 | 10.0% |
| | | |
| Duration of Contract (months) | 60 | 100% |
| Time Elapsed | 3 | 5.0% |
| Time Remaining | 57 | 95.0% |
| | | |
| Pipeline (committed less expended) | 170 | 85.0% |

Note: Table is not the complete Financial Report. Please refer to section C.5.3

Justification for significant discrepancies between funds and time expended need to be explained and/or justified.