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Closing Date: August 24, 2004
Closing Time: 4:00 PM (local Yerevan time)

To All TASC2 Global Health IQC Contractors

SUBJECT: Proposed Task Order under TASC2-Global Health IQC, RFP # 111-04-020
Rural Reproductive Health/Maternal and Child Health Program – Phase II

Dear Sir/Madam:

Enclosed is a scope of work for services to be performed under the above proposed task order. At your earliest opportunity, please provide me with a proposal for accomplishing these services. The proposal should contain the following:

1. A proposed time schedule for the proposed work;
2. A Certification that the proposed personnel were not suggested or requested by USAID;
3. A detailed level of effort estimate. Please provide a separate line item for each proposed individual and identify each by name and by functional labor category as set forth in the contract;
4. A detailed estimate of other direct costs - travel, etc. Please explain the basis for the estimate for each category of cost; and
5. Any proposed changes to the enclosed scope of work.

The proposal shall be submitted in envelopes marked RFP 111-04-020 Rural Reproductive Health/Maternal and Child Health Program – Phase II, inscribed thereon, to:

Courier
Contracting Office
USAID/Armenia
18 Marshall Baghramian Ave.
Yerevan 375019, Armenia

The offeror is requested to acknowledge receipt of this solicitation. Any technical questions or questions of a contractual nature concerning this RFP must be submitted in writing, no later than

August 3, 2004. Questions should be addressed to Nara Sarkisian, USAID/Armenia Acquisition Assistant at nsarkisian@usaid.gov. Please be advised that you are not authorized to incur costs under the proposed task order prior to the Contracting Officer's signature.

Sincerely,

David Brown
Contracting Officer
USAID/Armenia

Enclosure:

1. Statement of Work
2. Evaluation Criteria

STATEMENT OF WORK

Introduction:

The United States Agency for International Development in Armenia (USAID/A) seeks to obtain nation-wide coverage of high-quality rural reproductive/maternal and child healthcare (RH/MCH) services within the framework of primary healthcare (PHC) service provision in the Republic of Armenia (RA). Rural level healthcare facilities are comprised of Feldsher-Accoucheur posts (FAPs) and ambulatories. According to a June 2003 report from the RA Ministry of Health (MoH), there are approximately 610 FAPs and 234 rural ambulatories throughout Armenia. The winning Offeror will expand upon successful program activities of the current Global Cooperative Agreement with Intrah (PRIME II), which will come to a close in September 2004[1,2].

This document describes in the scope of work (SOW), which is focused on four (4) integrated programmatic areas, all within the PHC framework:

> **Area 1:** Improving rural RH/MCH primary healthcare provider knowledge and clinical skills, and providing basic PHC medical equipment and supplies as needed to support program activities;
>
> **Area 2:** Developing the capacity of regional health officials and local health facility administrators and practitioners to improve the quality of rural RH/MCH service management and delivery and ensure sustainability of successful practices;
>
> **Area 3:** Improving the process of RH/MCH policymaking and implementation at the national level
>
> **Area 4:** Increasing consumer demand for high-quality RH/MCH services, and developing community education and mobilization activities.

The estimated duration of this task order is five (5) years including a two (2) year base period, and a two (2) year option period followed by a one (1) year monitoring and evaluation option period at a significantly reduced funding level. This activity will begin on or about October 1, 2004. The approximate level of effort will require a full-time expatriate in-country chief of party (CoP), local staff, and short-term advisors. This activity will support one of the Mission's strategic objectives (SO): 3.2 "Increased Utilization of Sustainable, High-Quality Primary Healthcare Services".

Background:

General

Armenia is a small, landlocked, mountainous country with few natural resources, covering an area of 29,800 square kilometers. It is situated in the Southern Caucasus, bordered by Georgia, Azerbaijan, Iran, and Turkey. According to the census conducted in October 2001, the population is estimated at just over three million people. It is one of the most ethnically homogenous countries in the world (Armenian 95%; Kurd 2%; Russian, Greek, and other 3%). Armenia has had a troubled relationship with some of its neighbors, including an ongoing conflict with Azerbaijan over the ethnic Armenian enclave of Nagorno-Karabakh, which is located in the territory of the former Soviet republic of Azerbaijan. Although a cease-fire has been in place since 1994, Armenia continues to face closed borders with Azerbaijan to the east as well as Turkey to the west, including an economic blockade.

The Republic of Armenia is a sovereign, democratic, rule-of-law state with an Executive, Legislative (Parliament), and Judicial branch. Administratively, it is divided into 10 regions called "Marz(es)", which are headed by regional governors appointed by the president, plus the capital city

of Yerevan. The heads of Ministries are appointed by the Prime Minister and each Ministry has several deputy ministers. At the marz level, there are regional department heads (e.g. health and social affairs, education, etc.). For more information, facts and figures about Armenia, visit the CIA Factbook, http://www.cia.gov/cia/publications/factbook/geos/am.html; the U.S. State Department webpage, http://www.state.gov/p/eur/ci/am/; the Republic of Armenia website, http://www.gov.am; and the Armenian Embassy to America website, http://www.armeniaemb.org/.

Historical perspective of healthcare system and RH/MCH service provision

As part of the Soviet Union, Armenia's healthcare system was a planned public service provided by the state, with all healthcare personnel hired as state employees. The system was highly centralized and standardized with free services provided in state-owned facilities. All healthcare services were provided through a network of healthcare institutions: Feldsher-Accoucheur posts (FAPs, or rural health posts), rural ambulatories, regional polyclinics and hospitals, and maternity and other specialized hospitals. This system was generally successful in providing access to comprehensive services for the majority of the population, but required substantial and continuous state budgetary support and management.

Prior to the breakup of the Soviet Union, healthcare expenditures were on the decline from an already low range of 3 to 4 percent of the gross domestic product (GDP expenditures on healthcare average 6 to 10 percent in most developed countries). With the dissolution of the Soviet Union and subsequent collapse of Armenia's command economy in the early 1990's, the GDP fell by over 50% and health expenditures decreased to between 1 to 3 percent of the GDP where they currently remain. In addition, the economic blockade imposed by Turkey in 1993 in solidarity with Azerbaijan over the Nagorno-Karabakh conflict contributed to the worsening of the overall economic conditions and directly affected social service provision, including healthcare.

Without adequate financing over the past decade, many healthcare facilities have fallen into disrepair, workers' wages have gone unpaid for up to 18 months, information systems and providers' skills have not been updated, and community outreach services have not been maintained. Scarce resources have constrained the government's ability to implement reforms. Moreover, the legacy of an authoritarian, top-down approach to healthcare administration has discouraged individual initiative and stifled management and institutional development at the regional and local levels. This environment has resulted in low healthcare facility utilization, unfavorable health indicators where they had formerly been positive and general public discontent and mistrust of the system.

The FAPs, located in small villages, are run by nurses, midwives, and/or *feldshers* (a medical or surgical practitioner without full professional qualifications or status) and are supervised by staff from nearby polyclinics or ambulatories. Officially, the role of the FAP staff has been limited. For example, patients seeking routine MCH services are supposed to be referred to physicians at the next referral level. However, FAP staff is often forced by circumstances to deliver services for which it is not properly trained. The FAPs have also deteriorated since independence, but with minimum improvement, they remain a very viable option for delivering quality PHC and RH/MCH services to rural populations.

RH/MCH Health Indicators

According to the 2000 USAID-sponsored Armenia Demographic and Health Survey (ADHS), Armenia's total fertility rate (TFR) is 1.7 children per woman (2.1 rural vs. 1.5 urban women), infant mortality rate (IMR) is 36.1 per 1,000 live births, with rural rates (53 per 1,000) exceeding urban rates (36 per 1,000) by a factor of about 1.5. The under-five mortality rate is 39.0 per 1,000 with rural rates (59 per 1,000) exceeding urban rates (37 per 1,000) by a factor of 1.6. At the time

of the ADHS, official RA National Statistics Service (NSS) reported TFR as 1.2 children per woman (age 15-39) and IMR as 15.3 per 1,000. Under-five mortality rate from NSS data is not presented. IMR discrepancies exist in part due to the protocols established during the time of the former Soviet Union according to which live births and infant deaths in Armenia were defined. In 1995, Armenia officially adopted the World Health Organization definitions of live birth and infant death. However, it is thought that operationally, many maternity wards have yet to convert to the new definitions and continue to apply the Soviet era norms.

Other DHS indicators and the full report are available for viewing or download on the Measure DHS+ website, in particular, chapters 4 – Fertility, 9 – Infant and Child Mortality, and 10 – Maternal and Child Health[3].

Current USAID RH/MCH Program:

USAID/Armenia via the PRIME II Project has supported efforts to improve rural healthcare providers' (nurses, midwives and physicians) performance in RH/MCH, with special attention to sexually transmitted infections (STIs) and supportive supervision. The program also piloted an initiative in one urban polyclinic to prepare primary healthcare providers to respond appropriately to gender-based violence cases, which may serve as a model for government and NGOs to focus more intensively on this neglected area. Since 2001, USAID partners have worked with policy makers at the national level on RH/MCH policy and norms and with local health authorities and primary providers in Lori Marz on RH/MCH service quality and organizational issues.

While health reform efforts have evolved considerably since the 1990's, it is premature to predict the final outcome. Current RH/MCH health services are still characterized by antiquated and costly facilities, and a vertical, highly specialized, non-integrated approach to care. The unpopular optimization of healthcare staff and facilities, part of the MoH reform agenda, has only been partially realized. There are still too many healthcare providers with an inappropriate skill mix, and underutilized facilities. Some highly trained RH specialists oppose attempts to promote RH/MCH service provision within family medicine practice. Additional information is available in the PRIME II August 2003 report number 46, "Reproductive Health Care at the Primary Level in Armenia: Assessment of Providers' Services and the Factors Affecting Performance[4].

The current RH/MCH program has engaged host country and other development partners in a range of interventions in Lori Marz and Yerevan, and has had several positive results that should be geographically expanded throughout the country[5]. The major achievements are:

<u>Provider Skills Training</u>

A team of fourteen national and regional experts provided clinical training for an MoH-certified eight-module self-paced learning course. The course encompassed basic nursing skills, patient counseling, infection prevention, antenatal care, intrapartum care, postpartum/newborn care, infant care, and community outreach. An additional module of advanced practice intrapartum care was provided for the midwives and doctors who attend deliveries. Sixty nurses and midwives from sixty rural ambulatories and FAPs in Lori Marz, which constitute about 80% of the providers, were retrained with this course. Preliminary results show increases in antenatal visits, home visits and appropriate referrals to second tier facilities for prenatal, postnatal and infant care.

<u>Policy and Management</u>

A diverse MoH working group consisting of national and local health administrators and OB/GYN practitioners drafted new regulations on the safety and quality of maternal and newborn care. The new regulations introduce internationally accepted norms on infection prevention, client-focused care, and organization of services. These new regulations are in the final stages of governmental

approval. The RA has also approved updated national guidelines on integrated management of STIs at the primary healthcare level. These guidelines are currently being used by family physicians and obstetricians.

The program, in collaboration with the American University of Armenia Health Management Institute, developed and implemented guidelines for supportive supervision in pilot sites. These guidelines focus on enhancing supervision and human resource management at the primary care level. The initiative involved introduction of a supportive supervision manual and training of health care managers in updated practices related to problem-solving, giving appropriate feedback and creating a positive work environment. Currently, trained managers apply these guidelines to improve quality of care through clear job expectations, improved organization of work, and updated clinical skills.

Training Capacity

Training capacity in different RH/MCH disciplines is improved through strengthened national trainers from certified government institutions, updated curricula, and two hospitals and two polyclinics established as official MoH clinical practice sites. In addition to the fourteen national and regional experts providing clinical training support for the eight-module self-paced learning course, a team of thirteen national trainers is continuing to train obstetricians and family physicians in the updated STI treatment and prevention guidelines.

With guidance from the program, the Armenian National Institute of Health (NIH) and State Medical University (SMU) faculty have developed a nine-day clinical training program on reproductive health for family physicians. Thirteen faculty members from NIH and SMU are currently conducting clinical training in reproductive health and they have an increased capacity to design effective training programs.

Community Mobilization

A leveraged asset activity with Save the Children in twenty communities facilitated the formation of community action councils to address health needs at the local level. Through leadership training and identification and assessment of local resources, fourteen communities have pooled their funds and expertise to improve access to care with social insurance funding schemes and have renovated local FAPs.

Overall

The use of a performance improvement process, self-paced learning modules coupled with follow-up preceptor monitoring visits, the provision of basic equipment and supplies to FAPs and the implementation of supportive supervision practices have reinvigorated the delivery of services by Feldsher-Accoucheur posts, and rural ambulatories in Lori Marz. This work has also stimulated community utilization of these healthcare facilities, which is a priority for the RA and USAID.

USAID Family Planning:

A USAID-supported reproductive health information campaign was launched in January 2000, by Johns Hopkins University Population Communication Services (JHU/PCS). The purpose of the campaign was to implement a nationwide Information, Education, and Communication (IEC) campaign in reproductive health. In partnership with MoH and UNFPA, JHU/PCS promoted 77 MoH-supported family planning offices and awareness of modern contraceptive methods using local and national media, and community mobilization events. The program also trained NGOs and community members in community mobilization and assisted them in developing and implementing local events to support the regional mass media campaigns.

Clinic monitoring data showed a substantial increase in utilization by new clients and a moderate increase in utilization by returning clients at family planning offices during the six months of the campaign. A public opinion survey conducted 6 weeks post-campaign launch showed a large number of respondents supported family planning programs in Armenia.

This program was not without obstacles, however. Once the information campaign started, criticism and negative media coverage of the program questioned the motives behind the campaign. To respond to some of the complaints, JHU/PCS adjusted television spots to more clearly state the program objectives, and highlight each family's right to choose their family size. Because of the negative reaction to the term "family planning", the MoH has chosen to rename the family planning offices "Women's Wellness Centers". In the future, USAID will refer to other programs in this area as "reproductive health" or "family health" programs.

USAID Armenian Social Transition Program (ASTP):

In August 2000, USAID began its flagship five-year Armenia Social Transition Program (ASTP) to support reforms in the social and health sectors[6]. Healthcare activities designed to support the MoH include: design and implementation of the organizational and regulatory framework for family medicine as the predominant specialty for PHC; open enrollment schemes for the population to select PHC physicians; development of MoH, State Health Agency (SHA) and healthcare facilities' PHC information systems; better provision of PHC services to targeted vulnerable populations; reduction of corruption through transparent contracting, cost accounting and financial management practices; and establishing the groundwork for sustainable, national PHC coverage.

ASTP's successes include: official recognition of three polyclinics and three rural ambulatories as national health system pilots; creation and adoption of a new Unified Family Medicine Curriculum (UFMC) for physician pre-service and in-service training; strengthening of family medicine departments at the National Institute of Health and State Medical University; creation of pilot open enrollment schemes for the population; and introduction of quality improvement programs in pilot sites. Moreover, the MoH's primary healthcare strategy (for 2003 –2008) and the recent National Health Policy draft document (for 2004-2015) notably incorporate many of the strategies being promoted and piloted under ASTP.

Other USAID Programs in Healthcare:

USAID support to Armenia's health sector began in the 1990s. The American International Health Alliance (AIHA) partnership program linked premier U.S. healthcare institutions with select hospitals and polyclinics in Yerevan and four of Armenia's 11 regions[7]. U.S. partners leveraged matching funds, improved new health provider skills, and improved the quality and administration of services. Currently this program's agreement is in place through September 2004.

World Vision/Armenia Branch recently signed a five-year contract with USAID to provide increased access to primary health care for 57 isolated communities located in four marzes (Lori, Tavush, Gegharkunik and Syunik) through mobile medical teams[8]. Additional aspects of the program are: providing nutrition support; strengthening village level health structures; and building links to district hospitals for improved referrals. This program is assuming and expanding the USAID mobile medical team program that was in operation from September 2000 through November 2003, implemented by UMCOR (United Methodists Committee on Relief).

With grant funding from USAID, the World Council of Hellenes (SAE) began in 2001 a targeted Primary Health Care Initiative (PHCI) program implemented by International Relief and Development (IRD)[9]. The program provides mobile medical services to 12 rural communities in Lori Marz, conducts training for rural health facility personnel and aims to raise public knowledge

of health issues by sponsoring health education/promotion programs. The program is scheduled to end in September 2004.

In an effort to improve standards of care, and access to treatment, Carelift International has been working in partnership with the American International Health Alliance (AIHA) to provide equipment and supplies in support of three model primary care centers in located in Armavir, Gegharkunik and Lori Marzes. Carelift has supported basic and preventive services including: breast cancer and cervical cancer screening; maternal care; emergency care for newborns; disease prevention and health promotion; and disaster preparedness[10].

Other Donors/Health Activities:

In 1997, Armenia received a $10 million World Bank loan for a "Health Financing and Primary Health Care Development Project" to strengthen the government's health care reform efforts by improving the quality of primary health care and the efficiency of public health expenditures[11]. The project was designed to promote community based primary healthcare and increase access to health services that are particularly important for the poor, including immunizations, tuberculosis, prenatal care, and emergency services; the project closed in December 2003.

On June 10, 2004, the World Bank approved a $19 million equivalent credit for the "Armenia Health System Modernization Project." This project is intended to be the first of a two-phase, seven-year commitment by the World Bank to support broad structural reforms in the health sector[12]. The project will assist the government to scale-up the implementation of family medicine based primary health care reforms, help the Yerevan State Medical University, National Institute of Health and Yerevan Basic Nursing College to train 980 well qualified family doctors and family nurses using internationally recognized training plans, and support a pilot public hospital efficiency and quality improvement program in selected hospital network institutions. Additionally, the project intends to assist the Ministry of Health in improving policy development and monitoring, and in upgrading its capacity to provide oversight for autonomous health care institutions.

Médecins Sans Frontières Belgium (MSF-B) has been working in Armenia since 1988, at the time of the earthquake. The current programs target tuberculosis and sexually transmitted infections (STI). They work with health authorities in Lori Marz using the DOTS (Directly Observed Treatment, Short-course) strategy as well as train staff and provide public information. In Tavush Marz, MSF-B runs an STI/HIV treatment and prevention program targeting sex workers and the general community. In 2002, they opened a counseling and information center with a local women's group as part of a joint project on family planning and STI/HIV prevention in one small community.

The United Nations Development Program (UNDP) provides assistance for national strategic planning for AIDS prevention, as well as for elaborating HIV/AIDS Situational and Response Analyses through policy advice and direct support to people living with HIV/AIDS[13]. The project objectives are to: reduce spread of HIV/AIDS among different population groups; improve living conditions of people living with AIDS and integrate them into the society; improve the quality of activities implemented by public health specialized services; ensure collaboration between NGOs, private sector and the RA; increase potential of educational system relating to the introduction of special educational programmes; ensure sustainability of mother-to-child transmission prevention in HIV/AIDS activities.

In 1995 the United Nations Population Fund (UNFPA) began stand-alone RH projects in Armenia[14]. This assistance was focused on: establishing a network of 77 family planning offices; improving access to and the quality of antenatal services and emergency obstetric care; establishing a national reproductive health and reproductive rights legal framework; strengthening the capacity of the

Government to manage and deliver reproductive health services; improving the awareness of young people in sexual and reproductive health; and fostering partnerships between the Government and civil society. Currently, 75 of the family planning units are still in operation and the contraceptive prevalence rate has grown from less than 1 percent in 1994 to 22 percent in 2000. The Fund has also been an active partner in formulating broader national development frameworks such as: poverty eradication; strategies to achieve the Millennium Development Goals; national reproductive health program; the national strategy on HIV/AIDS; and national action plans to promote gender equality and to address the trafficking of women.

The United Nations International Children's Emergency Fund (UNICEF) program in Armenia aims to improve the quality of and access to primary healthcare services for children, with special emphasis on the remote areas of Armenia[15]. Disease prevention for children, prevention of micronutrient deficiencies, improved child developmental screening and Integrated Management of Childhood Illnesses (IMCI) are the key strategies of the project.

The World Health Organization (WHO) strategic assistance priorities for Armenia center on technical assistance with limited budget support. The focus areas are: health policy reform; PHC system strengthening; health promotion and tobacco control; health information systems and disease surveillance; maternal and child health including IMCI; malaria surveillance; and expansion of DOTS for TB control. Additional WHO statistics for Armenia are available at http://www.who.int/country/arm/en/.

World Vision/Armenia Branch is the primary implementer of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) grant entitled, "Support to the National Program on HIV/AIDS Prevention in Armenia". This five-year, $7.2 million program began in July, 2003. This project aims to reduce the spread of HIV/AIDS among injecting drug users, female sex workers, men who have sex with men, prisoners, migrants etc and to provide better care for people living with HIV/AIDS[16].

The German development organization, GTZ, is implementing a **"**Regional Program on Tuberculosis Control in the Caucasus: Armenia, Azerbaijan and Georgia". The aim of the program is to reduce tuberculosis morbidity and mortality rates by introducing national and cross-border efforts (Armenia, Azerbaijan and Georgia). The program focuses on DOTS strategy, training physicians and laboratory technicians in DOTS methodology, and improving management capabilities at all levels.

Republic of Armenia/Ministry of Health:

The RA resolution entitled, "Strategy of Maternal & Child Health Care for 2003-2015", approved in July 2003, states that maternal and child healthcare is the most important prerequisite for population health and that declining socioeconomic conditions affect women and children first. The strategy cites many international resolutions and documents on maternal and child health and states, "[W]omen and child healthcare has been given top priority and raised to the level of national importance."

This document, though not without its shortcomings, is a reasonable effort by the MoH to address this sector of the healthcare system. In the document, the top three of ten main objectives for child healthcare are: 1) Reduce the level of mortality in children (aged 0-1) and under 5 by 1/3rd, including a 30% reduction in respiratory diseases and a 50% reduction in diarrhea; 2) Reduce the number of underweight and prematurely born children by 1/3rd; and 3) Achieve a 5-7% reduction in the rate of birth defects. Two key objectives for maternal health relevant to USAID health activities are: 1) Reduce the level of maternal mortality by ½ by 2015 and 2) Ensure HIV screening tests for at least 80% of pregnant women by 2015. For reproductive health, there are three objectives

applicable to USAID health activities: 1) Double the number of women using modern contraceptives by 2009; 2) Reduce STI rates in women by at least $1/3^{rd}$ by 2015; and 3) Reduce the number of abortions by at least 30% by 2015.

The RA Poverty Reduction Strategy Paper (PRSP) approved in 2003, includes "Maternal and Child Health Care" as a priority program in the health sector[17]. The PRSP states:

> "Attaching relevant importance to women and child health care, including reproductive health issues, is of principal significance in terms of ensuring healthy generations and, subsequently, improvement of health conditions of the population and poverty reduction. It is necessary to reiterate the priority of women and children health care at national level through ensuring continued improvement of health conditions of pregnant and nursing women and nutrition of children in the age of 0-5 years old, encouragement of breast feeding, as well as provision of prenatal and postnatal quality medical service."

In the PRSP, the RA also emphasizes the United Nations Millennium Development Goals (MDG) with respect to infant and maternal mortality. The MoH plans to address these indicators by improving the quality of obstetric and gynecological services and upgrading equipment in maternity hospitals. The PRSP also addresses infectious disease and HIV/AIDS prevention; noting the proliferation of tuberculosis and syphilis in the recent decade. The document notes the importance of strengthening prevention measures, early diagnosis and thorough treatment, and redistributing budget resources to avert further spread of these infectious diseases.

Additionally, the MoH has drafted a national primary care health strategy. The 2003-2008 "Primary Health Care Strategy of the Republic of Armenia" is an ambitious document that recognizes the advantages of a PHC-based system over the past system based on specialty healthcare.

The State Health Agency (SHA), created in 1998 to serve as the principal public buyer of health services, is the conduit for 80% of state funds for healthcare. State funds to cover services authorized under the Basic Benefits Package (BBP) are transferred from the SHA, now located within the MoH, directly to healthcare facilities. Facilities generate additional revenues by providing other services (outside the BBP) and private care. However, the inefficient management practices that prevailed under the old system continue under the new. Locally elected governments have limited capacity to advocate for or fund better services. Health reformers recognize that the current attributes, roles and responsibilities of the different stakeholders must be modified if an effective primary healthcare system is to evolve.

Approved in November 2003, the Republic of Armenia Anti-Corruption Strategy contains a section on corruption in the healthcare sector and proposed anti-corruption measures[18]. According to the document, "[U]nofficial payments constitute a major obstacle to healthcare sector reforms, because they create rather a large area beyond financial control". While USAID agrees that unofficial payments are a major problem, the Mission views informal payments as a symptom of larger issues: the absence of basic cost accounting principles and transparent financial systems, low provider wages, and lack of consumer awareness of free and fee-for-service schedules. Proposed anti-corruption measures in the Anti-Corruption Strategy include institutional reforms and restructuring of the existing institutional, administrative, and management systems.

Today, the MoH's central roles include: creation of health policy and regulations, strategic planning, development of national programs, formation of pharmaceutical policy, and licensing of medical facilities. It also retains decision-making authority for the health sector budget, resource allocation, and pricing of services in public facilities. Regional and local health officials are responsible for the operational implementation of national programs and enforcing MoH policies and regulations, yet have limited budget support from the national level and little voice in resource allocation. The MoH does maintain a website. However at the time of this writing it was under reconstruction[19].

Current Direction:

The current rural RH/MCH program is considered to be a successful pilot program. However, due to the program's limited geographic coverage, the majority of RH/MCH services in Armenia remain below WHO standards. Many rural health providers are ill-prepared and ill-equipped to provide high-quality RH/MCH services in a PHC setting. In light of these conditions, USAID/Armenia seeks to continue support for a rural RH/MCH program.

This initiative will contribute directly to the Mission's Intermediate Result (IR) 3.2.2 "Improved Service Delivery in Priority PHC Disciplines". It will accomplish this by addressing the Lower-level Results (LLR) 3.2.2.1 "Expanded and Enhanced Services at the PHC Level", LLR 3.2.2.2 "Improved PHC Management and Administration of Services" and LLR 3.2.2.4 "Increased Consumer-Driven Demand for PHC Services in Program Areas". Subsequently, this activity will contribute to the overall Strategic Objective (SO) 3.2 "Increased Utilization of Sustainable, High-Quality Primary Healthcare Services."[20] The complete results framework is shown in Table 1 below.

Table 1: SO 3.2 Increased Utilization of Sustainable, High-Quality Primary Healthcare Services

IR 3.2.1: Strengthened Institutional Capacity to Implement GoAM/MOH PHC Reform	IR 3.2.2: Improved Service Delivery in Priority PHC Disciplines
LLR 3.2.1.1: Improved Capacity of Educational Institutions to Prepare PHC Providers	LLR 3.2.2.1: Expanded and Enhanced Services at the PHC Level
LLR 3.2.1.2: Improved PHC Financing Mechanisms and Practices	LLR 3.2.2.2: Improved PHC Management and Administration of Services
LLR 3.2.1.3: Improved Regulatory Environment for PHC Services Delivery	LLR 3.2.2.3: Increased PHC Outreach Services Provided to Vulnerable Populations
	LLR 3.2.2.4: Increased Consumer-Driven Demand for PHC Services in Program Areas

Scope of Work:

The objective of this program is to assist in the achievement of SO 3.2, "Increased Utilization of Sustainable, High-Quality Primary Healthcare Services" by developing sustainable high-quality rural RH/MCH service provision within the primary healthcare framework. At the end of this five (5) year period the expected results in program locations are: decreased infant mortality and maternal mortality rates; enhanced RH/MCH quality of care; increased number of antenatal visits and decreased incidence of home births. To accomplish the strategic objective and results, the program activities will: expand the successful practices of the current RH/MCH program to the majority of the country; increase client utilization of target facilities; continuously improve rural RH/MCH quality of care; and provide both local and national level sustainability mechanisms for program activities.

Specifically, this scope of work is focused on four (4) integrated programmatic areas; all within the PHC framework:

> **Area 1:** Improving rural RH/MCH primary healthcare provider knowledge and clinical skills, and providing basic PHC medical equipment and supplies as needed to support program activities;
>
> **Area 2:** Developing the capacity of regional health officials and local health facility administrators and practitioners to improve the quality of rural RH/MCH service management and delivery, and ensure sustainability of successful practices;
>
> **Area 3:** Improving the process of RH/MCH policymaking and implementation at the national level;
>
> **Area 4:** Increasing consumer demand for high-quality RH/MCH services, and developing community education and mobilization activities.

Detailed technical requirements

Although the four (4) areas above are listed separately, they are interrelated and the successful Offeror will propose innovative linkages among them in the technical approach, as appropriate. Offerors must clearly link all proposed activities to these four areas. The proposed activities must include but are not limited to the tasks outlined below and they must be designed to accomplish the tangible results outlined on pages 11 and 12.

Area 1:* *Improving rural RH/MCH primary healthcare provider knowledge and clinical skills, and providing basic PHC medical equipment and supplies as needed to support program activities

Tasks

- Upgrade RH/MCH provider competencies by expanding the existing RH/MCH training activities including cost-effective training strategies to an additional two to three marzes per year with no less than 90% inclusion of Feldsher-Accoucheur posts and ambulatories in each marz
- Continue limited support for current activities in Lori Marz in order to foster sustainability of high-quality RH/MCH service provision
- Ensure improved quality of care including: RH/MCH service provision in FAPs and rural ambulatories encompassing healthcare providers' clinical, managerial and patient-relation knowledge and clinical skills; STI syndromic management; and provision of basic PHC

supplies and equipment as needed (the latter not to exceed $400,000 USD for the life of the program)

Area 2: ***Developing the capacity of regional health officials and local health facility administrators and practitioners to improve the quality of rural RH/MCH service management and delivery, and ensure sustainability of successful practices***

Tasks

- Develop and institutionalize a quality management system for rural healthcare facility RH/MCH services
- Develop local capacity for monitoring and evaluation via criterion-referenced standards of provider performance
- Implement supportive supervisory practices (e.g. job description, contracting etc.) that improve quality of care and support anti-corruption strategies (e.g. transparency in service delivery, financial transactions etc.)

Area 3: *Improving the process of RH/MCH policymaking and implementation at the national level*

Tasks

- Ensure improvement and continuation of policymaking and implementation processes relevant to RH/MCH in the framework of PHC, including healthcare financing/budgeting systems (primarily at the local level) and anti-corruption strategies for regulatory activities (e.g. transparency in provider licensing, facility accreditation, healthcare financing, etc.)

Area 4: ***Increasing consumer demand for high-quality RH/MCH services, and developing community education and mobilization activities***

Tasks

- Promote and increase community participation in program activities including buy-in and leadership from local authorities
- Develop and institutionalize community health education activities (including men and women) relevant to RH/MCH with a mechanism to ensure sustainability (sample topics: childbirth preparation and infant care for new and first-time parents, congenital birth defects, family health, infertility, STI and HIV/AIDS prevention, etc.)
- Utilize private sector/community resource leveraging and/or community self-help models that directly affect delivery of RH/MCH services

Additional technical requirements

Training and building local capacity are significant elements of this program and the broad objectives of human and institutional capacity development must be integrated while designing and implementing the program. New training material and/or programs must fit within the MoH approved Unified Family Medicine Curriculum (UFMC) and any other MoH approved training frameworks that may be developed through the course of the program. Limited commodity support may be provided to counterpart institutions where it is determined that such support would significantly increase the effectiveness and/or transparency of their operations. The program will also support the Mission's cross-cutting commitment to reduce corruption by supporting increased transparency and access to information both in regulatory mechanisms and in healthcare resource allocation. The successful Offeror must identify clearly how they will determine whether there are

any significant gender considerations that need to be taken into account in design and implementation of the technical content of the program.

Another crucial element of this program is the development of partnerships with other US Government (USG) supported and non-USG supported programs, bilateral and multilateral development agencies, local and national government institutions, NGOs, and other programs that may come about during course of the award. The successful Offeror must also assure coordination with other health and community-based programs as well as the RA, MoH, National Institute of Health, State Health Agency, Yerevan State Medical University and Basic Nursing College.

Tangible Results:

The successful Offeror will state in specific terms within the provided guidelines how they propose to achieve the results USAID/Armenia is expecting from this program:

1. Complete national coverage of rural RH/MCH program activities with no less than 90% inclusion of Feldsher-Accoucheur posts (FAPs) and ambulatories in each marz is attained;
2. No less than 80% of the target population utilizes high-quality RH/MCH services in program areas; and
3. A sustainable model of rural RH/MCH primary healthcare service provision in target facilities is established and operational including but not limited to:

   Area 1: Improving rural RH/MCH primary healthcare provider practical knowledge and clinical skills, and providing basic PHC medical equipment and supplies as needed to support program activities

   a. High quality rural RH/MCH services integrated in the PHC framework are provided, including STI management;

   b. RH/MCH provider performance is measurably improved including sustainable mechanisms for non-mandatory in-service training;

   c. Sustainable transparent mechanisms are established for mandatory in-service training including: MoH licensed clinical faculty and preceptors; no less than two high-quality MoH accredited clinical practice sites per marz; and a mechanism for continuous quality improvement;

   d. Facilities are adequately equipped possessing basic RH/MCH supplies and equipment including mechanisms for restocking and biomedical support;

   Area 2: Developing the capacity of regional health officials and local health facility administrators and practitioners to improve the quality of rural RH/MCH service management and delivery, and ensure sustainability of successful practices

   e. A quality management system is established;

   f. Regional and local management capacity for planning, implementing, monitoring, and regulating high-quality rural RH/MCH healthcare service delivery is institutionalized;

   g. Supervisory systems are established that support performance improvement at the FAP and rural ambulatory level;

   h. Effective linkages of rural health posts and ambulatories to upper-level referral facilities are established;

Area 3: Improving the process of RH/MCH policymaking and implementation at the national level

i. Process improvement mechanisms for policy development and implementation are institutionalized;

j. Transparent mechanisms for facility level healthcare financing are employed;

Area 4: Developing consumer demand for high-quality RH/MCH services, and incorporating community education and mobilization activities

k. Community members are actively involved in improving their own health status; and

l. Local authorities and community members are actively involved in improving healthcare delivery in their community.

Required Plans:

Implementation Plan: Each annual Implementation Plan shall contain the approach for providing the services required under this activity. The Offeror will submit a draft implementation plan (a timeline/Gantt chart with benchmarks towards achievement of the expected results) with the proposal. The Implementation Plan for the first year is due a maximum of 30 days after the signing of the task order, and the Implementation Plan for the second year shall be submitted no later than 45 days prior to the start of each of the subsequent four (4) years of the award for USAID's approval. Both the initial implementation plan for the first year and the implementation plan for each of the subsequent four (4) years of the program shall contain specific programmatic benchmarks to measure progress in each of the four (4) areas within the scope of work.

Performance Management Plan: The Offeror will submit a draft Performance Management Plan (PMP) with the proposal and will finalize the PMP within 45 days of the award. For each performance indicator that is proposed, the contractor shall include baseline data, tangible results-oriented benchmarks and targets for each fiscal year, the data to be collected and the method and frequency of data collection. PMP resources are available at http://www.usaid.gov/am/ip-resources.html and http://www.iac.wur.nl/iaclo/htmlarea/docs/ppme/Performance_monitoring.pdf.

Reporting Requirements:

The contractor shall submit the following reports to the task order CTO and the Contracting Officer:

- Quarterly Performance Monitoring Reports: The Contractor will submit quarterly progress reports to the Cognizant Technical Officer a maximum of 30 days following the end of the quarter. Quarters are based on USAID's fiscal year (Oct-Dec, Jan-Mar, Apr-Jun, July-Sept). These reports must describe progress made in the quarter most recently ended towards goals, including comparing progress to planned achievements under the performance management plan (PMP). Every second quarterly report (semi-annually) for the quarters ending on March 31 and September 30, the Contractor shall include progress made specifically as it relates to the agreed upon indicators in the PMP. Reports should also mention any obstacles that might prohibit reaching goals, and proposed methods for addressing these obstacles.
- Reports by expatriate short term technical assistance (TA) providers: Unless otherwise agreed upon in writing by USAID/Armenia, the Contractor will submit to the task order CTO a brief report from any short term technical assistance providers within one (1) week after his/her departure. These reports will describe progress and observations made by the expert, identify significant issues, and describe follow-on activities and plans for the

Contractor and counterparts. Additionally, short-term TA providers will conduct an in-service training to USAID staff not to exceed one hour in duration.

- Final Report: The Contractor will submit a detailed final report which includes:
    a. A financial report detailing how funds were expended, by line item;
    b. A summary of the accomplishments and shortcomings of the contract, referenced to the results listed in this contract; and
    c. Comments and recommendations about future RH/MCH programs.

Personnel and Level of Effort:

To carry out the SOW, the Contractor shall assign at least one full-time expatriate to Armenia who will have overall, in-country management responsibility for the program. The contractor shall propose a mix of Armenian and short-term staff for the successful implementation of this activity. Working Armenian or Russian language fluency, in addition to strong technical qualifications and experience with reproductive health, is strongly preferred for long and short term assistance.

Public-Private Partnerships:

Contractors are encouraged to explore opportunities for public-private partnerships under the Global Development Alliance (GDA) mechanism. More information on the GDA can be found at http://www.usaid.gov/our_work/global_partnerships/gda/. In addition, contractors are encouraged to explore opportunities for making appropriate use of resources available within the Armenian Diaspora.

Period of Performance:

Subject to availability of funds, the expected period of performance for this task order is five (5) years in length including a two (2) year base and a two (2) year option period followed by a one (1) year monitoring and evaluation (M&E) option period. The one year M&E option period will have a significantly reduced funding level and must include institutionalization of successful program activities. The program is expected to begin on or about October 1, 2004.

Evaluation Criteria

Proposals will be evaluated according to the following criteria. The relative importance of each criterion is indicated in descending order of importance and will be evaluated adjectivally according to the following; Outstanding, Better, Acceptable, Marginal, Unacceptable. Applicants should note that these criteria serve to: (a) identify the significant subjects which Offerors should address in their applications and (b) set the standard against which all proposals will be evaluated.

1. Technical Approach
2. Organizational Capacity
3. Past Performance
4. Cost

Technical Evaluation

The technical proposal will be scored by a technical evaluation committee using the criteria shown in this section. The criteria below are presented by major category in descending order of importance, so that Offerors know which areas require emphasis in the preparation of proposals. Based on the assessment of the technical qualities of the proposals, a competitive range will be established. Cost proposals will be evaluated on the basis of realism and level and used in combination with the assessment of technical quality to determine best value from the competitive range.

1. **Technical Approach:** The Offeror must demonstrate a thorough understanding of the contextual and cultural work environment, program complexities and expected results. Technical approach will be reviewed for:

   a. Feasibility: Realism and innovativeness of the proposed methodology and detailed implementation plan with timeline that supports all four programmatic areas of the SOW; tangible, expected results for each activity or task proposed; quality of the performance management plan, in particular its ability to be both realistic and ambitious; mechanisms identified to ensure coordination with key local stakeholders and other donors; depth and breadth of local participation proposed; contribution to the human and institutional capacity development of partner institutions/organizations; exit plan and sustainability of the program once the award ends; and if sub-grants are to be included, process for awarding those grants, along with reach and proposed community mobilization activities;

   b. Anti-Corruption: Mechanisms identified to enhance transparency and support the RA Anti-Corruption Strategy[11]; and

   c. Gender: Sensitivity of approach incorporating the differential participation of men and women; gender analysis of data; consideration of unintended gender side effects of program implementation.

2. **Organizational Capacity:** The Offeror must demonstrate clearly how the proposed program organizational structure will support the technical approach to achieve results. Organizational capacity will be reviewed for management approach, key personnel and staffing.

   a. Management Approach: Demonstrated sound management practices running similar programs; sound financial and programmatic capability; capacity to monitor programs effectively; ability to gather and analyze data; US-based support experience managing

similar programs, fielding long- and short-term personnel and backstopping USAID programs; and

b. Key personnel and Staffing (long- and short-term): Appropriateness of academic background and years of work experience related to the RH/MCH Program components; experience in the NIS/CEE; chief of party will be assessed on quality of management and professional experience working on similar programs; staffing patterns, including skill categories of personnel as they relate to the specific activities and results of the implementation plan; teaming arrangements, including proposed use of local counterpart institutions/organizations, sub-contractors, grantees, and other involved donors and agencies.

3. **Past Performance:** The Offeror must provide relevant information to allow the evaluation committee to assess its:

   a. Demonstrated experience in achieving results in similar programs; and

   b. USAID past performance reports.

4. **Cost:** Cost is of significantly less importance than the technical evaluation criteria. However, where 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 for the cost. 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.

   Where proposals are considered essentially equal, cost may be the determining factor. The cost proposal should include a detailed budget for the base period as well as for the two option periods of the activity. 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.

Evaluation System:

The following adjectival scoring system will be used by the technical evaluation committee to assess each of the technical criteria and sub-criteria and the technical proposal as a whole:

"Outstanding"	O	Very significantly exceeds most or all solicitation requirements. Response exceeds a "Better" rating. The Applicant has clearly demonstrated an understanding of all aspects of the requirements to the extent that timely and highest quality performance is anticipated.
"Better"	B	Fully meets all solicitation requirements and significantly exceeds many of the solicitation requirements. Response exceeds an "Acceptable" rating. The areas in which the Applicant exceeds the requirements are anticipated to result in a high level of efficiency or productivity or quality.
"Acceptable"	A	Meets all solicitation requirements. Complete, comprehensive, and exemplifies an understanding of the scope and depth of the task requirements as well as the Applicant's understanding of the Government's requirements.
"Marginal"	M	Less than "Acceptable." There are some deficiencies in the technical proposal. However, given the opportunity for discussions, the technical proposal has a reasonable chance of becoming at least "Acceptable." (Areas of a technical proposal which remain to be "Marginal" after "Final Proposal Revision" offers shall not be subject to further discussion or revision.) If award is made on the initial offers, there will not be an opportunity for discussions nor a chance to become at least "Acceptable."
"Unacceptable"	U	Technical proposal has many deficiencies and/or gross omissions: Failure to understand much of the scope of work necessary to perform the required tasks; failure to provide a reasonable, logical approach to fulfilling much of the Government's requirements; failure to meet many personnel requirements of the solicitation. (When applying this adjective to the technical proposal as a whole, the technical proposal must be so unacceptable in one or more areas that it would have to be significantly revised to attempt to make it other than unacceptable.)