

SECTION C – STATEMENT OF WORK

9/29/03 draft

C.1 PURPOSE OF TASK ORDER

The purpose of this Task Order is to provide technical support for the implementation of Strategic Objective 4 (SO 4) under the Mission's 2003-2007 Integrated Strategic Plan. The Contractor will provide technical assistance, training, and selected commodities to develop the capacity of the Eritrean Ministry of Health (MOH) and other partners to achieve SO 4: **"Use of priority primary health and HIV/AIDS services increased and practices improved."**

The purpose of SO 4 is to increase the use of priority primary health services and improve practices in order to reduce infant and under-five mortality and morbidity, improve maternal health, and stop HIV at an early stage. The priority primary health programs are integrated management of childhood illness (IMCI), obstetric life saving skills, maternal and reproductive health, family planning (as birth spacing and post-abortion counseling), polio eradication, malaria, health communications, and HIV prevention. Nutrition will be integrated with IMCI, health communications, and maternal health interventions. Female genital cutting will be addressed with information, education, communication, and training activities. Emphasis among these areas will be adjusted during the life of the SO based on analysis of final 2002 Demographic and Health Survey results, other data, funding levels, and changes in other donor support.

The intermediate results (IRs) covered by this Task Order are:

- **IR 1: Active demand for primary health care expanded**
- **IR 2: Quality of priority primary health services improved**
- **IR 3: Institutional capacity for resource allocation decisions improved**

A fourth IR, HIV/AIDS prevention, is discussed below in order to provide a complete description of SO 4. However, it is planned that technical assistance for HIV/AIDS prevention and for malaria and polio surveillance will be provided through other mechanisms. Nonetheless, some HIV and malaria funds will be included in the TASC2 Task Order so that the Contractor can provide logistical support for other CAs providing technical assistance for HIV and malaria activities.

In order to help ensure that the results specified in this Task Order are achieved as effectively as possible, USAID/Eritrea encourages all interested TASC2 IQC Contractors to submit proposals.

C.2 BACKGROUND

The strong commitment of the Government of the State of Eritrea (GSE) to meeting people's health needs is clearly demonstrated by the progress in child survival between 1995 and 2002. Infant mortality fell from 72 per 1000 live births in 1995 to 48 in 2002 (Eritrea Demographic and Health Surveys). Under-five mortality was reduced from 136 to 93 during the same period, and there were corresponding improvements in intervention-related indicators. Further increases in utilization of priority primary health services are needed in order further reduce under-five mortality and to have a significant impact on maternal mortality.

Improvements have not been even across all health care interventions. At the most positive end of the spectrum, high immunization coverage has been achieved in Eritrea at a time when immunization coverage has declined in many African countries. Keys to Eritrea's success in immunization have been the focused use of resources, good monitoring and evaluation, and active involvement of partners and stakeholders at every level. Use of other primary health services (other child survival interventions, malaria prevention, etc.) falls in the middle of the progress spectrum, due to intervention-specific demand, quality, and resource management constraints. Use of safe delivery services has improved more slowly, and contraceptive prevalence has not increased since 1995. Thus, barriers to utilization need to be better understood, including such factors as cultural constraints on demand (especially those that impede women's care seeking), the uneven quality of emergency obstetric care, and uneven deployment of personnel trained to provide these services.

Additional constraints include the scarcity of human, material, and financial resources in the Ministry of Health (MOH), and the inability of users to access health care due to poverty. For example, analysis of planned health facility staffing patterns showed that the supply of nurses would be insufficient over the next ten years, even without taking account of continuing expansion of hospital beds. Nonetheless, analysis of use of time by nurses showed that personnel could be used more efficiently. The MOH has maintained a steady supply of pharmaceuticals and medical supplies to health care facilities, but this is becoming increasingly dependent on donor funding. User fees are charged at every level of care. The fees are low, but there is significant cost recovery at the

hospital level, especially for pharmaceuticals. Systematic cost containment measures also need to be developed. Given resource constraints, the MOH recognizes the need to build the capacity to better rationalize its scarce resources among different functions and levels of the health system.

The May 1998-December 2000 conflict with Ethiopia caused a serious strain on the financial and human resources needed to meet health needs. When demobilization occurs, the expected "baby boom" will make it challenging to maintain the gains in child health achieved during 1995-2002 while increasing the use of other primary health services and improving health practices.

C.2.1 Current health status

The health situation in the country shows many positive trends, with need and scope for further improvement. Based on Ministry of Health statistics, leading causes of under-five mortality include acute respiratory illness, malaria, and diarrhea. Preliminary results of the 2002 Demographic and Health Survey (DHS) compared with those of the 1995 DHS clearly show that Eritrea has achieved rapid progress in child survival over the last seven years. The infant mortality rate (IMR) has been reduced from 72 in 1995 to 48 in 2002, and under-five mortality fell from 136 to 93 during the same period. This is an extraordinary accomplishment for a poor nation, especially in the context of sub-Saharan Africa, where many countries have seen rising mortality rates due to the impact of HIV/AIDS and armed conflict. Nutritional status of children under three years of age has also improved: the percentage of children whose weight for age is below standard deviations from the mean has decreased from 44 percent in 1995 to 39 percent in 2002. Maternal health proxy indicators are also improving, but more slowly. For example, antenatal care increased from 49 percent in 1995 to 70 percent in 2002.

Based on Ministry of Health statistics, leading causes of under-five mortality include acute respiratory illness, malaria, and diarrhea. Preliminary results of the 2002 Demographic and Health Survey (DHS) show that coverage of children 12-23 months with both DPT-3 and polio-3 has increased from 48 percent in 1995 to 79 percent in 2002 (not including additional polio coverage through National Immunization Days). Care-seeking for childhood illnesses has increased from 37 percent in 1995 to 44 percent in 2002 for acute respiratory infection (ARI), and from 28 percent to 42 percent for diarrhea during the same period. Use of ORT for children with diarrhea has increased from 56 percent to 68 percent. Thus, prospects for further improvement of under-five mortality over the next five years are

good, especially as the Integrated Management of Childhood Illness (IMCI) Initiative only began implementation in early 2002. Household ownership of insecticide-treated nets (ITNs) for malaria prevention has reached 35 percent nationally (this average includes non-malarious areas); the Roll Back Malaria baseline survey in malarious areas put this figure at 65%. Use of iodized salt at the household level has reached 71 percent nationally.

Similarly, maternal health is jeopardized by closely spaced pregnancies, the high proportion of high-risk births, early marriage in some areas, malaria, female genital cutting (FGC), complications of abortion, and low use of obstetric care. Some progress has been made in increasing the proportion of deliveries in health facilities, up from 17 percent in 1995 to 26 percent in 2002, and the proportion delivered by health professionals rose from 21 percent in 1995 to 28 percent in 2002. Given a high desired family size and the sense of national insecurity resulting from the conflict, improving birth spacing and reducing the proportion of high-risk births are the most difficult challenges. By comparison, the 2002 DHS found that 17 percent of women aged 15-49 years wanted no more children, compared with 36 percent for Uganda and 32 percent for Ethiopia in their most recent surveys (2001/2000). Now that personnel have been trained, communications, quality assurance, outreach, and community involvement are needed to further increase the use of maternal health services.

FGC has decreased from 95 percent in the 1995 DHS to 89 percent in 2002. This reduction appears to be in less severe forms of FGC rather than infibulation. The percentage of women who believe the practice should continue has decreased from 57 percent to 49 percent. Further analysis and formative research are needed to refine strategies for addressing this health problem.

Special challenges and opportunities exist regarding HIV/AIDS. Eritrea is still at a relatively early stage of the HIV epidemic, with an estimated general population HIV sero-prevalence rate of around 3.0 percent. However, this figure represents a doubling in the officially reported rate over the last three years. Even at this early stage, HIV threatens to overwhelm the coping capacity of this new nation: HIV/AIDS has risen from the tenth to the first leading cause of inpatient deaths among those aged five years and above. Unique historic circumstances have shifted nearly an entire generation of Eritrean youth into a high-risk category for HIV: the military and national service. The planned demobilization of 200,000 troops brings the added risk of spreading HIV to families and communities across the country. At the same time, there is a high

awareness of the threat of HIV and strong commitment to stopping HIV in Eritrea. Eritrea's HIV prevention condom social marketing program is well established. HIV rates are highest among commercial sex workers and the military, presenting opportunities for focused efforts to slow the rate of infection.

C.2.2 Overcoming barriers to increased use of health services

In March 2002 USAID/Eritrea conducted a Health Strategy Assessment that has since guided USAID/Eritrea in developing SO 4 within the ISP. The assessment team worked closely with the GSE and identified four major barriers to utilization, which are described below. Strategy development was also based on the gender assessment completed in August 2002, which further highlighted barriers to utilization of maternal health care and HIV/AIDS prevention. The barriers identified through these assessments include demand constraints for health services, inconsistent service quality, scarcity of human and financial resources, and cultural and geographic factors.

Demand constraints for health services: Many people in Eritrea may not seek medical care until it is too late, or until they have used traditional resources available in their communities. Low quality of services can be a constraint, but perceived quality factors may not necessarily coincide with appropriate technical standards. The MOH and community health care providers need to better understand people's health care perceptions, practices, health-seeking behavior, and barriers to utilization. Rapid and participatory appraisal techniques can be used to obtain information needed to develop approaches to reduce these barriers. Interventions are needed to test new approaches and demonstrate to different groups within communities the benefits of underutilized but critical services such as emergency obstetric care. This is best done with active community participation and based on lessons learned from what is already being practiced. Thus, in the new SO 4 strategy, the concept of demand is broadened to achieve active involvement in primary health at all levels, including innovative communications, community participation, governance, and cost sharing approaches.

Inconsistent quality of available services: Assessments of IMCI, emergency obstetric care, and infection control activities, as well as DHS data on maternal care, show that the quality of services delivered in health care facilities can be improved. Human and financial resources will be scarce throughout the strategy period, but there is evidence that improved supervisory support, monitoring and evaluation, and quality assurance systems can help improve quality even in a resource-

constrained setting. Several important factors present good prospects for further improvement in reducing shortages of health personnel: the GSE's demonstrated commitment to health improvement, the low level of corruption, the strong MOH interest in quality assurance techniques, and the potential of planned demobilization and reintegration.

Scarcity of trained health personnel and financial resources: The MOH operating budget constrains expansion of the health system in terms of both facilities and staffing. This situation is intensified by an increase in hospitals and hospital beds resulting from hospital replacement and expansion supported by the World Bank, China, and other donors. Competition for health workers between hospitals and other levels of the system will increase pressure on human and other resources. The MOH has reinitiated efforts to decentralize its services and improve resource allocation across different health care systems. USAID/Eritrea has a unique opportunity to support the Ministry and zonal administration to develop systems and tools to manage resource allocation for improved overall health care system performance, and to demonstrate greater results at all levels.

Additional cultural and geographic factors to consider: There are additional factors that must be taken into account in efforts to improve service utilization. Eritrea has cultural and geographic diversity even within zones. There are nine different ethnic groups, and the population is roughly half Moslem and half Christian (mainly Eritrean Orthodox, with some Catholics and Protestants). Lowland areas tend to be Moslem, and highland areas tend to be Christian. Education, economic conditions, access to services, and cultural patterns differ across zones. Different approaches may be required in meeting the needs of the different groups and removing barriers to utilization of health services.

Gender: The 2002 DHS does not show gender differences for child health parameters such as immunization coverage, treatment-seeking behavior, and nutritional status. However, boys were more likely to receive oral rehydration therapy for diarrhea than were girls. Initial IMCI referral studies show that girls may be less likely than boys to be referred appropriately to higher levels of care. These findings need to be monitored on a larger scale and addressed as needed. There is an obvious differential between the high childhood immunization coverage cited above and lower maternal care indicators such as percentage of women receiving at least one tetanus toxoid injection during last pregnancy (51 percent), and the percentage given iron supplements (40 percent). This must reflect not only gender-based demand constraints but also the need for further improvement in the quality of maternal care. For example, since the

percentage of women with antenatal care from a health professional was 70 percent, tetanus toxoid coverage and iron supplementation could have been higher.

Further information is needed on community and household decision making; for example, whose authorization is needed for expenditures on emergency transportation for complications of childbirth or severe childhood illness? How can programs focused on maternal and child health educate and involve male as well as female household members and communities? Formative research for health communications, baseline and progress assessments, technical analyses, and training activities must identify gender-related barriers to use of health services and how programs can reduce these.

C.2.3 Transition to SO 4 and TASC2

From June 2000 through December 2003, multiple cooperating agencies (CAs) have been working together to achieve the SO that preceded SO 4. The predecessor SO was referred to as Investment Objective 1 (IO 1), Increased use of sustainable, integrated primary health care by Eritreans. During this period, the primary technical support for maternal and child health, family planning, health communications, and the health information system was provided by a competed Task Order under the Technical Assistance and Support Contract (TASC) contract with John Snow, Inc. In addition, this TASC Task Order provided logistical support for several other CAs. Technical assistance for quality assurance and quality management was provided through the Quality Assurance Project II (now Quality Assurance and Workforce Development -- QA/WD) with University Research Corporation. Health management training, financial management training, and financial analysis have been provided through the Partnerships for Healthcare Reform Plus (PHRplus) project with Abt, Associates.

The TASC Task Order supported by IO 1 ends on December 30, 2003. It is intended that the TASC2 Task Order supported by SO 4 will be contracted to begin before that date. TASC2 will ultimately include technical support for quality assurance and health management, as well as health communications, priority primary health programs such as maternal and child health, and logistical support for other CAs working in HIV/AIDS and malaria. This is intended to consolidate implementation and streamline management of the health portfolio.

However, in order to maintain momentum in quality assurance and health management activities, SO 4 has provided funding for QA/WD and

PHRplus from September 2003 through August 2004. This will allow TASC2 a phased start-up, with technical support for quality assurance and health management systems through TASC2 beginning o/a July-August 2004, rather than at the beginning of the TASC2 Task Order. In the interim, TASC2 will be required to provide logistical support for QA/WD and PHRplus through August 2004, as TASC has done.

C.3 DESCRIPTION OF SO 4 AND EXPECTED RESULTS

As noted, the purpose of SO 4 is to increase the use of priority primary health and HIV/AIDS services and improve practices in order to reduce infant and under-five mortality and morbidity, improve maternal health, and stop HIV at an early stage. Based on results to date and USAID's comparative advantages, core program areas under this SO will continue to include the following: IMCI, obstetric life saving skills, maternal and reproductive health, family planning (as birth spacing and post-abortion counseling), polio eradication, malaria, health communications, and HIV prevention. These are the priority primary health services which will be addressed by SO 4. Nutrition will be integrated with IMCI, health communications, and maternal health interventions. Female genital cutting will be addressed with information, education, communication, and training activities. Emphasis among these areas will be adjusted based on analysis of final 2002 DHS results, funding levels, and changes in other donor support.

The results framework, illustrating the relationship between the SO and the four intermediate results, and summarizing illustrative activities and preliminary indicators for the IRs, is included as Annex A. The indicators and targets for monitoring achievement of results at the SO level are shown in Annex B.

C.3.1 Intermediate results

Four interrelated intermediate results (IRs) have been identified to achieve the strategic objective. All four IRs are described below, in order to provide a complete description of SO 4. **However, it is planned that this Task Order will provide technical support only for the first three IRs.** It is anticipated that technical support for the fourth IR, HIV/AIDS prevention, will be provided through other cooperating agencies (CAs), as will technical support for malaria and polio surveillance. Nonetheless, as described below, the Contractor will provide logistical and administrative support for other CAs in order to avoid duplication of effort and expense

of multiple CA offices. Therefore, some HIV and malaria funds will be included in the contract for this purpose.

- **IR 1: Active demand for primary health care expanded**

Increased use of priority primary health services depends on people's demand for these services. Expanding active demand for primary health services -- including participation of communities, individuals, households, and multiple sectors in health improvement -- is needed to solve Eritrea's most challenging health problems. Achievement of this IR will build on health communications capacity developed over the last several years.

USAID/Eritrea will focus on interventions that can have high impact on creating demand and improving health practices, using innovative approaches that involve active participation by the people. Opportunities will be sought and encouraged to involve people through behavior change, decentralization, governance (community health committees, community representatives on boards of directors of facilities), public-private partnerships, studies on barriers to demand, advocacy, cost sharing, and gender-sensitive approaches. This community approach is a new phase of health improvement, and must be designed to reach and involve people who are difficult to reach. However, this approach will be underpinned by a strong communications effort -- including behavior change communications -- that will continue and expand from the communications thrust of the current strategy in order to help achieve IR1.

IR 1 will encourage a spectrum of involvement in health from personal/individual actions to the household, community, sub-zonal, zonal, and national levels. The range of institutions will include MOH and local government structures at each level, health committees at each level, Eritrean NGOs and CBOs, faith-based organizations, the business community, and labor organizations. USAID and its partners will encourage gender-balanced group participation.

- **IR 2: Quality of priority primary health services improved**

Continued improvement in the quality of primary health services is a prerequisite for increased use of those services. People will not travel to health facilities or take advantage of services if services are of poor quality or do not meet their needs. IR 2 will improve quality of primary health services in the following ways, with a principal focus on the zonal level and below:

- Update or develop service delivery policies, standards, guidelines, job aids, and quality monitoring tools;
- Strengthen in-service and pre-service training to develop or improve skills, especially in priority primary health interventions and quality management; and
- Integrate quality assurance and quality management concepts and practices into training, service delivery, monitoring, and management at each level.

High-quality care is critical for attracting clients to priority health services and ensuring the impact of the interventions offered. Training of health workers is a fundamental means of improving quality. Training should be reinforced with quality improvement efforts to help address other barriers to quality services. These include reorganization of patient flow within facilities, changes in staff shift schedules, procurement of pediatric-size supplies (oxygen masks, intravenous fluid bags), and development of job aids and self-assessment tools.

Based on experience during the current program, quality assurance activities will be expanded to enhance key maternal and reproductive health program areas such as prenatal care, safe deliveries, emergency obstetric care, post-abortion care, and encouraging improved birth spacing.

- **IR 3: Institutional capacity for resource allocation decisions improved**

Increased use of priority primary health services cannot be achieved or sustained without effective use and reallocation of scarce resources – human, financial, pharmaceutical, equipment, and physical infrastructure. Strengthening critical management and financial systems will make this possible. This will include systems and skills needed for planning health services, analyzing both the cost of services and their utilization, budgeting for programs, allocating and managing resources, and monitoring and evaluating performance. Without this information and these resource management tools and skills, allocation of resources cannot be optimized for maximum results and impact.

Building on the systems work and training to date, this IR will strengthen management systems at all levels in the following ways, with an emphasis on the zonal level and below:

- Developing and strengthening guidelines and operational policies related to management systems

- Strengthening health service management and financial management systems, practices and skills
- Increasing analytical and program management capacity
- Improving referral systems

USAID-funded assistance will focus on strengthening financial and other resource management skills and systems at the zonal Health Management Team and facility levels. To support these efforts, some of the same systems and management tools that need to be introduced at the zonal level – such as improved financial accounting, planning, and performance monitoring – need to be introduced at the central level. In addition, continued support is needed to expand and strengthen the HMIS, including feedback to reporting levels and use of the data in monitoring, planning, and resource allocation.

As part of IR 3, USAID will provide technical support to the MOH in identifying the specific roles, functions and responsibilities of the zonal Health Management Teams and zonal hospitals. This technical support will also provide training in administering overall management and financial accounting systems, planning, performance monitoring, and other management tools and systems to improve the efficiency and effectiveness of health service delivery within the zones.

USAID/Eritrea’s assistance to the National Malaria Control Program has supported the development of improved information and surveillance systems through the use of both entomology and epidemiology. Support under SO 4 will build on that work, and will assist the national program to increase its capacity for collecting, managing, analyzing, and using data through improving its surveillance systems, operational research program, and information systems. Strengthening evidence-based programming for malaria prevention and control will result in more effective use of program resources in combating malaria.

However, as described elsewhere, technical assistance for the malaria surveillance activity is not within the Contractor’s scope of work, but will be provided through other CAs.

- **IR 4: Quality of and demand for HIV/AIDS preventive services increased**

Due to Eritrea’s classification by USAID/Washington’s Office of HIV/AIDS as a “basic country” and consequently receiving limited resources for HIV/AIDS programming, USAID/Eritrea’s HIV/AIDS strategy focuses on a

limited number of preventive interventions that will have the most impact and make optimal use of available resources. This focus is consistent with and supports the preventive elements of Eritrea's national HIV/AIDS strategy.

Increased use of priority HIV/AIDS prevention services cannot be achieved without effective demand, quality services, and improved information on the trends of the epidemic. Building on work to date in condom social marketing, training to develop VCT services, BCC interventions, and program planning, IR 4 will increase use of priority HIV/AIDS prevention services in the following ways, with a focus on high-risk groups:

- Establish or maintain prevention programs focused on those most likely to contract and spread HIV
- Expand prevention efforts to those with somewhat lower risk
- Build capacity necessary for efforts to mitigate the impact of AIDS.

As described elsewhere, technical assistance for HIV/AIDS activities will be provided through other CA mechanisms rather than through TASC2.

C.3.2 Cross-cutting themes and linkages within the Mission's strategy

In developing its 2003-2007 ISP, USAID/Eritrea identified several cross-cutting themes that will be addressed across the entire portfolio. Those which are relevant to this Task Order are summarized below:

Gender: The USAID/Eritrea gender assessment showed that women are disadvantaged in many respects. Increasing the percentage of women and girls who receive quality health services will help to ensure that females are not only healthier but better able to pursue education and become more productive.

The gender assessment concluded that the maternal mortality rate 1) is a core indicator of gender inequity and 2) reflects women's lack of opportunity to obtain critical health care services during pregnancy, at birth, and after delivery. While IR 1 will focus on increasing the demand and broader community support for maternal and reproductive health services, IR 2 will improve the quality of these services. Together, over the long term they should have an impact on reducing maternal mortality and improving the quality of life of Eritrean women. Similarly, the same outcome should result for the other priority primary health services.

In turn, improved educational attainment and socioeconomic status of women usually correlates with improved health status. Thus efforts in SO 2 and SO 6 to extend these benefits to women reinforce the health improvement efforts of SO 4. (SO 2, the economic growth SO of the previous country strategy, continues through September 2005.)

Linking development and relief: In the health sector, USAID/Eritrea's current SO has complemented and reinforced relief efforts by strengthening primary health care, which is essential for both development and crisis response. The focus of the new SO 4 has shifted from supporting primary health care access to enhancing health sector management and development. In the event that a disaster were to occur, SO 4 would increase programming to meet nutritional gaps, provide emergency access to health care, and enhance access to water. It would also modify existing programs in the health sector to enhance their mobility in the event of widespread population movements by establishing mobile clinics, moving health services with the population and increasing outreach in areas of population displacement.

Complementary program outcomes: There are specific linkages among the three SOs. For example, SO 2, in the process of improving economic growth in rural areas, will create new jobs and provide income to rural residents who previously were unemployed. In turn, some of this income will be available for improving household health conditions, cost sharing of primary health services, improved nutrition, and so on, thus helping to improve health status. SO 6 will also complement SO 4 efforts to strengthen community and public-private partnerships.

C.4 CONTRACTOR SCOPE OF WORK

The Contractor will provide long-term technical advisors and an administrative support team that will manage the delivery of project assistance, short-term technical assistance, institutional back-up through home office support, procurement of selected commodities related to technical support, and other related support as stated in Section C.4.1. The Contractor may execute sub-contracts and/or sub-grants as necessary to meet the requirements of this Task Order.

As reflected in the specific tasks described below, this Task Order does not include technical assistance to improve malaria or polio surveillance systems (otherwise a component of IR 3). Although the Contractor will not have primary responsibility for implementing IR 4 (HIV/AIDS prevention), the Contractor will provide mutually agreed logistical and administrative

support for other CAs providing technical assistance for HIV/AIDS prevention and malaria surveillance. This collaboration is important in order to avoid duplication of effort and expense that would otherwise be incurred in the operation of multiple CA offices. As indicated in Section 8, annual increments of funds earmarked specifically for HIV/AIDS and malaria will be included in the Task Order for this purpose. Amounts will depend on the funding levels for these earmarks.

C.4.1 Specific tasks of the Contractor

Although the tasks listed below are described separately, there are many linkages and interrelationships among them – especially among Tasks 1, 2 and 3. For example, the service quality improvements that will be developed in Task 2 will help increase demand (Task 1). Offerors shall explicitly describe how these linkages and interrelationships will become an integral part of their technical approach.

The three major tasks corresponding to the three IRs supported by the Task Order (IRs 1, 2, and 3) are listed first, so that the task numbers correspond to the respective IR numbers. Major sub-tasks are shown for each of the seven tasks, along with illustrative activities and preliminary performance standards. For the first three tasks, the preliminary performance standards are based on the preliminary results indicators from the SO framework and text of the USAID/Eritrea Integrated Strategic Plan for FY 2003 to FY 2007. USAID/Eritrea anticipates that at least some of the preliminary results indicators shown here will be revised as the SO performance monitoring plan is finalized, as additional data become available, during action plan development with the MOH and other partners, based on actual rates of progress, and due to changes in the country situation.

The final indicators, together with corresponding targets, will be mutually agreed among the MOH, the Contractor and USAID/Eritrea. They will be finalized at the time the five-year strategic plan and year 1 action plan for the Task Order are developed (see Section C.5).

Since USAID resource levels for health are not expected to rise during the FY 2003-2007 strategy period, SO 4 will maintain the geographic focus developed during the current program. The principal geographic focus for maternal and child health activities has been three (out of six) Zones – Central (Maakel), Gash Barka, and Southern (Dehub). The latter two are also the zones where the health system suffered the most damage during the 1998-2000 border conflict. Together, these three zones comprise approximately 60 percent of the population. At the request of the MOH, personnel from all zones are included in fundamental training (such as

obstetric life-saving skills and health management information systems). Roll-out of systems developed (such as HMIS improvements) will generally be national, with efforts to leverage other-donor funding for hardware, especially in non-focus zones. (Malaria and HIV/AIDS activities are focused on high risk areas for these diseases, across Zones.)

TASC2 will maintain the geographic focus described above through the base period. After that, if the MOH and USAID agree to review progress and amend Annex 1, the Amplified Program Description, of the SO 4 Strategic Objective Agreement to adjust the geographic focus, the Contractor may be requested to focus on different zones during the option periods. This adjustment must be undertaken in such a way as not to increase the cost of the option periods, unless the MOH and USAID are able and agree to increase funding accordingly.

- **TASK 1: Expand active demand for primary health care**

Principal sub-tasks:

1.1: Using innovative approaches that involve active participation by community members and/or groups, help the MOH and other partners to identify, develop, and implement interventions at the community level that can have a high impact on creating demand.

1.2: In these approaches, involve people through a variety of mechanisms in order to identify those with the most potential for successful replication. Illustrative mechanisms include (a) designing and implementing studies on barriers to demand, advocacy, cost sharing, and gender-sensitive approaches; (b) behavior change communications; (c) capitalizing on the expansion of the MOH's decentralization program in encouraging local involvement; (d) focusing on governance in different settings (e.g., community health committees, other community organizations, community representatives on boards of directors of facilities); and (e) developing public-private partnerships.

1.3: As successful models are identified, help disseminate these approaches to other communities and sub-zones within the three principal focus Zones.

Illustrative activities:

1.1: Expand behavior change communications to support community IMCI, emergency obstetric care, further FGC reduction, and malaria control.

1.2: Encourage sub-zonal and community health committees to develop transportation plans and procedures for obstetric emergencies and severely ill children.

1.3: Examine worldwide experience in community financing schemes and test promising approaches in Eritrea.

1.4: Use rapid, qualitative research techniques to define key barriers to use of primary health services (especially obstetric care) and modify services to reduce the barriers identified.

1.5: Provide training for the business community, faith-based organizations, and other Eritrean NGOs that can provide or encourage the use of primary health services.

Preliminary performance standards: The key performance indicators for Task 2 are:

1.1: Number of new community-level approaches to increase demand and support for primary health care designed and tested

1.2: Number of health facility governance boards with community representatives

1.3: Percent improvement in selected key health knowledge and attitude indicators (e.g., knowledge of maternal complications of pregnancy and childbirth, knowledge of location of IMCI services, use of good hygiene practices)

- **TASK 2: Improve quality of priority primary health services**

Principal sub-tasks:

2.1: Develop and/or update service delivery policies, standards, guidelines, job aids, and quality monitoring tools.

2.2: Strengthen in-service and pre-service training and facilitative supervision to develop or improve skills, especially in priority primary health interventions and quality management.

2.3: Integrate quality assurance and quality management concepts and practices into training, service delivery, monitoring, and management at each level.

Illustrative activities:

2.1: Strengthen and expand pre-service and in-service training curricula and methodologies for primary health personnel (nurses and health assistants) to incorporate quality assurance.

2.2: Incorporate management, problem-solving, and quality assurance skills into pre-service and in-service health worker training programs.

2.3: Assess the tasks of current primary health care staff, modify job descriptions and duties to reflect the new quality assurance emphasis, and assist in ensuring their acceptance and use.

- 2.4: Incorporate quality assurance into health service management training as a means of both increasing health service quality and making management more effective.
- 2.5: Use rapid operational assessment techniques to identify the most feasible solutions to improving service delivery.
- 2.6: Roll out quality assurance committees, facilitative supervision, self-assessments and other quality improvement techniques, all of which have been introduced during the current program.
- 2.7: Develop and produce job aids such as checklists for priority services, self-assessment tools, monitoring methods, etc.
- 2.8: Strengthen performance-based monitoring and evaluation of priority services, including use of available health system data to fine-tune approaches and boost performance.
- 2.9: Expand current USAID-funded quality assurance efforts to develop user-friendly services and procedures at facilities providing primary health services
- 2.10: Include key gender-sensitive quality assurance measures in the HMIS and use them in assessing service quality

Preliminary performance standards: The key performance indicators for Task 3 are:

- 2.1: Number of facilities implementing emergency obstetric care to standards
- 2.2: Number of facilities implementing IMCI to standards
- 2.3: Percentage of children in target facilities receiving appropriate malaria treatment through the IMCI program

- **TASK 3: Improve capacity for resource allocation decisions**

Principal sub-tasks:

- 3.1: Developing and strengthening guidelines and operational policies related to management systems, with emphasis on the zonal level
- 3.2: Strengthening health service management and financial management systems, practices and skills, with emphasis on the zonal level
- 3.3: Increasing analytical and program management capacity, using the strengthened systems
- 3.4: Improving referral systems

Illustrative activities:

- 3.1: Develop and establish management systems policies and guidelines at zonal, sub-zonal, and facility levels.

3.2: Develop and/or upgrade critical resource management systems such as HMIS, pharmaceutical logistics, financial management, etc., for use by Zonal Health Management Teams, facility managers, and policymakers.

3.3: Provide training at each level to develop and use appropriate management skills.

3.4: Rationalize and fine-tune cost recovery systems, fees, and cost-containment mechanisms.

3.5: Ensure use of the HMIS and other management systems data to monitor the performance of the health system and facilities at each level, and to improve the targeting of interventions and resources.

3.6: Assist in ensuring the use of health services and management data in the development of health financing policy.

Preliminary performance standards: The key performance indicators for Task 4 are:

3.1: Use of specific management systems (pharmaceutical logistics, service performance, financial management, human resources, etc.) according to phased plan at each level

3.2: Presence of ongoing management training program(s) and number of managers trained

3.3: Use of HMIS and other information systems to monitor and improve effectiveness of priority primary health programs (e.g., number of target zones that present annual reports and plans using HMIS data to measure progress in core programs)

- **TASK 4: Transition from current program to services provided under this Task Order**

Principal sub-tasks:

4.1: This Task Order is expected to be awarded not later than November 30, 2003. This date will allow at least the month of December 2003 for the TASC2 Task Order Contractor to work with JSI/TASC (the current TASC contractor) to ensure a smooth transition as the TASC2 Task Order Contractor takes on responsibility for providing technical assistance for the program elements that currently receive technical support from JSI/TASC, namely, IMCI, maternal and reproductive health, family planning, the health management information system, the pharmaceutical logistics system, behavior change communications, and logistical support for other CAs. In order to avoid loss of momentum while the Year 1 action plan and five-year strategic plan are developed, the Contractor will continue support for ongoing efforts in those areas prior to approval of the plans.

4.2: In order to provide continuity and to help ensure a smooth transition for both the quality assurance activities and the health systems and management activities, USAID/Eritrea has funded the existing implementing agencies (QA/WD and PHRplus) to continue to provide technical assistance in those areas through July 2004. After that time, the TASC2 Contractor will be responsible for providing the technical assistance needed in quality assurance and health management to implement tasks described below. The Contractor shall ensure that there is a smooth transition between the technical assistance provided by QA/WD and PHRplus and that to be provided under this Task Order, as well as continuity in programming and implementation. Offerors shall explicitly describe how this will be accomplished. Relevant elements of this transition plan will be incorporated into the five-year strategic plan and year 1 action plan, as discussed in Section C.7.

Preliminary performance standards:

4.1: Effective participation by all relevant implementing organizations, the Contractor, and USAID/Eritrea in periodic planning and monitoring sessions

4.2: Evidence of adhering to and/or adjusting the Contractor's transition plan during the transition period

- **TASK 5: Effective collaboration among key partners**

Principal sub-tasks:

5.1: The Contractor will foster strong, effective and continuing collaboration among relevant partners and the Contractor. At the Task Order oversight and management level, this includes the MOH, the Contractor, and USAID. At the implementation level, this includes the MOH and other partners, the Contractor, and the other USAID cooperating agencies.

5.2: An additional opportunity for collaboration may occur at the community level in selected sites. The purpose of USAID/Eritrea's SO 6 is to enhance participation by the people in growth and development. To achieve this, one of the intermediate results proposed is Community-Based Organization (CBO)-Local Administration Partnerships Strengthened. SO 6 will initially work with at least ten CBOs to implement community-level activities in partnership with local administrations. If SO 6 identifies CBOs in the SO 4 target Zones that are interested in health activities that would contribute to SO 4 results, the TASC2 Contractor will provide training or related technical support to the CBOs, resources permitting.

Preliminary performance standard:

5.1: Evidence of strong collaboration in the execution of and results achieved by the Contractor and other USAID-supported CAs.

- **TASK 6: Plan Development and Implementation**

The Contractor shall work with the MOH and other partners to develop the five-year strategic plan and annual action plans described below in Section C.7. Plans should build on existing MOH sector and program plans and should be coordinated with other donor efforts.

The annual plan package will include training and procurement plans, as described in Section C.7. Based on the annual action plans, the Contractor shall procure selected, mutually agreed commodities in a timely fashion. These commodities may include office and residential furniture for TASC2, office equipment and supplies for TASC2 and counterparts, and vehicles to support the field visits, and selected clinic furniture, computers, training materials, audio-visual, and similar equipment needed to provide technical support under this Task Order. During planning, the MOH and the Contractor will ensure coordination with other donor support to increase impact and reduce duplication of effort.

At the beginning of the Task Order, the Contractor shall submit for USAID/Eritrea approval a list of those items that must be purchased initially to support contract start-up. Future procurement will be based on approved annual procurement plans, which are an integral part of the annual action plan package (see Section C.7).

Principal sub-tasks:

6.1: Assist the MOH in defining five-year results and interim annual results and capacity development activities needed to achieve the results in priority primary health program areas addressed by the Task Order and SO 4.

6.2: Prepare training and procurement plans that are part of the annual action plan package.

6.3: Develop specifications for short-term technical assistance, training, and procurement. Make any necessary arrangements for shipment and/or delivery of materials and equipment, arrange for customs clearance by the MOH in accordance with tax exemption requirements, and maintain records on local procurement transactions in order to follow Embassy guidelines on requesting sales refunds for transactions in excess of \$500.

6.5: Ensure that training arrangements comply with USAID training regulations and guidelines including lead-time for US visa requests, Mission training plan review, TraiNet reporting, and so on.

6.4: Maintain an inventory of and perform end-use checks on equipment procured, in accordance with USAID regulations.

6.6: The Contractor will also make the necessary arrangements for the leasing of housing for the three long-term expatriate team members. The Contractor will also lease office space for TASC2 advisors and consultants. Office space leased will be sufficient to support other CA advisors and consultants as part of logistical support to other CAs.

Preliminary performance standard:

6.1: Five-year strategic plan and annual action plans developed and approved.

6.2: Evidence of performance of agreed technical assistance, training, logistical support, behavior change communications, commodities, and other technical support for plans.

6.2: Documentation of inventory and end-use checks for commodities.

- **TASK 7: Support for other USAID-funded CAs**

The current JSI/TASC Task Order will terminate on December 31, 2003. Among other tasks, JSI/TASC is responsible for providing office and logistical support for a number of CAs from that date. The scope of support provided varies among the CAs, but may include office space for in-country advisors or short-term consultants, office services (e.g., copying of documents, message service), in-country transport, sending Eritrean participants to conferences in other countries, payments related to in-country workshops, off-the-shelf procurement, administration of in-country survey costs, other costs that would otherwise require the CA to have in-country office or accounting services. The contractor shall document costs of this support and charge them to the appropriate line item in the mutually agreed budget format (see Section C.7.5). See Section C.7.9 for further information on estimating the cost of support to programs and other CAs.

The CAs requiring this logistical support fall into two groups:

- CAs that have a long-term presence in Eritrea but do not provide their own office, transport, and other logistical and administrative services. These currently include the following CAs: Family Health International/IMPACT (HIV/AIDS), and Camp Dresser & McKee/Environmental Health Project II (malaria surveillance). For the period from January through July 2004, support services will also

be provided for both Abt, Associates/PHRplus and University Research Corporation/Quality Assurance and Workforce Development Project, until these activities are phased into TASC2.

- CAs that provide specialized technical assistance on a short-term or intermittent basis and have no offices or other support mechanisms in Eritrea. These are expected to include (1) MEASURE Evaluation, (2) MEASURE Demographic and Health Survey (DHS) Plus (in preparation for the planned DHS 2007).

Principal sub-task:

7.1: The Contractor shall provide office and logistical support for these CAs throughout the period of this Task Order. The nature and intensity of this support will vary among the CAs, and will be mutually agreed in writing for between each CA and the Contractor annually. Other CAs and their counterparts will be consulted in the development of the five-year strategic plan and annual action plans to ensure good coordination.

Performance standard:

7.1: Evidence of mutual agreements between the Contractor and each CA on the required nature and scope of support services

7.2: Evidence of an ongoing mechanism of formal quarterly reviews between the Contractor and each CA, to review and refine support services for the next three-month period

C.5 CONTRACTOR PERSONNEL

The Contractor will recruit, hire, orient, and support the technical, administrative and support personnel to plan and implement all Task Order activities. The Contractor will provide all administrative, logistical and technical support for its personnel, including both long-term employees and short-term consultants. These categories of personnel are described in the following subsections.

C.5.1 Long-term personnel

The Contractor will provide a team of three long-term, expatriate specialists to provide technical support needed to strengthen the capacity of the MOH and other partners to achieve SO 4. The specialists will lead the Contractor's effort to implement the six tasks described in Section C.5.1. The qualifications, skills, and experience required for these three specialists are stated below. Relevant experience of all long-term, expatriate specialists shall include long-term experience in projects in developing

countries that are similar to that represented in this scope of work. Previous experience in USAID-funded projects is highly desirable for the Team Leader and other long-term specialists.

Offerors shall propose one of the three long-term expatriate specialists as Team Leader (Chief of Party). This choice may be affected by a number of factors, including the previous experience as Chief of Party for a technical assistance team. Criteria for team leader (over and above the technical qualifications required to fill one of the three specialist positions), are included following the descriptions of the three expatriate long-term specialists, below.

Offerors shall ensure that one of the three long-term personnel is an M.D. with additional formal training in public health. Offerors shall also describe in their technical proposals how the qualifications and experience of the set of advisors proposed addresses each of the priority primary health program areas, and how any gaps will be covered with short-term or intermittent advisors.

Signed letters of commitment shall be provided for each long-term candidate. The three long-term specialists are designated key personnel.

- **Behavior Change Communications and Community-Based Services Development Specialist**

This individual shall have a minimum of five years of experience and progressively increasing responsibility in the areas of behavior change communications and the development of community-based health services. As shown in the Contractor's scope of work (especially the descriptions of IR 1 and the corresponding Task 1, this specialist must be able to provide a combination of the skills and experience in development of community-based services, behavior change communications and health promotion, innovation, and strong interpersonal skills. Experience in providing training in these skills is required. Experience in USAID-funded projects is highly desirable. At a minimum, the specialist shall have an MPH or other Masters degree relevant to primary health care. The individual shall be fluent in reading, writing and speaking English.

- **Quality Assurance/Maternal and Child Health Specialist**

This specialist shall have at least seven years of experience and progressively increasing responsibility in improving the quality of health services in developing country settings, primarily in the areas of

maternal and reproductive health and child health. Explicit experience with quality assurance techniques, such as quality improvement, quality management, and facilitative supervision, as applied to developing country health systems, is required. Experience in USAID-funded projects is highly desirable. While “quality assurance” is not necessarily an area of academic specialization, specific education or training in this area is required. The emphasis of prior international experience shall have been in improving the quality of maternal and child health (MCH) services, reproductive health, and family planning services in a developing country environment. In addition, the individual shall have substantive experience in the implementation, monitoring and evaluation, and provision of training to strengthen MCH/RH/FP services. S/he shall also have strong interpersonal skills. At a minimum, the specialist shall have a degree in nursing or other health profession. An MPH degree with a focus on health service delivery is desirable. The specialist shall be fluent in reading, writing and speaking English.

- **Health Systems and Management Specialist**

This individual shall have at least seven years of experience and progressively increasing responsibility in the areas of health systems and management. The emphasis of prior work shall have been in health services management and health systems development in a developing country environment. Substantive experience in development of (or managing specialists who are developing) resource allocation-related information systems (such as health management information systems, financial management systems, pharmaceutical logistics systems, human resource management systems) is required. Significant involvement in health reform activities is desirable. Experience in USAID-funded health projects is highly desirable. Strong interpersonal skills are also required. The specialist shall possess, at a minimum, a Masters degree in health management or administration from an accredited university program, or a combination of health professional degree-level training and a Masters degree in management, business, or public administration. The specialist shall be fluent in reading, writing and speaking English.

- **Additional criteria for the Team Leader**

The offeror shall propose one of the three specialists described above to serve in a dual capacity as Team Leader. In addition to fulfilling the qualifications described above for one of the specialist positions, the individual proposed as Team Leader shall have the following additional

qualifications: (1) strong leadership and management skills; (2) experience as Team Leader (Chief of Party) in developing country health projects of similar scope and complexity to SO 4; (3) prior experience in USAID-funded activities and knowledge of USAID regulations is highly desirable; (3) strong interpersonal skills, including diplomatic interaction with government officials at all levels in a developing country setting; and (4) excellent analytical skills.

- **Local support staff**

The Contractor will provide an Eritrean Training Advisor and Administrator. These specialists will not be nominated as part of the proposal, but rather will be nominated for the approval of the Ministry of Health and USAID/Eritrea following contract award. (This is to level the playing field for bidders and to take account of the shortage of such personnel in Eritrea.) In addition, the Contractor shall propose a local-hire staffing plan that will provide administrative and logistical support that will ensure the timely and effective implementation of activities and the achievement of the Contractor's tasks.

C.5.2 Short-term personnel

In specifying short-term consultants required to support the long-term team in implementation and capacity development, the Contractor should consider the use of intermittent technical specialists, where possible. While some tasks (as specified in the annual work plans to be developed) can be supported by short-term consultants on a one-time basis, other tasks will benefit from intermittent technical specialists who are available for repeated visits to ensure both continuity and effective involvement in activities that continue over time and require periodic inputs of the same skills. Offerors should be prepared to provide approximately 52 person weeks of short-term technical assistance per year.

C.5.3 Home office staff

The Contractor will provide home office technical, logistical and administrative staff necessary to support the long-term TA team both in executing the Contractor's tasks and in achieving the project's intermediate results.

C.6 PERIOD OF PERFORMANCE

The initial award and period of performance shall be from the date of Task Order award through September 30, 2006. This comprises the base period for the Task Order. There will be two additional option years, from October 1, 2006, through September 30, 2007, and from October 1, 2007, through September 30, 2008. Offerors' technical proposals and cost proposals shall reflect these three periods. Programmatically, however, the technical proposals shall reflect the continuity of activities and interventions through the entire five-year period (minus roughly two months during the first, partial year, i.e., from date of award through September 30, 2004). Although USAID/Eritrea expects to make awards for both option periods as well as the base period, USAID/Eritrea reserves the right not to make an award for the option periods.

C.7 REPORTS AND OTHER DELIVERABLES

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 annual action plan will be a package including a training plan and procurement plan, based on the main action plan. The format of all of the different plans and reports should be compatible and designed to allow analysis among the plans of activities completed, expenditures, and results for each project year. Because of the interrelationships, the timing of the delivery of these documents should also be coordinated. For example, the Year 1 performance monitoring report and Year 1 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 the Year 2 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 mutually agreed once the Contractor's TA team is actively involved in implementing the scope of work.

In order to ensure rapid start-up for SO 4 and a smooth transition from TASC to TASC2, the Contractor may continue to support training for priority primary health programs initiated under TASC and provide support for other CAs while TASC2 action plans, described below, are being developed and reviewed based on CTO approval.

C.7.1 Five-year strategic action plan

Within the first 90 days after the arrival of the first long-term TA team member in Eritrea, the Contractor will submit to the MOH and USAID/Eritrea a 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.7.2, below), the five-year strategic action plan will focus on the five-year chain of actions needed to achieve the targeted end results of SO 4 and IRs 1, 2, and 3. The Contractor will work closely with the MOH and other CAs in developing this plan. This five-year strategic plan will be submitted in a format mutually agreed among the MOH, the Contractor and USAID/Eritrea.

C.7.2 Annual action plans

Coincident with the preparation and submission of the five-year strategic plan, the Contractor will prepare and submit to the MOH and USAID/Eritrea the annual action plan for Year 1. 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 integral components both an annual training plan and an annual procurement plan, as described in the following subsections. The annual action plan will also incorporate a financial status report (see Section C.7.5). The annual action plans will provide information in a format mutually agreed with the MOH and USAID/Eritrea.

C.7.3 Annual training plans

As part of the annual action plan package, the Contractor will submit an annual training plan for all Contract-funded training activities. The training plan will be based on the annual action plan and consist of training designed to support the annual action plan and achievement of SO 4. The timing of training actions will be shown in the annual action plan. The separate training plan will be used to meet USAID review and reporting requirements. The training plan will include a brief description of the relationship to the SO framework, types of training proposed by category of training (U.S., third country, and in-country); expected cost; source of training; and proposed timing. The annual training plans will provide information in a format mutually agreed with the MOH and USAID/Eritrea. The format and content shall follow the guidance for Mission Training Plans in Mission Orders and ADS 253.

C.7.4 Annual procurement plans

As part of the annual action plan submissions, the Contractor will submit an annual procurement plan for project goods and services planned for procurement during the year. This procurement plan will be based on the

annual action plan, and the timing of procurement actions will also be incorporated into the action plan. The procurement plan will indicate planned procurement actions for goods and services including items to be procured, relationship to planned activities, expected cost, anticipated source and origin, procurement mechanism(s), proposed timing and estimated delivery date. The procurement plan will conform to all applicable USAID federal regulations incorporated into the Contract and updated and/or supplemented by USAID/Eritrea from time to time. The annual procurement plans will provide information in a format mutually agreed with the MOH and USAID/Eritrea.

C.7.5 Financial status reports

The financial status report is another key document related to the annual action plans, and will provide the basis for considering the effective use of project resources. USAID/Eritrea understands that such financial information will be preliminary, subject to changes that may result as financial data are reviewed and revised by the Contractor's home office.

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. The financial status reporting format will be mutually agreed with the MOH and USAID/Eritrea.

C.7.6 Performance monitoring and reporting

Performance monitoring and reporting will include program activities, outcomes, and results based on the five-year strategic plan, annual action plans, and the indicators and targets in the SO 4 performance monitoring plan. As specified in these plans, the data for performance monitoring may be from a variety of sources, including: (1) the MOH health information system, (2) KAP surveys, (3) facility and community level assessments; (4) field visits; (5) other relevant analyses and reports; and (3) the Contractor's primary monitoring and reporting system for this Task Order. Performance reporting will be in a form mutually agreed with USAID/Eritrea, in order to facilitate quarterly reviews with the MOH and periodic portfolio reviews within the Mission, and to provide performance results in the required format for the Mission's annual performance report to USAID/Washington, including information on training required for TraiNet.

Copies of individual consultant reports, assessments, surveys, survey questionnaires and interviewer manuals, guidelines, health education materials, or other products funded by the Contract will also be provided to USAID/Eritrea and MOH counterparts.

The Contractor's final report will be the last performance monitoring report, and will follow the same format as the annual reports. The final report will assess overall achievement of the SO 4 intermediate results, and will incorporate a full financial status report (subject to final adjustments required after the end of the contract).

C.7.7 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.
- **Ownership.** All plans, reports and other documentation under this Task Order shall become the property of USAID/Eritrea and may not be used by the Contractor for any other purpose than to satisfy the requirements of this Task Order.
- **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 both USAID/Eritrea and the MOH in a mutually agreed form.

C.7.8 CTO Approval of Plans

The Contractor will develop plans in collaboration with the MOH and the USAID/Eritrea Health Team. The plans are subject to the approval of USAID/Eritrea CTO for the TASC2 task order. The USAID/Eritrea CTO will review and approve plans to in consultation with the MOH to ensure that

they are within the TASC2 task order scope of work and contribute to the SO 4 results framework.

C.7.9 Planning Program, Office, and Logistical Support

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

While the MOH will provide office space and equipment to allow technical advisors to co-locate with counterparts to the extent possible, the Contractor will need to provide shared office space for its own staff and consultants, for FHI/IMPACT resident advisors and consultants, and other occasional consultants from other CAs. Through July 2004, the Contractor will need to provide office space for QA/WD and PHRplus advisors (afterwards, its own staff will phase into those functions, so this is not additional to the Contractor's own space). Contractors should expect to find and provide modest office space and avoid the appearance of extravagance. It may be necessary to lease two smaller houses rather than one large building.

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.

The following level of program support should be assumed in preparing proposals.

	YR 1	YRS 2-4 (Annual)
Short-term training, conferences, and study tours	\$100,000	\$150,000
Commodities and materials production	300,000	420,000
Support for other community activities	40,000	60,000
Office Equipment and Vehicles	\$210,000	--

Note that the the short-term training category does not include the cost of resident advisors or short-term consultants who conduct in-country training, but rather other in-country training costs, such as participant per diem, space rental, travel to conferences, and so on. Of the contract funding in FY 03, \$150,000 in HIV earmarked funds will be provided for

HIV/AIDS support and \$100,000 in infectious disease earmarked funds for malaria support. This will be split among the above categories, and office and logistical support (secretarial support, transport, etc.). It is currently estimated that in subsequent fiscal years, approximately \$200,000 in HIV earmarked funds and \$150,000 in malaria earmarked funds will be provided. The Contractor must be able to track these funds separately in accounting.

C.8 BASE AND OPTION PERIODS AND RELATED INFORMATION

C.8.1 Base period and option periods

The base period of performance and option periods of performance for this Task Order are described in Section 6. In budgeting for these periods of performance, Offerors shall provide three separate budgets, but shall plan and budget activities to provide continuity between the three periods.

Based on availability of funding, particularly for HIV/AIDS 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.8.2 Joint proposals

The scope of work for TASC2 is designed to provide comprehensive support for SO 4, combining functions previously carried out by multiple organizations. USAID will consider joint proposals from multiple TASC2 IQC holders as long as working arrangements are clearly defined in the joint proposal.