ATTACHMENT I

DESCRIPTION/SPECIFICATIONS/STATEMENT OF WORK

BACKGROUND:

a. Setting

Three decades ago, the Iraqi health system was considered one of the best in the Middle East region. The system, which was fully subsidized and provided free health care to all Iraqis, focused primarily on providing hospital based curative care by specialist physicians through a network of well-equipped and well-staffed health care facilities. The system also included public health programs for malaria and tuberculosis control and an expanded program of immunization.

In the mid-80s, in an effort to stimulate population growth in response to deaths from the Iran-Iraq war, the Government initiated a child survival campaign. It set up a network of rural and urban primary health care facilities and mobile outreach service teams in rural areas. It supported immunization campaigns, breastfeeding promotion, diarrhea treatment, and outreach for tuberculosis. The government of Iraq estimated at the time that 97% of urban and over 70% of rural populations had access to health care and that it had begun to achieve reductions in infant and child mortality.

However, following the 1980-88 war with the Islamic Republic of Iran and the Gulf War, the health system began to experience rapid declines in quality and effectiveness. With hospitals and health centers damaged, expatriate medical personnel departing the country and no systematic outreach programs, access to services declined significantly and health status deteriorated. Plants for generating electricity were also damaged, affecting the supply of electricity to remaining facilities and as a result limiting the routine provision of health services as well as the utilization of specialized medical equipment. With water purification and sewage treatment facilities also suffering damage, there was a significant increase in deaths from diarrhea. Throughout the 1990s, the health infrastructure continued to deteriorate due to conflict, sanctions, and inappropriate government policies, including declining financial resources for the sector and lack of investment in human resource development.

Today, Iraq’s health sector is faced with an extremely high disease burden, with health status very poor in comparison to many countries in the Middle East and North Africa region. It is characterized by high levels of maternal mortality (292/100,000) and high levels of fertility (Total Fertility Rate, 5.4). Infant mortality (107/1,000) and under five mortality (133/1,000) are also excessive, linked to diseases such as respiratory illness, diarrhea, measles and malaria. This is further compounded by high levels of under nutrition and malnutrition, which affect 30% of children under five, as well as limited access to potable water.

The sector lacks strong physical infrastructure; facilities are largely run down and equipment is either in short supply or out of date. There are severe shortages of health professionals and distribution of these cadres is inefficient. Decades back, Iraq routinely imported nurses to

meet provider shortages; considering the key roles nurses play in health care delivery, there is now a critical need to build an in country professional cadre of nurses and increase nurse numbers, particularly female nurses, with just under 6 nurses per 10,000 population. Additionally, there is a need to upgrade nursing quality since only 300 of an estimated 17,200 nurses are university educated, with over 80% of trained nurses graduates of high school or post-high school nursing institutes. There are currently three levels of nursing education in Iraq producing different categories of nurses: skilled nurses, which receive three years of training following nine years of general schooling; technical nurses, which receive two and a half years of training after 12 years of general schooling, and college level nurses, which receive four years of university education. With such a broad range of nurse training and quality, it is essential to rationalize the nursing education system and establish a system to upgrade and standardize nursing care.

Finally, a number of emerging challenges must be confronted as quickly as possible to prevent future strain on the system. Communicable diseases such as tuberculosis and cholera, for example, have reemerged, and primary and community mental health issues have long been neglected. Moreover, with 48% percent of the population under 18 and an annual growth rate of 3.3%, measures should be taken to alleviate large population increases during the next decades.

b. Ministry of Health

The Ministry of Health 's mission focuses on building a comprehensive healthcare system that is financially sound and capable of providing accessible, affordable, high quality services that meet the needs of Iraqis regardless of their ethnicity, geographic origin, gender or religious affiliation. Its goal is the improvement of public health, particularly maternal and child health, through the provision of services as close to the client as possible and with the full involvement of community groups.

The Central Ministry of Health includes General Directorates of: Public Health and Primary Health Care; Medical Operations and Specialized Services; Planning and Human Resources Development; Projects and Engineering Services; Technical Affairs; Drugs and Medical Supplies; Administration, Finance and Legal Affairs; Public Clinics; Inspector General; and the Council for International Health, Public Affairs and Media Information. The Inspector General of Health is charged with the enforcement of health laws and regulations. At the governorate level, Ministry of Health functions are managed by Directorates of Health, which maintain a structure similar to that of the Central MOH.

In an effort to ensure that programs effectively meet local needs and provide equitable access to health services around the country, the MOH is currently attempting to initiate a process of decentralizing program implementation and gradually devolving program authority to governorates. In this, the MOH provides a national framework for program implementation. This framework is adapted to epidemiological and institutional realities at the regional, governorate and district level; it also makes use of local partnerships at all levels to promote the participation of civil society and community associations in health programs. While the approach does not allow for financial

decentralization, recent MOH Delegations of Authority do provide increased authorities to Directorates of Health in spending against allotted budgets using established parameters. For example, Directorates of Health may use budgeted funds to contract directly with groups, to develop its own projects, or to buy certain supplies or medicines in accordance with central guidelines

c. Primary Health Care: System, Structure and Staffing

Public Sector Centers

The Ministry of Health signed on the Alma Ata declaration on Primary Care in 1978 and used this as part of the basis for the Public Health Laws of 1981 and 1989. The MOH's strategic vision, developed last year, underlines its commitment to shift from a historically centralized, hospital-based curative system to one which is centered on the delivery of quality primary health care services within communities that participate in primary health and disease prevention activities. Accordingly, a top priority of the MOH is expanding the availability of primary health care infrastructure and service delivery programs. MOH primary health care programs focus particularly on maternal and child health to support reductions in maternal and child morbidity and mortality.

Primary Health Care Centers (PHCCs) are an integral part of the health care system, responsible for providing a wide range of preventive care services such as vaccination and pre-and ante-natal care as well as some curative care services. There are currently 1,718 public sector primary health care centers (PHCCs) in Iraq. Less than 50% of them are staffed with at least one medical doctor. The remainder are staffed with trained health workers such as nurses and medical assistants. On average, each PHCC with a physician is responsible for providing primary health care to a catchment area population of about 35,000.

PHCCs are supported by the central Ministry of Health, but are managed directly by the Directorate of Health at the governorate level. The MOH provides an annual allocation for PHCCs for each governorate. This budget is then used by the governorate level Directorate General of Health to pay salaries to PHCC staff and support other operating expenses for PHCCs. Although PHCCs are provided monthly with funds to support operational costs, PHCC Directors do not manage their own budgets, nor do they have financial flexibility or authority to spend these funds.

Distribution of PHCCs around the country is uneven. In the southern region, in the marshlands, which encompass the Governorates of Missan, Wassit, Nasiriya, and Basrah, primary health care services are rudimentary or lacking in approximately 37 districts, with a population of approximately 150,000. The distribution of health professionals is also uneven, with greater numbers of trained providers in urban centers. In Baghdad, for example, there are 925 physicians in 142 PHCCs compared to an actual need of 656 as estimated by the MOH. In contrast, there are 74 physicians assigned to PHCCs in Nasiriya governorate against the real need of 147 estimated by the MOH. Governorates with shortages of PHC physicians include Najaf, Missan, Wassit, Anbar, Babil and Erbil, while Kirkuk, Suleimaniya, Dohuk, and Salaheddin are comparatively overstaffed.

Staffing of PHCCs is also variable. On average, a PHC with doctors has about 4 medical doctors, 11 nurses, and 1.5 dentists; however, staffing averages vary widely, with most PHCCs understaffed. There is a severe shortage of pharmacists and nurses, particularly female nurses, in almost all governorates. On average, a PHCC has a workload of 120 patients per day. This number is much higher in urban (134) and suburban (144) centers than in rural centers (78). At health centers, most physicians work for three hours, from 9 a.m. to noon, during which they see between 30-100 patients, As a result, consultation time ranges from 2-6 minutes per patient. There is currently no systematic patient recordkeeping system in most PHCCs.

Overall, available assessments indicate that access to primary care is inadequate, the level of perceived quality of care is low, the state of physical infrastructure is not satisfactory and requires major repairs, equipment is grossly deficient, drug supply is very short, and essential services are not always available. A series of local forums conducted by a USAID contractor during 2004 highlight the need to improve the standards of care provided by PHCCs, with nearly 60% of people interviewed believing that PHCCs cannot provide basic health care as well as a hospital can. Over 70% of individuals interviewed felt that private health care is better than public health care and that it was better to see a specialist rather than a general practitioner when sick.

Public or “People’s” Clinics

PHCCs officially work between the hours of 8:30 am to 2 pm. However, between approximately 5 to 8 pm, many PHC facilities are used as public, or ‘people’s’ clinics in urban areas. In rural areas, health insurance clinics also increase access to curative health care services at the primary level. Both types of clinics provide outpatient medical services primarily to treat chronic illnesses and provide services for patients with acute diseases. This meets an important service need, since after 2 p.m. all PHCCs and hospital outpatient facilities are closed, and acute care is provided only in emergency rooms in hospitals. Moreover, the public clinics offer patients with chronic diseases access to services and drugs outside of the expensive pharmacy setting and at a nominal fee which is regulated by the government.

Revenue collected at the people’s clinics is utilized in two ways: part of the collected revenue is submitted to the Ministry of Finance through the MOH Directorate of Public Clinics, and part of it forms the income of the staff of the public or health insurance clinics. In public clinics, staff are either physicians working in public facilities or physicians retired from the public sector. Health insurance clinics, on the other hand, are staffed with newly graduated Junior Physicians performing their obligatory one year of rural service after graduation.

It should be noted that primary health care model centers developed through this program will not be utilized as public clinics. Instead, the MOH is planning to develop and implement a policy to extend working hours for these primary health care centers, particularly model centers with delivery and emergency services.

d. US Government Support to the Health Sector: Iraq Reconstruction and Redevelopment Fund (IRRF)

US Government support to the reconstruction of Iraq is financed through the Fiscal Year 2003 Emergency Wartime Supplemental Appropriations Act, Public Law 108-11, and the FY 2004 Emergency Appropriations Act for Defense and for the Reconstruction of Iraq and Afghanistan, Public Law 108-106, under the Heading Iraq Relief and Reconstruction Fund (IRRF). The Coalition Provisional Authority (CPA) in Baghdad, in consultation with the USG Administration, set priorities in 2003 to guide Supplemental Funding investment.

The CPA's strategic plan has five principal objectives:

- Security, to defeat terrorists and Baathists and provide a secure environment that enables Iraqi citizens to participate fully in political and economic life;
- Essential Services, to provide essential services and infrastructure, especially infrastructure, water and health care, at an acceptable standard accessible by all citizens;
- Economy, to provide financial market structures, as well as fiscal and regulatory conditions, that will enable sustainable economic growth, the development of a dynamic private sector, the creation of jobs, and rising living standards for the Iraqi people;
- Governance, to enable Iraq to have a representative form of government that promotes the rule of law and protects the right of all, including freedom of expression and religious practice, supported by a vibrant civil society. This objective will be underpinned by a democratically agreed constitution, a transparent electoral process, and political institutions that do not tolerate corruption, as well as an accountable and responsive system of local government;
- Strategic Communications, to foster unity of effort among Iraqis, Coalition nations and the international community in achieving the above objectives. Achievement of this goal will mean the Iraqi people participate in a sustained, informed and active manner in the civil affairs of the country.

IRRF funds for health, under which support for this training program is included, are broken down into three categories. The first, nationwide hospital and clinic improvement, includes the construction of approximately 150 primary health care (PHC) facilities and the renovation of 19 maternal and child health (MCH) and other hospitals undertaken through the Project Contracts Office (PCO), an office set up under the Coalition Provisional Authority to manage construction and some non-construction programs. The second, construction of a pediatric hospital in Basrah, is supported through USAID. The third, equipment procurement, modernization and training, is jointly implemented by PCO and USAID and includes procurement of medical equipment for the primary health care centers and selected hospitals (PCO); a partnership in health care program, which supports partnerships between US and Iraq institutions and organizations (PCO); the training program described in this statement of work aimed at conducting training of staff of the

newly constructed primary health care clinics (USAID); construction of a National Academy for Health Sciences to support MOH training and educational programs (PCO); and a targeted capacity development program providing a broad range of human, institutional and systems strengthening support aimed at strengthening Ministry of Health capacity to improve access to, quality of, delivery of and demand for maternal and child health services (USAID).

While IRRF health activities are implemented through mechanisms and contractors managed directly by PCO and USAID, the health sector program receives additional implementation support through the Multi-National Force of Iraq. This group of US and coalition military agency members work together in partnership to provide, as appropriate, a broad range of technical, program and logistical support to the health portfolio. A Health Attache's office, staffed by a representative of the Department of Health and Human Services (DHHS), serves in a Senior Advisory capacity to the US Embassy's Iraq Reconstruction Management Office (IRMO) and in that role, leads coordination efforts within the sector to ensure efficient and effective leveraging of institutional resources.

As part of the U.S. government's overall reconstruction assistance in Iraq, USAID does not maintain a separate Mission strategy but functions within the strategic framework of the IRRF program by implementing programs which support four broad objectives:

1. Restoring Essential Infrastructure, to rebuild and rehabilitate the vital components of Iraq's infrastructure, including power, water, sanitation and transportation networks;
2. Supporting Essential Education, Health and Social Services, to ensure that the basic health care needs of the population are met and to improve access to and quality of education;
3. Expanding Economic Opportunity, to rejuvenate the Iraqi economy, rebuild Iraq's agricultural sector, and revitalize the southern marshlands and assist marshland dwellers;
4. Improving Government Efficiency and Accountability, to enhance local governance in support of stability, effective social service delivery and increased citizen participation, support community development projects in impoverished communities in cooperation with NGOs.

In the health sector, USAID's key objectives during the first year of implementation aimed to support recovery of the health sector through assisting the MOH in the rapid re-establishment of essential health services such as immunization; improving the effectiveness of services through training, clinic refurbishment and the provision of essential equipment; strengthening MOH health sector management and ensuring the availability of potable water through the provision of emergency water supplies and repair of water and sanitation facilities. USAID's longer term goal aims to enable the MOH to improve health status and reduce mortality and morbidity, particularly among women and children. To accomplish this end, USAID longer term program objectives seek to enhance MOH capacity to increase the availability of and access to services, improve the quality of services, and increase demand for services.

e. Model Primary Health Care Centers: A Vision of Excellence

As noted previously, IRRF II funds will support the construction of model primary health care centers to enable the MOH to operationalize its goals of improving access to and quality of primary health care. The MOH vision for implementation of these centers is a comprehensive one which is built on the fundamental principles of primary health care delivery outlined at Alma Aty.

MOH model primary health care centers will provide high quality, patient-oriented primary health care and curative care services for community members of all ages within the center's catchment area, which will range from 25,000 to 40,000. Services will be based on clear service delivery standards, and center staff will be monitored regularly to ensure performance against these standards. Services for each client will be integrated in nature, utilizing intra-center referral systems to ensure, for example, that the child who presents for a routine vaccination is referred for growth monitoring if he or she is underweight. Preventive health activities and health education will be incorporated into each patient encounter. Center providers will be skilled in communicating with clients. Family files will ensure continuity of treatment and facilitate case follow-up. Ongoing training of medical and support staff at the center will increase their skills in diagnosis and management of conditions and strengthen their ability to communicate with and effectively serve community members.

The primary health care center will incorporate community health principles into the daily activities of center staff, including primary and community mental health efforts. Accordingly, center staff will assess and monitor the social, economic, cultural and environmental conditions of the surrounding community and geographic area in order to better understand and respond to local health issues and special concerns of the community. Center staff will routinely interact with the surrounding community and promote community participation in all center activities in order to ensure that services and programs effectively meet the needs of community members.

Finally, center staff will utilize a team-based approach to health care which ensures that community members receive a well coordinated, comprehensive set of services. Additionally, the centers will emphasize cooperation and collaboration with other centers in the district, with the local department of health, and with other organizations involved in providing health care to the community in order to facilitate a coordinated response to addressing community level health problems and to motivate centers to maintain high service delivery standards.

Development of the first phase of the MOH vision for primary health care model centers throughout the country will offer important lessons that will not only facilitate broader replication of approaches utilized in these centers, but will enable the MOH to build sustainable improvements into its national primary health care program.

The complete list of planned staffing for model centers is attached as Attachment A.

Three types of model centers are currently under construction and expected to be completed by August 2005:

1. Model Primary Health Care Centers (110)

These model centers will provide a comprehensive range of primary health care services, including maternal and child primary care services; immunization; diagnostic, curative and outpatient services; dental services; laboratory facilities; radiology; and pharmacy services. The centers will also support school health activities both within the center and through outreach activities conducted at the start of each school year. Finally, the centers will support health education and communication activities to increase health awareness.

With a total of 6 physicians and 18 nurses assigned per center along with a number of allied health and other staff, centers will be structured around three medical 'units' or 'sectors'. Each unit, which will support a population of approximately 10,000 people, will be staffed by one male and one female physician and two medical assistants. Total model center staff will number 57.

2. Model Primary Health Care Centers with Training Facilities (21)

Model centers with training facilities will provide the services offered in the 110 model centers described previously, but will also include a training unit. This facility will support training of students from medical and nursing schools as well as providers from health facilities and staff of medical and health organizations.

The staff of 62 in each model center with training facilities will include an additional specialized physician with training in either community or family medicine, or training and at least three years of experience in internal medicine.

3. Model Primary Health Care Centers with Delivery Services and Emergency Services (19)

Model centers with delivery and emergency services will provide core services as described above but will also include a maternity ward and emergency room.

The staff of 59 at model centers with delivery and emergency services will include an OB/GYN specialist or a female physician to supervise the maternity ward, a female Senior Resident to work in the maternity ward, and three midwives. Emergency room staff will consist of a specialist in either internal medicine or surgery or a general practitioner for supervision of the ER, a Senior Resident to work in the emergency ward, and four medical assistants or nurses.

PURPOSE OF TASK ORDER: Training Model Primary Providers (TMPP)

The purpose of the one-year USAID/Iraq Training Model Primary Providers Program is to support Ministry of Health training of staff for 150 model primary health care centers currently under construction around the country. Successful implementation of this program will increase access to quality provision of primary health care services and interventions effective in reducing infant, child and maternal morbidity and mortality. This will be accomplished through the implementation of a comprehensive provider training program aimed at

upgrading the technical knowledge and clinical skills of providers assigned to model centers through intensive refresher training that gradually moves providers toward utilization of a family practice model for service delivery.

The provider training program undertaken through this Task Order is designed as part of a comprehensive package of US Government support aimed at assisting the Ministry of Health to initiate implementation of a national program of model primary health care centers. Separate USG funds managed by the Project Management Office (PCO) will support the construction and equipping of the 150 model primary health care centers. Activities under this Task Order will leverage this support by improving the skills, knowledge and performance of primary health care center staff working in these model centers through a package of refresher and in-service training.

To support the Ministry of Health in its goal of making quality care more available nationwide, this program will assist, specifically, in: the finalization and enhancement of technical training curricula, including clinical training for service providers; refresher training of experienced MOH master trainers as well as subsequent training of new master trainers; the planning, implementation, management and monitoring of refresher training and targeted in-service training activities; the preparation and delivery of team training for the entire PHCC staff and management training for Center Directors; and the planning for ongoing staff development within these centers. It is expected that training programs will support approximately 1,400 physicians, 1,000 nurses, 2,100 medical assistants; 150 Center Directors. Team training of center staff will benefit an additional 5,027 center staff.

A chart outlining projected numbers of trainees by cadre and type of training is attached as Attachment B.

SCOPE OF WORK

The scope of work will support the training of model primary health care center staff using both central level (Baghdad) training of MOH trainers to implement training curricula, and cascade training at the governorate level implemented by MOH trainers. The contractor shall assist in central level training of trainers while enhancing the capacity of the MOH to plan, implement and monitor cascade training. The contractor shall not be responsible for implementing step down training; however, the contractor shall assist the MOH to prepare for and implement step down training and to institutionalize a system for the continued training and management of primary health care center staff. Accordingly, the contractor shall be expected to provide direct technical support at the central level and to provide technical input which enables and facilitates MOH implementation of a training and management program for model primary health care centers.

Given the unpredictability of security conditions during the next months and throughout the program year, the expectation is that team members will operate out of a Baghdad-based training center and that team members may not be engaged in governorate level training oversight activities. Accordingly, the program must plan for rapid skills building in MOH trainers to enable them to independently carry out

quality training activities. Should security conditions improve during the program year, the contractor should be prepared to provide technical support as needed and requested by the MOH at the governorate level.

To undertake the Scope of Work, the contractor shall provide long and short-term technical advisors and an administrative support team that will manage the delivery of program assistance, ensure home office institutional back-up support, and provide other assistance as required to enable the contractor to carry out this program. The contractor may execute subcontracts and/or sub-grants as needed to meet the requirements of this Task Order, for example, to assist in providing technical assistance and support at the governorate level.

All project implementation and technical assistance within this program will be implemented in partnership with the MOH. Accordingly, the contractor will need to work in close collaboration with Ministry of Health counterparts in the planning, implementation and oversight of this program. The MOH Director General of Public Health and Primary Health Care or his designee will serve as the primary MOH point of contact and will provide ongoing technical input and guidance to program activities.

SPECIFIC TASKS

The contractor shall undertake the following tasks:

Task 1: Finalize Training Curricula

Principal Sub-Tasks:

1.1: Finalize and Enhance Refresher Training Curricula for Physicians and Center Directors. The Ministry of Health has recently completed a two-year process of adaptation of WHO's Integrated Management of Childhood Illness (IMCI) curriculum to the Iraq setting. The MOH has determined that this 11-day curriculum will form the foundation of a 15-day core training program for PHCC physicians. Additionally, a team from the MOH Public Health and Primary Health Care Directorate is currently incorporating an additional four days of refresher training content in adult health, emergency health, women's health and infection prevention/control into this training program using material from other available training programs, including a primary health care training course developed last year with the assistance of Abt Associates, Inc.

The contractor shall provide technical assistance to assist the MOH in rapidly finalizing this training curriculum content and turning it into a set of competency-based training and teaching and support materials for planned initiation of training in April/May 2005. This curriculum will be used by MOH trainers in conducting step down training for approximately 1,400 primary health care physicians and 150 primary health care center directors who will staff the 150 centers around the country. Accordingly, the curricula and associated training support materials must be designed as a standalone trainers' program that MOH trainers can use independently, without expatriate technical support for training implementation.

Training of physicians and center directors will be conducted in English. Therefore, the contractor shall provide training curricula and training support materials in English to support physician and center director training.

1.2: Finalize and Enhance Refresher Training Curricula for Nurses and Medical Assistants: The WHO IMCI training curricula for nurses has also been adapted for nurses as a five day program A team of MOH staff from the Public Health and Primary Health Care Directorate will incorporate one additional day of content into this program to address adult, emergency and women's health and infection prevention. This 6-day curricula will be used by MOH trainers for training approximately 1,000 nurses and 2,100 medical assistants who effectively function in a nursing capacity at the primary level.

The contractor shall assist the MOH in finalizing this curricula and turning it into a set of competency-based training and teaching materials that MOH trainers can use independently in carrying out cascade training. Training, which is planned to start in April/May 2005, shall be conducted in Arabic and in Kurdish. The contractor shall provide training curricula and training support materials in English, Arabic and Kurdish.

Because of varying levels of background training for different cadres of nurses and for medical assistants, the contractor will need to take into consideration the differing rates of learning among the different groups and will need to build this into preparation of training curricula.

1.3: Adapt curriculum for team training to build health center staff as a team and strengthen health center team problem solving skills. The Ministry of Health has previously conducted training of governorate level staff in District Team Problem Solving (DTPS). This curriculum is currently available in Arabic. The MOH has determined that the DTPS curriculum will serve as the foundation for development of a five-day health care team building training program for the entire center staff, including administrators, physicians, nurses, and allied health professionals.

The contractor shall assist the MOH in utilizing the DTPS curricula to develop a five day team building/problem solving training program for model center staff. The contractor shall develop, with MOH input, competency-based training and teaching materials that MOH trainers can use independently in carrying out cascade training. As appropriate, the curriculum will use practical issues to be encountered at a primary health care center for problem solving exercises. For example, the contractor might address the issue of continuous quality assurance. Training will be conducted in English, Arabic and Kurdish. The contractor shall provide curricula and training support materials in English, Arabic and Kurdish.

Tangible Results/Progress Benchmarks

- Refresher training curricula for physicians and center directors completed in English in time to initiate training in April/May 2005

- Refresher training curricula for nurses and medical assistants completed in English, Arabic and Kurdish in time to initiate training in April/May 2005
- Team training curricula developed in English, Arabic and Kurdish in time to initiate training by August 2005
- Gender concepts/principles emphasizing gender sensitivity incorporated into training curricula.

Task 2: Training Implementation

Principal Sub-Tasks:

2.1: Conduct a refresher Training of Trainers (TOT) course for experienced MOH trainers in preparation for cascade training. As noted earlier, the MOH has staff located in each governorate who were previously trained and utilized as trainers by the MOH. To facilitate rapid startup and implementation of this training program, the MOH will assign these trainers to this program for the duration of the one-year training period. Building on the curricula described in Task 1 for physicians/center directors and nurses/medical assistants, the contractor shall conduct a brief refresher TOT course that trains trainers to carry out rollout training for providers assigned to model primary health care centers. The contractor may consider adding the TOT update training course onto the 15 day training program for physicians and center directors and the 6 day training program for nurses and medical assistants. This training shall be conducted at the central level (Baghdad).

2.2: Implement team training to build health center staff as a team and strengthen health center team problem solving skills. All center staff for each model center will be trained as a unit to facilitate a team-based, team-centric approach to managing the center. Using the curriculum developed in Task 1.3, the contractor shall conduct a five-day health care team building training program for the entire center staff, including administrators, physicians, nurses, and allied health professionals. This training shall be conducted at the central level (Baghdad).

2.3: Conduct Training of Trainers for new trainers for future MOH training programs. As part of its longer term plan for human resources development, the MOH would like to utilize this training program to identify additional trainers for future training programs. To facilitate the identification of appropriate candidates for preparation as trainers, the contractor shall collaborate with the MOH in setting criteria for the selection of trainers. Subsequently, throughout the cascade training program, MOH trainers will identify a selected number of additional 'trainers' in each governorate. Toward the end of the program period, the contractor shall provide these individuals with targeted training in training methodology and course facilitation to equip them to develop into a cadre of future trainers for the MOH. It is expected that up to10 trainers may be trained in each of the 18 governorates; however, the final number of trainers to be trained will be determined in consultation with the MOH. Training of Trainers will be conducted at the central level (Bagdhad).

Tangible Results/Progress Benchmarks

- TOT update training completed and methodological, communications and management skills of MOH trainers enhanced
- Core staff of model primary health care centers more skilled in working as part of a team and team problem solving techniques
- Criteria for future MOH trainers established in collaboration with MOH
- Future trainers identified by MOH trainers
- Future trainers trained in training methodology and course facilitation

Task 3: Ensure Training Implementation, Monitoring and Evaluation (TIME)

Principal Sub-Tasks

3.1: Design a plan and timeline for cascade training to be conducted by the MOH
The contractor shall assist the MOH in developing a plan and schedule for rollout training for providers for its model primary health care centers. The MOH has indicated it will use 'hub' training centers located in seven sites to complete this training. The contractor will work with the MOH to facilitate the planned completion of cascade refresher training for providers assigned to all 150 model centers by December 2005. As noted previously, the MOH will independently manage the cascade training process and the contractor shall not be directly responsible for the completion of cascade training. However, to ensure the quality of cascade training, the contractor shall assist the MOH in monitoring cascade training. This may be accomplished through the utilization of subcontracts or sub-grants as described in Section 3.2.

3.2: Develop a monitoring and evaluation system for the MOH cascade training program. The contractor shall assist the MOH to develop and utilize a system for monitoring the quality and outputs of its cascade provider training programs and for evaluating training program impact and outcomes over time. The contractor shall also assist the MOH to develop a process for the ongoing monitoring, reinforcement of and support to trainers implementing the training program. To this end, the contractor may propose the utilization of sub-contracts or sub-grants to local organizations to assist the MOH in monitoring cascade training and to provide technical support as needed and requested by the MOH at the governorate level.

Tangible Results/Progress Benchmarks
- Cascade training plan and timeline developed and implemented by MOH within 60 days of arrival in country.
- Monitoring and evaluation system for cascade training program developed and utilized to promote quality cascade training.

Task 4: Develop in-Service Training Program to Improve Center Effectiveness

Primary Sub-Tasks:

4.1: Develop in-service training modules. The contractor shall work with the MOH in assessing key in-service training needs for primary health care center providers and center staff. The contractor shall

develop a series of in-service training modules with accompanying training guides that MOH trainers can use to conduct in-service training for primary health care center providers. This will include primary and community mental health care. Other illustrative areas for in-service training might include such topics as: family practice approach to primary health care delivery; primary health care best practices; quality assurance; infection prevention; and rational drug use. The contractor shall assist the MOH to develop a package of courses that can be offered by MOH trainers to primary health care center providers to lead to the award of a "Certificate of Excellence".

Tangible Results/Progress Benchmarks

- In-service program designed in collaboration with MOH by October 2005 to lead to certificate of excellence
- In-service training program modules completed and transferred to the MOH by December 2005.

Task 5: Maintain training output and outcomes.

5.1: Develop training centers of excellence. Of the 150 primary health care centers being constructed, 21 will be model primary health care training centers, with one in each governorate and four in Baghdad. The contractor shall work with MOH staff in designing a system for developing and maintaining the 21 model primary health care training centers as 'training centers of excellence' which offer modern, efficient and effective primary health care delivery and training, utilizing the family practice model. The contractor will assist the MOH to strengthen staff skills at these centers and develop the capacity of center staff as trainers. To accomplish this end, the contractor may propose the utilization of sub-contracts or sub-grants to local organizations to provide technical support to training center development.

5.2: Design management training program for center directors. The contractor shall coordinate with the MOH in developing model center management and administration guidelines and ensuring center directors sufficient authorities to implement these guidelines. Using these guidelines, the contractor shall develop a program for regularly training and mentoring primary health care center directors in administration and management throughout the Task Order period. The contractor shall give special emphasis to training managers to incorporate basic principles of applied epidemiology and available health information into management decision-making to ensure that programs are responsive to community needs.

This program will consist of initial training followed by regular meetings which bring center directors together to introduce them to new techniques and to enable these directors to share lessons learned. The contractor will propose innovative approaches to offering center directors opportunities for continued development of management and administrative skills. The contractor might consider, for example, a chat room system managers can use for online joint discussion purposes.

The contractor shall be responsible for implementing this training program for directors of all 150 centers. Initial training will be carried out at the central level (Baghdad). The contractor may propose sub-contracts or sub-grants to assist in completion of continuing

training interventions to support, for example, center-based follow up activities or on-the-job mentoring.

5.3: Develop a medium term training strategy and plan. The contractor shall assist the MOH to develop a 3 year, medium-term training plan for primary health care model centers. The plan will include/outline an approach to identifying ongoing training needs through the conduct of training needs assessments, to developing new training programs, to regularly monitor and evaluate training program outputs and outcomes or impact. The contractor shall assist the central MOH and, if feasible, model PHC training centers to conduct and institutionalize ongoing training impact assessments to enable the MOH to measure the impact of training on provider performance over time and to use in updating training programs. The medium term training strategy and plan should demonstrate development of processes to ensure an integrated approach to primary health care training as opposed to the current vertical training programs managed by different sections within the primary health care directorate.

Tangible Results/Progress Benchmarks

- By October 2005, system developed and initiated for utilizing model training centers as training centers of excellence
- Model center directors skilled in center management and administration
- Medium term training strategy and plan developed by October 2005 which outlines approach to utilizing training to maintain primary health care program quality.

END OF PROGRAM TANGIBLE RESULTS/PROGRESS BENCHMARKS:

- Technical and communications skills and competencies of core provider staff of model primary health care centers developed
- Management, administrative and communications skills and competencies of center directors for model centers developed
- Primary health care provision incorporates family medicine principles and approaches
- Training methodological and communications skills and capacity of training staff improved
- Essential PHC curricula developed

PROJECT START UP

This activity is a fast track, priority activity for the US Government, and primary health care model center staff training must be completed by the time the 150 centers under construction come on line as currently planned between August and December 2005. Accordingly, the contractor shall begin deployment to Iraq within 15 days of Task Order award to ensure that administrative and logistics systems are in place and functioning to facilitate the timely completion of planned activities in training MOH trainers and facilitating MOH implementation of cascade training activities. The contractor will be expected to deploy all long-term staff to Iraq within thirty days of Task Order award

The contractor's proposal must include a mobilization plan which illustrates its approach to completing full mobilization of its long

term team and final development of an implementation plan during the first 45 days following contract award.

PERIOD OF PERFORMANCE

The period of performance of this Task Order is approximately 12 months.

STAFFING AND KEY PERSONNEL

Program staff and the key consultant team must be fluent in written and spoken English. Additionally, the team must include bilingual fluency in English and written and spoken Arabic, as curricula will need to be developed and delivered in both languages across the program. The contractor team should also include fluency in written and spoken Kurdish.

The contractor shall propose a team that clearly demonstrates the contractor's capability to effectively carry out this statement of work. The following staff categories are illustrative. If the contractor proposes to utilize these categories of staff, the contractor shall describe in the proposal the proposed role of each advisor in the program. The contractor shall also provide a CV for each proposed candidate which clearly outlines his or her experience and background. Alternatively, the contractor can propose and describe alternate staffing numbers and configurations. In this case, the contractor shall title and describe the role of each proposed advisor and provide a CV which clearly outlines the candidate's experience and background appropriate to the proposed position.

Curriculum Development Advisor
TOT/Training Methodology Advisor
Training Program Planning and Management Advisor
Family Medicine Advisor
Medical Training Advisor
Nurse Training Advisor
Health Education/Communication Advisor
Management Training Advisor
In-Service Training Advisor
Training Monitoring and Evaluation Advisor
Training Quality Assurance Advisor
HIS Advisor

Short-Term Technical Assistance: The contractor shall propose categories for professional short-term TA as necessary for successful performance under the contract. The contractor shall describe the role of each proposed short-term advisor and provide a CV which clearly outlines the candidate's experience and background appropriate to the proposed consultancy. The contractor will be expected to maximize use of Iraqi or other Arabic and Kurdish-fluent consultants and/or subcontractors to the full extent possible.

Along with CVs as noted above, the offeror shall also provide biodata sheets for all proposed personnel, including third country nationals (TCNs) and cooperating country nationals (CCNs). Biodata sheets for proposed short term consultants shall also be included with the proposal to eliminate the need for later Contracting Officer approval.

MONITORING AND EVALUATION

Expected program results with illustrative indicators/benchmarks are provided in this document. In submitting its draft implementation plan, the contractor should also include a preliminary monitoring and evaluation/performance monitoring plan for use in assessing program inputs, processes, outputs and outcomes. In developing this preliminary performance monitoring plan, the contractor can propose alternate or additional indicators/benchmarks to those listed in this document. During the initial program planning period within the first 45 days after award of this Task Order, the contractor shall work closely with the MOH and USAID to agree on final indicators and benchmarks and develop a performance monitoring plan which monitors progress towards results outlined in its implementation plan.

USAID/Iraq assumes the responsibility for overall management of Task Order activities. However, to ensure that this program is effectively coordinated with other US Government programs in the health sector to promote, as appropriate, collaboration among partners in the health sector, a Joint Training Program Steering Committee consisting of the MOH, USAID, IRMO, PCO and MNFI staff will be established. This committee will meet regularly to review progress against this Task Order. While the contractor will be directly managed by USAID and will be expected to report directly to USAID under this Task Order, the CTO may, from time to time, request the contractor to meet with the Training Program Committee for program monitoring purposes.

REPORTING REQUIREMENTS

Contractor reports shall consist of the following:

a. **Final Implementation Plan**: Within 45 days of the award of this Task Order, the Contractor will submit to the USAID Cognizant Technical Officer (CTO) a final Task Order workplan. The workplan should include, at a minimum:
    i. Activities and benchmarks required to achieve Task Order Tangible Results
    ii. Timeline with target completion dates
    iii. Personnel required for completing activities and benchmarks
    iv. Activities in which coordination is required and with whom

b. **Monthly performance reports**: The contractor shall prepare and submit to the CTO a brief monthly report within 5 days following the end of each month of implementation. Length of the monthly report will be decided in collaboration with the CTO and MOH but should contain at a minimum:
    i. Period progress against activities and benchmarks in the implementation plan.
    ii. Numbers of individuals trained, broken down by course, provider or other staff cadre, gender and location.
    iii. Numbers employed directly or indirectly by the program (through subcontracts or sub-grants)

iv. Constraints or problems identified; resolution or proposed resolution
v. Compelling success stories or best practices (if appropriate)
vi. Upcoming activities and dates

c. **Special reports:** Periodically, the contractor will be required to prepare and submit to USAID special reports concerning specific activities and topics. The contractor, for example, will be required to submit weekly updates on selected indicators/metrics as well as numbers of staff employed directly and indirectly through the program. The contractor will also regularly submit short updates on successful activities that can be highlighted in USAID's Daily Report, in IRMO/Department of State Weekly Updates, and in other regular reporting tasks.

d. **Completion report:** At the end of the Task Order period, the contractor shall prepare a final report which highlights accomplishments against the implementation plan, describes final status of progress against benchmarks and tangible results, addresses lessons learned during implementation, and suggests ways to resolve constraints identified. The report may provide recommendations for follow-on work to complement work completed under the Task Order.

e. **Monthly and quarterly financial status reports:** The contractor shall prepare and submit to the Mission within five days of the end of each month a financial status report which outlines total funds spent during the month, cumulative funds expended to date by the contractor, pipeline, and funds remaining. Every third month, the contractor shall include a quarterly financial status report outlining total funds expended to date including accrued expenditures against budget elements, pipeline, and funds remaining.

One electronic and eight hard copies of each report completed (excepting financial status reports and special reports) will be provided in English to the USAID CTO. The CTO will be responsible for dissemination of these reports as appropriate to the MOH Designated Counterpart and other members of the Training Program Management Committee. The requirement for Arabic and/or Kurdish versions of these reports may be required by USAID/Iraq during the course of implementation in order to facilitate broader review by MOH counterparts outside of Baghdad.

Documents produced under this Task Order must be provided to USAID's Center for Development and Information Exchange (CDIE) at the address below. The contractor shall ensure submission of one electronic copy and one hard copy of such development experience documentation to PPC/CDIE/DI in accordance with AIDAR 752.7005.

Development Experience Clearinghouse
1611 North Kent Street, Suite 200
Arlington, Virginia 22209-2111
Telephone Number: (703) 351-4006, ext. 100
Fax Number: (703) 351-4039
E-Mail: docsubmit@dec.cdie.org; http://www.dec.org