

I. TITLE: Tuberculosis (TB) Task Order

II. Introduction

Tuberculosis (TB) threatens the lives and health of adults during their most economically productive years. A disease of poverty, TB is a major killer of women of reproductive age and it is the leading cause of death in HIV-positive people. Strengthening the capacity of countries to detect and cure TB reduces TB deaths and contributes to improving the economic productivity and social well-being of entire societies.

The goal of the USG’s TB program is to reduce, by 50%, the number of deaths due to TB in each of the 19 USG focus countries. By 2011, the USG objective is to detect at least 70% of estimated TB cases and the successful treatment of at least 85% of those detected cases in each of the 19 focus countries. USAID is the lead USG agency responsible for achievement of these objectives in these focus countries. This will be accomplished by using USG TB funds to introduce and expand priority interventions in accordance with the WHO STOP TB Strategy.

TB Focus Countries:

Africa	Asia Near East	Latin America and the Caribbean	Easter Europe and Eurasia
DR Congo Ethiopia Kenya Mozambique Nigeria South Africa Tanzania Zambia Uganda	Afghanistan Bangladesh Cambodia India Indonesia Pakistan Philippines	Brazil	Russia Ukraine

Achievement of these targets will contribute to the achievement of the epidemiological targets as set forth in the STOP TB Partnership’s “Global Plan to STOP TB 2006 – 2015” which are: to sustain or exceed the 70/85 targets; by 2015, to reduce the burden of TB disease (prevalence and deaths) by 50% relative to 1990 levels; and to eliminate TB as a global public health problem by 2050.

USAID’s TB program is part of the US government (USG) foreign assistance program and contributes to the USG goal of “Helping to build and sustain democratic, well-governed states that will respond to the needs of their people and conduct themselves responsibly in the international system.” Tuberculosis activities fall under the objective three - Investing in People, program area 1 (health), tuberculosis element 1.2. For more information about the USG foreign assistance framework see: <http://f.state.gov/>

The TB Task Order (TB TO) will contribute to USAID's efforts to achieve the USG's goal to reduce, by 50%, the number of deaths due to TB, as well as to the USG objective to detect at least 70% of estimated TB cases and to successfully treat at least 85% of those detected cases in each of the 19 focus countries. By providing short and long term technical assistance for implementation of the STOP TB Strategy and by contributing to the success of Global Fund grants, case detection and treatment success rates will improve in countries assisted through the TB TO.

The TB TO will be managed by the USAID Bureau for Global Health, Office of Health Infectious Diseases and Nutrition (GH/HIDN). Funding for the TB TO will be provided by GH/HIDN core funds for requested task areas of core work; funding from missions and regional bureaus is anticipated but not guaranteed, and may include TB funding and/or HIV/AIDS funding (the latter funding would be for TB/HIV-AIDS related activities).

Offerors are encouraged to identify new partners to work with them to implement the scope of work (SOW) described in this Request for Task Order Proposals (RFTOP).

III. Background

TB kills approximately two million people per year. Of the estimated two billion people infected with TB, eight million develop the disease annually. TB is a major killer among women of reproductive age and is the leading cause of death in HIV-positive people, accounting for one third of AIDS deaths worldwide. Just 22 high burden countries (HBCs) account for 80% of the global TB burden, with half of these countries located in Asia. In Africa, 19 countries have an estimated TB case notification rate greater than 100/100,000, as compared to an estimated case notification rate of 6/100,000 in the United States.

The global resurgence of TB has been fueled by increasing HIV/AIDS prevalence, inadequate investments in public health systems, and emerging TB drug resistance and extensive drug resistance. The disease threatens the poorest and most marginalized groups, disrupts the social fabric of society, and slows or undermines gains in economic development. Ninety-five percent of all TB cases and 98% of all TB deaths occur in developing countries.

Much progress has been made since The Stop TB Partnership (of which USAID is a member) was launched in 1998. The Amsterdam Ministerial Conference on Tuberculosis and Sustainable Development held in March 2000 established global targets of 70% TB case detection and 85% treatment success rates in sputum smear positive pulmonary TB cases¹ to be achieved by the year 2005 in the 22 HBCs, and served to catalyze governments and donors to address TB by implementing the first Global Plan to STOP TB. In January 2006, the STOP TB Partnership launched the Global Plan to STOP TB 2006 – 2015 (GP2). The GP2 describes the actions, benchmarks, targets, resources required to achieve the STOP TB Partnership goals and Millennium Development Goals

¹ Sputum smear positive TB cases are the most infectious and therefore the most responsible for transmission of the disease.

for TB. The Stop TB partners and countries have also endorsed STOP TB Strategy which was launched by the World Health Organization (WHO) on World TB Day 2006. Based on Directly Observed Treatment, Short-Course² (DOTS) strategy, the STOP TB Strategy is a package of interventions to enhance and strengthen DOTS and to achieve the targets set forth in GP2. See <http://www.stoptb.org/> for more information about the Global Plan and the STOP TB Strategy.

These efforts have produced results. The number of countries implementing DOTS increased from 112 in 1998 to 183 in 2004 and one high burden country (Peru) reduced TB incidence sufficiently to graduate from the list of 22 HBCs. Substantial additional resources have been mobilized for TB from both national governments as well as donors, in particular, from the Global Fund to Fight AIDS, TB and Malaria (GFATM). Countries are now preparing new medium terms plans for TB control that are consistent with the new STOP TB Strategy and the GP2. The Partnership has grown to include over 400 donors, non-governmental organizations (NGOs) and other institutions, which demonstrates the strong global commitment to combat TB and to collaboration in that effort. Globally, WHO estimates that at the end of 2005, approximately 59% of the estimated sputum smear positive TB cases were detected, and of these 84% were treated successfully.

However despite this progress, much more remains to be done. Implementation of the STOP TB Strategy must be accelerated to help ensure that all countries reach the 70/85 targets more quickly followed by the STOP TB targets and the Millenium development goals. Reported global DOTS coverage of 84% (2004) masks the reality that many people, even in areas where DOTS is reportedly available, lack true access to DOTS. While overall treatment success in DOTS areas is 84% (2004 cohort), treatment success rates are lagging in sub-Saharan Africa due to HIV/AIDS, and in the Eastern European region due to multi-drug resistant (MDR) TB. Continued acceleration of TB case detection is paramount to achieving the targets. Interventions such as DOTS Plus, Public Private Mix (PPM), Advocacy, Communications and Social Mobilization (ACSM), community TB care, TB/HIV collaborative activities, and approaches to reach hard to reach populations need to be introduced or expanded, and the sustainability of programs must be increased.

In September 2006, the WHO issued a global alert about the emergence of new strains of extensively drug resistant³ (XDR) TB. This new challenge threatens the gains that have been achieved in TB control in recent years. A survey conducted by WHO and the US Centers for Disease Control and Prevention (CDC) of isolates collected by supranational reference labs examined 18,000 samples from 48 countries and documented the presence of XDR-TB in all regions of the world. The results revealed that 20% of the isolates

² The DOTS Strategy has five components: political commitment; passive case detection among patients seeking care at health facilities and diagnosis using sputum smear microscopy; standardized short-course treatment with direct observation of therapy at least in the initial phase; assurance of an uninterrupted supply of high-quality drugs; and standardized recording/reporting with systematic evaluation of treatment outcomes.

³ XDR-TB is defined as multi-drug resistant TB (MDR TB) that is resistant to at least two of the most potent first line anti-TB drugs, isoniazid and rifampicin, plus resistance to any fluoroquinolone, and one of the second-line injectable drugs (amikacin, kanamycin or capreomycin).

where MDR, and 10% of the MDR isolates were XDR with high rates in some countries of the former Soviet Union and parts of Asia. This probably represents the “tip of the iceberg” since the presence or extent of XDR TB is unknown in many countries. In South Africa, extremely high mortality rates have been reported among persons co-infected with HIV/AIDs and XDR TB. This emerging problem points to the urgent need to improve the quality of DOTS, introduce and expand DOTS Plus for MDR TB under proper case management conditions, improve laboratory networks, including diagnosis and drug sensitivity testing, improve infection control in congregate settings and to accelerate the development and introduction of new tools.

IV. Objective and Scope of Work

The objective of the TB Task Order (TB TO) is to support the implementation of the TB element in USG focus countries through supporting implementation of the STOP TB Strategy. Activities implemented by the TB TO must contribute to the USG goal and objective described in section II, and support the achievement of the STOP TB Partnership goal and national TB control plans in the nineteen USG focus countries. Actual level of effort to be undertaken for country and regional funded TB activities depends on the provision of funds by USAID missions and regional bureaus.

Funds under this task order will be used for the following:

- Provide short- and long- term technical assistance (TA) to help support the implementation of USAID funded TB programs and activities in the 19 focus countries.
- Provide short term TA to help prepare proposals to the GFATM and to address implementation bottlenecks in TB grants funded by the GFATM.
- Provide TA to assist in the development and implementation of ACSM components of national TB programs.
- Provide TA to develop and implement interventions to address MDR and XDR TB, including case management, infection control, strengthening of laboratory services, ACSM, operations research and introduction of new technologies.
- Conduct special studies and periodic analyses and assessments at the direction of USAID global or regional bureaus, and/or missions

V. Scope of work

Task 1: Develop, implement, and monitor USAID funded TB activities in focus countries. (The countries where the contractor will work will be determined by the provision of funds from USAID country level missions or regional bureaus)

The principal objective of this task area is the implementation of USAID mission or regional bureau funded TB activities that are consistent with the recommended interventions of the STOP TB strategy and contribute to USG TB goals and objectives.

While USAID anticipates that the majority of the work will consist of activities related to components 1 – 5 of the STOP TB strategy, the contractor may be requested to undertake activities related to component 6 (operations research). **The actual Level of Effort and location of this work will depend solely upon the provision and source** of funds from various USAID missions and/or regional bureaus. USAID *anticipates that the majority of the work under this task area will take place in focus countries in the Asia Near East or Africa regions.* Under this task area, the contractor will:

- Working with USAID and local counterparts, identify the population and/or geographic area to be targeted. In selecting target populations or geographic areas, consideration will be given to magnitude or severity of the TB epidemic, TB/HIV co-infection or MDR TB, as well as other factors such as lack of adequate funding from other sources.
- Specify how assistance to the specific target population or geographic areas will contribute to achievement of the 70/85 targets at the national level.
- Identify outcomes attributable to USG for USAID funded program areas. These will include coverage of key interventions with overall five year targets, and relevant benchmarks.
- Develop and implement work plans for USAID funded assistance including objectives, activities and timelines/benchmarks. Activities and interventions must be consistent with international recommendations and policies, including the STOP TB Strategy.
- Develop and implement plans for monitoring and evaluation (M and E) of implementation and results, including progress toward five-year targets. Apply internationally recommended instruments and tools for M and E.
- Collaborate with local and regional partners, international organizations, and other funding mechanisms such as the other bilateral and multilateral donors, including the GFATM and the Global TB Drug Facility (GDF).
- Recruit and contract local personnel to carry out in-country activities.
- Develop and maintain a roster of consultants with diverse expertise in areas described in this task. The roster should include international, regional or local consultants.
- Identify technical assistance needs, and identify and/or recruit advisors and/or consultants to address short and long term technical assistance needs.
- Procure equipment, supplies and other commodities to support program implementation. Illustratively this may include vehicles, laboratory equipment and supplies, computers, and drugs.
- Undertake human resource capacity building activities such as pre-service and in-service training, development of training materials, training follow up and supervision.
- Put in place management processes that will ensure effective implementation and cost containment. Illustratively, this would include:
 1. How the Offeror will use existing in-country resources for rapid start up, to maximize cost savings, and leveraging of other in-country and international partners.
 2. How the Offeror will use existing in-country offices.
 3. The role of subcontractors if appropriate.

4. Lines of communication and how the Project Director will liaise with the USAID CTO, USAID Missions, in-country staff, and headquarters staff.
5. Reporting processes and approaches to resolve problems or conflicts.

Estimated Level of Effort (Days):

	Local Hire	Consultants
Country A	11,760	80
Country B	11,760	80
Country C	14,700	80
Country D	14,700	80
Country E	11,760	80
TOTAL	52,920	400

Task 2: Provide TA to address GFATM grant implementation bottlenecks and to help prepare TB grant proposals.

The principal objectives of this task area are to help countries access GFATM funds through successful grant applications, and to contribute to the successful implementation of GFATM TB grants. TA will generally be catalytic or bottleneck breaking in nature in that it will address key challenges and grant implementation issues that threaten the success of TB grants. While USAID TB core funds will be focused on the provision of TA to USAID TB focus countries, the contractor should be able to respond to any country which has a GFATM TB grant and to countries where a local USAID mission or regional bureau chooses to provide funding for such TA. Under this task area, the contractor will:

- Develop and maintain a roster of consultants with diverse expertise in areas described in this task area. The roster should include international, regional or local consultants.
- Assist with finalization of SOWs for GFATM TA.
- Provide short term technical assistance: to prepare TB grant proposals in partnership with National TB programs and Country Coordinating Mechanisms (CCMs); prepare work plans, monitoring and evaluation plans, procurement plans, and human resource plans for TB proposals that have been approved by the GFATM (this is pre grant signing TA); training of CCMs; development of appropriate policies, guidelines, standards, and service protocols that will improve or support grant implementation; conduct technical, administrative, and management training leading to improved implementation capacity; and technical assistance to strengthen critical systems, such as surveillance, and monitoring and evaluation.
- Provide specific TB technical assistance in areas such as PPM, labs, MDR TB, and ACSM, to enhance the implementation of these components of GFATM grants.

Estimated Level of Effort:

4 Countries x 1 TA visit x 1 consultant x 15 days/visit = 60 days

Task 3: Provide TA to accelerate the introduction of ACSM activities in USAID focus countries.

The principal objective of this task area is to help accelerate the introduction and expansion of ACSM activities by enhancing country-level capacity in the area of ACSM. The actual routine implementation of country-level ACSM activities would be supported under task area one above or from other sources such as GFATM grants. GH/HIDN anticipates the provision of core funds for this task area. Funding from missions and /or regional offices may also be provided. Under this task area, the contractor will:

- Develop and maintain a roster of consultants with diverse expertise in areas described in this task area. The roster should include international, regional or local consultants.
- Participate in the STOP TB Partnership ACSM country-level sub-working group, and contribute to the development of ACSM tools undertaken by this working group.
- Provide short term TA to assist countries to prepare ACSM plans and ACSM components of Global Fund TB grant proposals.
- Provide short term TA to help strengthen the implementation of ACSM components of national TB program plans/and or GFATM TB grants. Illustratively, this TA would include: design of formative behavioral, demographic or market research study protocols; data analysis and interpretation for message formation and targeting; planning for sequencing and roll out of ACSM activities, including planning for ACSM implementation at the sub-national level; development of ACSM data collection instruments for monitoring and evaluation.

Estimated Level of Effort:

4 Countries x 1 TA visit x 1 consultant x 15 days/visit = 60 days

Task 4: Provide TA to assist countries to respond to MDR and XDR TB.

Countries often lack the required technical expertise to plan, develop and implement programs to manage and control MDR and XDR TB. The objective of this task area is to provide TA to improve country level capacity to respond to MDR and XDR TB in accordance with WHO recommendations for the management of MDR TB and XDR TB. Core and/or regional bureau funded TA will be undertaken to enhance country level capacity in MDR/XDR TB. *However, full scale implementation or scale up of DOTS Plus and programs to contain XDR TB would be supported by USAID country level funding or by other sources such as the GFATM.* Under this task area, the contractor will:

- Develop and maintain a roster of consultants with technical expertise described in this task area. The roster should include international, regional or local consultants.
- Provide TA in the following areas: management of MDR and XDR TB and TB suspects (in high and low HIV prevalence settings); programmatic management of XDR-TB and design of treatment regimens in HIV negative and positive patients; strengthening of laboratory services, including culture, drug sensitivity testing and the deployment of rapid diagnostic tests; infection control in health care and other congregate settings such as prisons (to reduce transmissions of drug resistant TB, especially among HIV+ individuals and health workers); TB drug resistance surveillance; operations research; development of ACSM strategies to promote prevention, treatment and control of MDR and XDR TB; monitoring and evaluation of these programs/activities.
- Develop human resource capacity to respond to MDR and XDR TB, including development and/or adaptation of training material and training courses.
- Procure equipment, supplies and other commodities to support program implementation. Illustratively this may include laboratory equipment and supplies, computers, drugs, and infection control supplies.

Estimated Level of Effort:

6 Countries x 1 TA visit x 1 consultant x 15 days/visit = 90 days

Task 5: Design, implement and participate in special studies, analyses, and evaluations.

The principal objective of this task area is to respond to specific requests for studies, analyses, reviews or evaluations from GH/HIDN, missions or regional bureaus. Under this task area, the contractor will:

- Develop and maintain a roster of consultants with diverse expertise and language skills.
- Conduct evaluations or assessments of USAID funded TB activities. The contractor will not be asked to undertake work potentially related to future USAID-funded procurements.
- Conduct analyses and assist with updates of technical reference materials, and/or web sites.
- Participate in coordinated national TB program reviews with in-country and external technical partners.

Estimated Level of Effort:

1 consultant x 30 days = 30 days

VI - PRODUCTS / DELIVERABLES

- A database of consultants with expertise in the task areas described above, including language(s) and country experience.
- Submission of work plans for obligated funds within 45 days of initial award; for subsequent fiscal years or funding obligations, work plans are to be submitted by September first of each year, or within 30 days of receipt of MAARDs. Work plans must include activities, benchmarks, indicators, targets, timelines and budgets.
- Submission of a monitoring and evaluation plan within 90 days of the initial award.
- Submissions of an mid year report by March 30 and an annual report by October 30 of each year.
- Submission of data for USAID portfolio reviews annually including results, challenges/issues and pipeline information at a date to be determined by USAID (usually during the first two months of each fiscal year).
- Submission of consultant reports within 30 days after the completion of each TA visit.
- Final documents or reports for all special studies or analysis. Deadlines for submission to be determined in the workplan for these activities.

VII. TRAVEL:

International and in-country travel will be allowed under this Task Order.

VIII. Geographic Code:

The authorized geographic code for procurement of goods and services under this order is 935.

IX. REPORTING REQUIREMENTS:

The following contract reports will be delivered:

- Mid year, annual and final reports (see deliverables above)
- Trip reports for core-funded short term TA (see deliverables above)
- Baseline and results reports for annual USAID portfolio reviews (see deliverables above)
- Quarterly reports are to be submitted if so requested by the operating unit that obligates the funds.

X. PERIOD OF PERFORMANCE:

From award date to September 30, 2011

XI. TECHNICAL DIRECTION AND RELATIONSHIPS

The CTO authority for this Task Order shall be specified by the USAID Contracting Officer in the CTO designation letter, a copy of which will be provided to the contractor. This activity will be managed by the USAID GH/HIDN. USAID may conduct a mid term or final evaluation or management review of this Task Order if necessary.

XII. METHOD OF AWARD AND INSTRUCTIONS FOR PROPOSAL PREPARATION

USAID may, without discussion or negotiations, award a task order resulting from this RFTOP to the responsible contractor whose proposal conforms to the SOW and offers the best value. Therefore, the initial proposal should contain the contractor's best terms from a cost and technical standpoint. USAID may reject any or all proposals, accept other than the lowest cost proposal, and waive informalities and minor irregularities in proposals received. The technical proposal evaluation criteria provided below are in descending order of importance.

Although technical evaluation factors are significantly more important than cost factors, the closer the technical evaluations of the various proposals are to one another, the more important cost considerations become. The Contracting Officer may determine what highly ranked proposal based on the technical evaluation factors would mean in terms of performance and what it would cost to the Government to take advantage of it in determining the best overall value to the Government.

The proposals should include the following information:

A. Technical Proposal

The technical proposal should be no longer than 30-pages (maximum including all executive summary, tables and figures) with text in 12 Times New Roman point font, on 8 1/2" by 11" paper with one inch margins. The Annexes (CVs, matrices, etc.) are not counted against the 30-page maximum.

1. Technical Approach

a. Written component (recommended length 20 pages): Describe the approach to achieving the objectives of the SOW and to implementing the tasks (1 – 5) outlined in sections IV and V, including the engagement of partner organizations as appropriate to provide the needed technical expertise. The approach for monitoring and evaluating execution of the tasks should be described. For tasks 1 – 4, Offerors should describe their approach by choosing at least two countries from the following country list and develop country case studies as part of the technical approach (included in the 20 pages). One country must be from the Asia Near East region, and one country must be from the Africa region. No more than one country case study is required for each task area, however at least two countries total must be used from the following list.

Africa: Tanzania, Kenya, Ethiopia, DR Congo, Mozambique, South Africa, Zambia, Nigeria, Uganda

Asia/Near East: Cambodia, Pakistan, India, Indonesia, Philippines, Bangladesh, Afghanistan

Latin America: Brazil

Eastern Europe/Eurasia: Russia, Ukraine

b. **Oral Presentation:** The oral presentation will be evaluated as part of the technical proposal and will occur within 30 days after the RF TOP closing date. The oral presentation must be led by the Offeror's proposed Project Director and may involve other key staff proposed. Within 15 days after the submission of the written proposal, Offerors will be provided specific instructions and a date for the oral presentation. The presentation will be no longer than 2 hours total, including presentation and questions for follow up (if any). The presentation will be given to the Technical Evaluation Panel. At the time of the oral presentation Offerors will be required to submit a printed copy of their presentation in power point format.

2. Personnel (Written, recommended length 3 pages)

A Project Director should be identified and designated as key personnel. Offerors may propose other key personnel if they choose. For each "key" personnel proposed including the project director, the offeror should provide a proposed short job description.

Project Director

The Project Director will provide technical leadership and managerial oversight for the task order, and ensure timely implementation and reporting of activities. The Project Director will liaise with other organizations in order to ensure coordination of this task order with activities being undertaken by other partners. The CV of the proposed project director and any other proposed key personnel should be included as an Annex. At a minimum, the Project Director shall have:

- A masters' degree in health sciences or a related advanced degree;
- Extensive experience in the field of TB control, including at least 3 years of experience working with TB programs in developing countries;
- At least 5 years of experience working with public health programs in developing and transitioning countries;
- Demonstrated skills and experience managing a program of similar magnitude and complexity;
- Excellent communication skills, demonstrated leadership, and the ability to work collaboratively across technical disciplines.

Other Personnel

The Offeror should propose other long and short-term staff and consultants as appropriate to carry out the SOW and based on the offerors proposed approach. The offeror should propose a combination of local, regional and/or international staff and consultants. The Offeror should provide a matrix (included in an annex) of proposed staff and consultants. The matrix should provide the following information: Name, Functional Labor Category, Task Area of expertise, estimated Level of Effort, education, language skills, and developing country experience.

3. Management (Written, recommended length 3 pages)

The Applicant should propose a management structure to address the breadth, depth, and technical areas required to successfully undertake this Task Order. The Offeror should describe how the tasks will be organized and managed to minimize non-productive costs to the government such as multiple overheads and how the contractor will utilize the complementary capabilities of any proposed sub-contractors most effectively and efficiently. Applicants should describe how lines of authority will be managed within their own organization and between the Offeror and any sub-contractors. The management plan should demonstrate the Offeror's understanding of efficient management practices, including approaches to cost containment, avoidance of duplication of effort, and use of technology. The plan should also demonstrate how the Offeror will use existing in-country resources and describe opportunities for leveraging other resources of in-country and international partners. This plan should describe lines of communication and reporting, and how the Project Director will liaise with the USAID CTO, USAID Missions, in-country staff. Offerors are encouraged to include an organizational chart in an Annex to the technical proposal.

4. Organizational Capacity and Past Performance (Written - recommended length 2 pages)

The Offeror should describe its organizational capacity to implement the SOW described in this RFTOP. In addition, the Offeror should describe past performance of the offeror, relevant to the task areas and work requested in the SOW. If sub contractors are proposed, past performance information should also be provided for these sub contractors (past performance references should be provided in an annex).

B. Cost Proposal

A budget with narrative providing detailed justification of costs anticipated under this proposed task order in the following format:

- a. Summary Cost Breakdown - Please provide a breakdown, by cost category and task area, of the anticipated costs of performing the work.
- b. Detailed level of effort and labor cost estimates must be submitted in accordance with the SOW. Please provide a separate line item for each proposed individual and identify each by name, labor category, daily rate, and the level of effort for that individual. Please provide a salary history for the prior three years, for "key" personnel and professional

staff. Offerors should use the USAID biographical data form. Describe the anticipated salary levels of other personnel that are reflective of salary requirements to recruit high quality personnel in host countries.

c. Travel/Per Diem: While the countries still remain to be determined, the offeror should propose travel costs for both international and in-country work, that are appropriate based upon the offerors proposed use of local hire, regional and international staff and contractors. For each country proposed, provide an overall breakdown between per diem and airfare (as applicable).

d. Other Direct Costs: Please provide a breakdown of all anticipated other direct costs (i.e., the amount, type, and unit cost), including workshops, training and commodities.

e. Indirect Costs: Provide a breakdown for all anticipated costs for this line item (i.e., the amount, type, and unit cost).

f. Fixed Fee

g. Estimate of Leveraged Funds – An estimate of the costs of in-kind contributions to TB task order, either direct contributions or costs saved because offerors approach builds on or leverages existing activities.

C. Evaluation Criteria for Award (% weights as indicated)

Each proposal will be evaluated in relation to the evaluation factors set forth in this RF TOP. These factors have been tailored to the requirements of this Task Order to allow USAID to choose the highest quality proposal. These criteria identify the significant areas that Offerors should address in their proposals and serve as the standard against which all proposals will be evaluated. USAID will award a contract to the Offeror that is most advantageous to the Government, cost effectiveness, and other factors considered.

The Government intends to evaluate proposals and award a task order without discussions with applicants. However, the Government reserves the right to conduct discussions if later determined by the Agreement Officer as necessary. Therefore, each initial proposal (written and oral) should contain the Offeror's best terms from a cost or price and technical standpoint.

1. Technical Approach (30%):

- a. Degree to which the technical proposal demonstrates a clear understanding of the TB control issues in USAID focus countries, and the best practices to address these issues for the required task areas;
- b. Extent to which the proposed approach to the tasks has merit and is feasible; and
- c. Merit and feasibility of the monitoring and evaluation plan for the task areas.

2. Personnel (30 %):

- a. The extent to which the proposed Project Director meets or exceeds the minimum requirements set forth in Section XII.A;

- b. The extent to which the proposed staff and consultants possess demonstrated expertise, skills and experience required to implement the full range of technical, field, and administrative tasks described in the SOW (Section V.); and
 - c. The extent to which any additional key personnel proposed by the Offeror possess the necessary skills and experience to carry out the job description proposed by the Offeror.
3. Management (20 %):
- a. Merit, feasibility, and overall efficiency of management plan for accomplishing all aspects of task implementation;
 - b. Clear plan for containing costs and leveraging other resources; and
 - c. Clear, logical and appropriate lines of authority for managing all contract staff, including consultants and sub-contractors.
4. Organizational Capacity and Past Performance (20 %):
- a. Demonstrated successful past performance in similar previous agreements or contracts to implement similar health programs, in the following areas: quality of work, timeliness of performance, quality of USG relations with the Offeror, and quality/performance of key personnel;
 - b. Demonstrated successful history of working collaboratively with varied public and private institutions in developing and transitioning countries; and
 - c. Demonstrated successful history of good organizational and management practices, including financial management and cost control.

Adjectival Rating

USAID will award the contractor whose proposal(s) best addresses the SOW and represents the best value to the Government, all factors being considered. Proposals for each the activity will be evaluated based on adjectival ranking for overall proposal and each section of the proposal respectively. The following adjectives will be used in assessing the criteria set forth:

1. **Outstanding:** The contractor's proposal convincingly demonstrates that the requirements of the task order scope of work were fully understood, and that execution under the task order would lead to the accomplishment of all work in a timely, efficient, and economical manor, with no major deficiencies and no minor deficiencies that negatively affect the contractor's performance or deliverables.
2. **Very Good:** The contractor's proposal meets the requirements of the solicitation and demonstrates that the requirements were fully understood, and that execution under the task order would lead to the accomplishment of all work in a timely, efficient, and economical manor, with no major deficiencies and no minor deficiencies, or only minor deficiencies that are not expected to negatively affect the contractor's performance or deliverables.

3. **Good:** The contractor's proposal demonstrates a shallow understanding of the requirements of the scope of work, and execution of the task order would lead to the satisfactory completion of all work in a timely, efficient, and economical manor. The proposal may contain major and/or minor deficiencies that are not expected to adversely affect the contractor's performance or quality of deliverables.
4. **Marginal:** The contractor's proposal meets performance and capacity standards, but demonstrates a shallow understanding of the requirements of the scope of work, and execution under the task order may lead to the unsatisfactory performance of the SOW. The proposal may contain major and minor deficiencies that may negatively affect the contractor's performance or deliverables.
5. **Unsatisfactory:** The proposal is incomplete, vague, incompatible, incomprehensible, or so incorrect as to be unacceptable. The contractor's proposal fails to meet performance or capacity standards, and/or that the proposal contains major deficiencies and/or minor deficiencies that are uncorrectable without major revisions to the SOW. The deficiencies are deemed to have a potentially negative impact on satisfactory project completion.