



**SECTION B – SUPPLIES OR SERVICES AND PRICE/COSTS**

**B.1 PURPOSE**

The United States Agency for International Development (USAID), Health Population and Nutrition Office requires support to expand use of selected health services and products and improve health practices in Madagascar as detailed in Section C.

**B.2 CONTRACT TYPE**

This is a Cost Plus Fixed Fee completion task order. For the consideration set forth in the contract, the Contractor shall provide the deliverables or outputs described in Section C and comply with all contract requirements.

**B.3 BUDGET**

a) The Total Estimated Cost of this acquisition is [REDACTED]  
[REDACTED] \$31,787,458, [REDACTED]  
[REDACTED].

[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED].

[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

[REDACTED]

**B.4 PAYMENT**

The paying office is provided in section G.

**END OF SECTION B**

## SECTION C – DESCRIPTION / SPECIFICATIONS/STATEMENT OF WORK

### Acronyms

ACT	Artemisinin-based combination therapy
ADB	African Development Bank
ADRA	Adventist Development and Relief Agency
AISC	National Avian Influenza Steering Committee
ASBC	<i>Agent de Santé à Base Communautaire</i> (Community Health Worker)
BAD	Banque Africaine de Developpement
BCC	Behavior Change Communication
CA	Cooperating Agency
CAC	Comité d'Appui aux Communes (Communal Support Committee)
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CHD	Centre Hospitalier de District (District Hospital)
CI	Conservation International
CNLS	<i>Comite National Lutte Contre Le SIDA</i> (National AIDS Control Committee)
COP	Chief of Party
CPR	Contraceptive Prevalence Rate
CSB	Centre de Santé de Base (Health Center)
CYP	Couple Years of Protection
DEPA	Potable Water and Sanitation Department
DHS	Demographic Health Survey
DMO	District Medical Officer
DOD	Department of Defense
DPT3	Diphtheria, Pertussis, and Tetanus, 3 <sup>rd</sup> dose
ENA	Essential Nutrition Actions
ENS	Essential Nutrition Services
EU	European Union
FBO	Faith-Based Organization
FP	Family Planning
FY	Fiscal Year
GDA	Global Development Alliance
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOM	Governmental of Madagascar
GSM	Grant Solicitation Mechanism
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation Agency)
HIP	Hygiene Improvement Project
HPE	Health, Population and Environment
HPN	Health Population Nutrition Office
ICT	Information and Communications Technology
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Bed Net

JICA	Japanese International Cooperation Agency
KM	<i>Kominina Mendrika</i> (Champion Community)
LLIN	Long-Lasting Insecticide Treated Nets
LQAS	Lot Quality Assurance Sampling
MAP	Madagascar Action Plan
MFB	Ministry of Finance and Budget
MOHFP	Ministry of Health and Family Planning
MOP	Malaria Operational Plan
MSS	Mission Strategy Statement
NGO	Non-Governmental Organization
NMCP	National Malaria Control Program
ONN	Office National de Nutrition
OP	Operational Plan
ORS	Oral Rehydration Solution
PAFI	Small Doable Important Actions
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMPS	World Bank Multi-sectoral AIDS Project
POU	Point of Use
PRSP	Poverty Reduction Strategy Paper
PSI	Population Services International
RBM	Roll Back Malaria
RFTOP	Request For Task Order Proposal
RH	Reproductive Health
SLP	<i>Service de Lutte contre le Paludisme</i> (National Malaria Control Program)
SO5	Strategic Objective 5
SOTA	State of the Art
SP	Sulfadoxine-Pyrimethamine
SSD	Service de Santé de District (District Health Service)
STI	Sexually Transmitted Infections
SWAp	Health Sector Wide Approach
TOCO	Task Order Contracting Officer
TOCTO	Task Order Cognizant Technical Officer
UN	United Nations
UNICEF	United Nations Children's Fund
USG	United States Government
USP	US Pharmacopeia
USPSC	United States Personal Service Contractor
VCT	Voluntary Counseling and Testing
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organization
WWF	World Wildlife Fund for Nature

## **EXPANDING THE USE OF SELECTED HEALTH SERVICES AND PRODUCTS AND IMPROVING HEALTH PRACTICES IN MADAGASCAR**

### **SECTION A – STATEMENT OF WORK<sup>1</sup>**

#### **I. GENERAL INFORMATION**

##### **A. Background**

##### **1. Context**

Madagascar has a population of around 19 million, 16.7% of whom are children under five years of age. One of the poorest countries in the world, the average per capita income is only \$280 (World Bank online dataset); 46% of the population is illiterate; 70% of the population lives below the poverty line; and 49% of children under age five are malnourished (DHS 2003/04). The most common causes of death among children under five are malaria, diarrheal diseases, and respiratory infections often associated with malnutrition. Life expectancy hovers at 55 years. This dire social situation springs from several factors: a weak health system, poor economic growth, and a high population growth rate of 2.8%.

The 2002 political crisis brought to power a democratic government with a reform agenda and renewed hope for the future. The new democratic Government of Madagascar (GOM) recognizes that improvements in health, nutrition, and food security are critical components for rapid and sustainable economic development and has incorporated ambitious health objectives in the new Madagascar Action Plan (MAP), including a bold goal to eliminate malaria by 2012.

The last decade has witnessed marked health improvements in Madagascar, especially among children. According to the 2003/04 Demographic and Health Survey (DHS), infant and child mortality fell by 43% and 41%, respectively, between 1997 and 2004. Other determinants of child survival, such as morbidity and coverage of important health interventions, have also improved significantly. For instance, the prevalence of diarrhea in children decreased about 63% and the proportion of anemic children fell about 31% between 1997 and 2004. At the same time, the coverage of vaccinations, vitamin A supplementation, and exclusive breastfeeding increased.

Despite these recent improvements in child health indicators, Madagascar still faces major health challenges which threaten social and economic development. Health service quality is substantially below standard and basic medicines and supplies are regularly in short supply. Public and non-governmental sector capacity to plan effectively and manage health programs is weak, particularly in the areas of financial and administrative management, and the use of data for program planning and monitoring is low. National health infrastructure, human resource, information, pharmaceutical and commodity management systems are extremely weak, and much remains to be done at central and regional levels to ensure sustainable health financing.

---

<sup>1</sup> Reference documents from GOM, USAID and other donors, lists and maps of intervention areas, and available equipment can be found by clicking on the link for background documents on the HPN page of the USAID/Madagascar web site:  
<http://www.usaid.gov/missions/mg/program/health.html>.

Administratively, the country is divided in 6 provinces (which are being phased out), 22 new regions (created in 2005), and 111 districts. The health delivery system in the country consists of a four-step pyramidal system. The basic health centers (*Centre de Santé de Base I* or CSB I and *Centre de Santé de Base II* or CSB II) represent the first level of the health system. The distinction between CSB II and I is that the former is staffed with a physician whereas the latter is staffed by nurse provider or other healthcare worker. In each of the 111 districts, the CSBs are under the *Service de Santé de District* (SSD). The most recent data from the MOHFP (Annuaire Statistique de Santé 2004) show that there are 1,842 CSB II and 1,106 CSB I in the country. There are also 85 district hospitals *Centre Hospitalier de District* (CHD I) offering similar services to those offered in a CSB II. The next level in the pyramid is composed of CHD II or district hospitals offering emergency surgery and comprehensive obstetrical care. There are currently 55 CHD II<sup>2</sup>. Finally there are 4 *Centres Hospitaliers de Référence Provinciaux* offering second referral services and 6 *Centres Hospitaliers Universitaires* offering comprehensive national referral services.

The private sector, mainly concentrated in urban areas, represents an important source of service delivery. About one out of every five primary health care facilities and two out of every five referral hospitals are privately owned. The majority of these facilities are concentrated in Antananarivo and other major cities. The private sector has an even larger presence in the retail sale of pharmaceuticals. There are 203 pharmacies, mainly concentrated in Antananarivo, and 1,625 drug retailers more evenly distributed throughout the country.

The public sector, especially the CSBs I and II, is a major source for health care in Madagascar. It accounts for more than 30% of first contacts in urban areas and more than 70% of first contacts in rural areas.

There is a growing network of more than 12,000 volunteer community health workers, *agents de santé à base communautaire* (ASBCs), who provide health education and promotion to families in their villages. Most of these workers are trained and supervised by local, international and faith-based non-governmental organizations (NGOs). Many of the NGOs work with the USAID-supported social marketing program which provides a start-up stock of education materials and health products including safe water solution and long-lasting insecticide treated nets (LLINs) that the ASBCs sell at a highly subsidized price to families in the community. The revenue from these products allows the ASBCs to procure replacement stock and earn some income as well. This income motivates the volunteers to remain in service and is an effective strategy to increase rural reach. Some, but not all, of the health outreach agents are adequately linked to the public health center. The MOHFP is currently in the process of formalizing a structure that would recognize the volunteers and create a stronger relationship with the public health clinics.

The health sector in Madagascar faces many challenges relating to the level of overall financing, utilization of health services, distribution of health personnel, availability of drugs and medical supplies in health facilities, and internal administration of the health system, especially in respect to budget execution. Also, not enough resources flow to the CSBs, which partially explain the low quality of the services rendered at the periphery.

**Health sector reform:** Madagascar's efforts to provide services to the poor have focused on increasing the availability of quality services and ensuring the financial accessibility of these services. Health is a key goal of Madagascar's poverty reduction strategy, and health policy

---

<sup>2</sup> The data on CSB I, CSB II, CHD I and CHD II include both public and private/NGO sector facilities.

issues feature prominently in the country development plans, including the Madagascar Action Plan (MAP), 2007-2011. The MAP sets very ambitious targets in the areas of maternal and child mortality, fertility rate, malaria, tuberculosis, sexually transmitted diseases and HIV/AIDS control, and reduction of malnutrition in children under the age of five. Following publication of these broad objectives, the MOHFP prepared a National Health Sector Strategy and Development Plan (*Plan de Développement du Secteur Santé*) for the period 2007-2011, which seeks to define the various interventions necessary for the realization of the MAP objectives within a logical framework of priorities, activities and results.

**Health care financing:** Foreign aid represents the main source of funding for the health system, followed by public and private funds. In 2003, it was estimated that donor funds represented 37% of all finances flowing to the health sector. Public funds represent about 32% of the total, the majority of which come from general taxation. Finally, the private sector represents 31% of the total financing by source. Families themselves are the main source of private financing. Community health insurance schemes are starting in the country, but currently cover only a very small percentage of the population.

A large proportion of the population does not receive care when in need. Data from a 2005 household survey show that only 40% of residents receive care in case of illness or injury. In addition, there are large regional differences in the proportion of people receiving care. Financial barriers to accessing health care represent the main cause of low utilization of health services. These financial barriers are often related not only to the direct cost of the services but also to other expenditures, such as transportation costs and the opportunity cost of seeking care.

The government has tried to alleviate these financial barriers, first by eliminating user fees during 2002 political crisis and then by creating a new cost-recovery system and Equity funds, in which 2.2% of the sale of drugs is now set in each CSB to allow free access to drugs for the poor. After the 2002 economic crisis, health service fees were abolished, including co-payment on drugs, following which utilization of health services increased significantly. However, as the increase in health resources was not sufficient to compensate for the loss of user fees, drug stock-outs became common, the quality of services deteriorated further, and the workload of the already over-extended health personnel increased. At the end of 2003, the Government reinstated user fees, and by 2004 a new cost recovery system was put in place that was accompanied by an exemption mechanism to ensure that the poor had access to health care.

Despite the documented high prevalence of poverty among the general population and the introduction of payment mechanisms to assist those who have been identified as poor to access basic health services, the small number of persons who claim to be indigent indicates that there may be significant cultural barriers to identifying oneself publicly as poor or indigent.

Geographic access to health care facilities is limited in rural areas, and approximately 30% of those needing care live more than 10 km from the nearest health facility causing a delay or non utilization of health services when ill.

**Distribution of health services:** A fundamental issue underlying the uneven production and delivery of health services in Madagascar is the large variation in the allocation, training and competency levels of medical personnel. Almost 50% of the personnel of the MOHFP are concentrated in the region where Antananarivo is located. Nurses and midwives are much better distributed as the share of each province is similar to their population share. The distribution of doctors across rural and urban areas also shows large imbalances. In addition,

the relatively low productivity of medical personnel in the public sector also poses a major problem, together with a lack of essential supplies and equipment to facilitate diagnosis and treatment.

**Quality of services:** The quality of health care, especially at the level of the CSB and in rural areas has suffered and the system is marked by little or no integration of preventive and curative care, the absence of continuity of care, and irrational use of drugs. Even non-clinical activities are of poor quality, with poor patient reception, long waiting times, and insufficient communication with the patient. Only 59% of basic public health centers have access to clean water, 53% have electricity, and only 16% have transportation available. Furthermore, only 21% of public facilities collected all the information required by the IMCI protocol (age, weight, health card, temperature, and breathing frequency). Similarly, in only eight of 58 public facilities were children examined for the standard four signs of health risk (vomiting, convulsions, anemia, and capacity to drink). Additionally, only 61% of patients with anemia or severe malnutrition were correctly identified in public facilities.

The health system also performs poorly at the hospital level, limiting referral to urban areas and only when it is not further compounded by financial barriers. The quality of services at hospital level is affected by the lack of medical specialists, equipment, maintenance, essential drugs, and consumables. However, the creation of the health regions has significantly modified the set-up of district health facilities and reference hospitals. With support from development partners, hospital level services are being reviewed. This should lead to a reorganization of the referral system and a transformation of the role and mandates of district and regional hospitals for more effective and efficient service delivery.

**Supply chain management:** After the 2002 crisis, the GOM eliminated user fees at facility level and started to distribute drugs free of charge. During this time, a health facility survey recorded widespread drug stock-outs in the CSBs. Only 15% of the CSBs did not suffer shortages. About 30% of facilities had shortages of chloroquine, cotrimoxazole (trimethoprim-sulfamethoxazole), mebendazole, and alcohol; about 46% had shortages of paracetamol (acetaminophen); and more than half had no acetylsalicylic acid. The mean duration of the stock outs varied from 32 days for mebendazole to 70 days for acetylsalicylic acid. After the re-introduction of user fees and the cost-recovery/Equity Fund, the situation improved, although drug shortages are still a problem.

The 35% markup on generic drugs in Madagascar is among the lowest in Africa; this low markup, consequently, does not leave much room for additional resources to improve quality. While the GOM has succeeded in maintaining low drug prices through subsidies to compensate for the 2004 devaluation, it will have to carefully manage the restoration of prices reflecting drugs' real cost in the near future.

**Budget execution:** Health system management at the local level is improving, although budget management capacity remains a major challenge. The planning, programming, and monitoring functions of regional and district health management teams have been strengthened. All regions and districts have adjusted their budgeting process to the new budget/program format, and some have begun to introduce performance-based planning using management tools and technical support from various partners. The performance of the district management teams has started to improve as a result of technical support and staff recruitment and all but a few of the districts are now able to formulate their three-year plans and develop annual work programs. However, implementation of those annual plans is still weak due to insufficient resources and low capacity for procurement of the large quantities of commodities and equipment needed to

expand health services. Furthermore, support from regional and communal administrative authorities is still weak.

## 2. Government of Madagascar Strategy

The GOM recognizes that improvements in health, nutrition, and food security are critical components for rapid and sustainable economic development. To address the current health conditions in Madagascar, the GOM articulated its goals and strategies in the Madagascar Action Plan (MAP) 2007-2012 which is a bold and exciting plan for rapid development within the country. The plan outlines the major intervention priorities the GOM has identified to ignite rapid growth, lead to the reduction of poverty and respond to the challenges of globalization. The main health and food security challenges identified in the MAP are<sup>3</sup>:

- Provide Quality Health Services to All;
- Eradicate Major Diseases (malaria and sexually transmitted infections);
- Win the Fight Against HIV and AIDS;
- Implement a Highly Successful Family Planning Strategy;
- Reduce Infant Mortality;
- Reduce Maternal and Neonatal Mortality;
- Improve Nutrition and Food Security; and
- Provide Safe Water and Widespread Use of Hygienic Practices

*Provide Quality Health Services for All:* Provision of quality health service activities focus on ensuring that a package of essential health services are available at all health centers and that referral hospitals are staffed with qualified professionals who can provide the basic package of services. The GOM health program also emphasizes extending services to the rural areas through a large network of ASBCs who supplement and complement the work of the CSBs, thus extending the health system's reach to the non- and underserved population of areas of the country.

*Eradicate Major Diseases:* The Government's disease eradication program focuses on malaria and sexually transmitted diseases. Malaria is a major health problem in Madagascar with about 90% of the population at risk. Malaria is also responsible for about 16% of all outpatient visits and 20% of all children under five years old admitted to a hospital are diagnosed with severe malaria. It is among the leading causes of death of children under five.<sup>4</sup> Syphilis prevalence in pregnant women is as high as 15% and among commercial sex workers in some areas it is as high as 35%.<sup>5</sup> Priority activities include supporting prevention and surveillance activities, improving patient care and case management, reinforcing existing programs, and implementing a rapid and sound system using data for decision making. The GOM has also established a Country Coordinating Mechanism (CCM) to reinforce coordination and manage activities supported by a variety of donors and through the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM).

*Win the Fight Against HIV and AIDS:* The President of Madagascar has publicly established his leadership in AIDS prevention and chairs the *Comité National Lutte Contre Le SIDA* (National AIDS Committee) or CNLS. This has given new impetus to the HIV/AIDS program and

---

<sup>3</sup> <http://www.madagascar.gov.mg/MAP/>

<sup>4</sup> President's Malaria Initiative, Malaria Operational Plan FY 08

<sup>5</sup> USAID/Madagascar STI/HIVAIDS Strategy, 2002

strengthened the GOM's ability to exhibit leadership in addressing the issues. The CNLS has a substantial Voluntary Testing and Counseling program and has recently renewed its focus on prevention education targeting youth and high risk groups such as commercial sex workers, men who are involved in mobile occupations, such as truckers and miners, and men who have sex with men. Also, given the relatively high STI rates, the GOM has prioritized scaling up its STI control program.

*Implement a Highly Successful Family Planning Strategy:* The GOM has raised the profile of family planning and reproductive health on the national agenda. A national family planning strategy has been adopted and all health centers have contraceptives readily available. The GOM is committed to increasing the contraceptive prevalence rate (CPR) to 30% by 2012 and has even created a budgetary line item for the purchase of contraceptives. Activities focus on increasing demand for and access to family planning and reproductive health services and products. The GOM strategy specifically addresses the need to reduce unintended pregnancies among adolescent girls through provision of family planning services.

*Reduce Infant Mortality:* Activities focus on lowering childhood mortality rates by reinforcing the national vaccination program, supporting an epidemiological surveillance system, increasing efforts for the integrated management of childhood illnesses (IMCI), improving accessibility and quality of services, and mobilizing communities to take charge of their own health. Increasing attention is placed on prevention programs and exclusive breastfeeding for the first six months of a child's life.

*Reduce Maternal and Neonatal Mortality:* The program focuses on improving the pre and in-service training of nurses and midwives in safe obstetrical practices. A national plan has been developed, but has still not been widely implemented. The program also addresses community emergency obstetrical care and involves ASBCs and CSBs in appropriate care of the new-born.

*Improve Nutrition and Food Security:* To address malnutrition, the GOM established a National Nutrition Policy that guides the implementation of nutrition priorities, including a focus on addressing micronutrient deficiencies, promoting breastfeeding, revitalizing the community infrastructure for education and nutritional demonstrations, increasing community nutrition sites, and implementing a national nutrition monitoring system. The GOM encourages food or cash-for-work programs to improve infrastructure and the environment, and preventing and managing natural disasters. These activities will be achieved through intensive efforts that mobilize and empower communities to respond to food security and disaster reduction needs, reinforce multi-sectoral approaches, promote civil society action, and strengthen NGO partnerships. A primary goal is to reduce malnutrition in children under five years old from 42% in 2005 to 28% in 2012.<sup>6</sup>

*Provide Safe Water and Widespread Use of Hygiene Practices:* The priority projects of the GOM with respect to safe water include provision of safe drinking water and education of parents and children in safe sanitary and hygiene practices. A special focus is attached to strengthening the coordination among ministries to implement the international Water Sanitation and Hygiene (WASH) strategy.

---

<sup>6</sup> Government of Madagascar, Madagascar Action Plan 2007-2012.

### **3. USAID/Madagascar Strategies**

#### **a) Madagascar Mission Strategy Statement (MSS): 2006-2011**

USAID/Madagascar's Mission Strategy Statement, approved in 2006, details the Mission's strategic focus for the period 2006-2011<sup>7</sup>. Based on the Agency's Strategic Framework for Africa, it supports host-country priorities and is aligned with US foreign policy goals. This strategy underscores the importance of economic and democratic transformation, which is sustainable and involves and benefits all segments of society. The strategy also corresponds to the Madagascar Action Plan (MAP), the Government of Madagascar's bold poverty reduction strategy. The MSS is built around four strategic objectives:

- Governance in Targeted Areas Improved
- Use of Selected Health Services and Products Increased, and Practices Improved
- Biologically Diverse Forest Ecosystems Conserved
- Critical Private Markets Expanded

In addition, USAID's last 15 years in Madagascar have demonstrated that there are strong cause and effect linkages within and between these strategic objective sectors and a number of vital cross-cutting areas. Under the MSS, the Mission intends to continue and reinforce its innovative, integrated cross-sectoral efforts in the areas of food security, strengthening linkages between Health, Population, Environment, Rural Development, Agricultural production, water and nutrition; HIV/AIDS prevention, good governance, Information and Communications Technology (ICT), disaster and conflict vulnerability, gender equity, and public-private alliances. The approved USAID strategy builds on over 10 years of United States Government (USG) humanitarian relief, health and development experience in Madagascar.

#### **b) HPN Strategy**

The Mission activities under the current strategic objective, "Use of Selected Health Services and Products Increased, and Practices Improved," fall within the following components:

- Improve Child Survival, Health and Nutrition:
- Reduce Unintended Pregnancy and Improve Healthy Reproductive Behavior:
- Prevent and Control Infectious Diseases of Major Importance:
- Reduce Transmission and Impact of HIV/AIDS

As the HPN program evolves with new programs and the addition of the new PMI activities, it will build on previous HPN activities to expand high impact quality maternal, child and reproductive health services, focusing on two levels: strengthening national health systems , and by expanding commune-based activities, broader and deeper, reaching more communities. At the national level, the HPN program will strengthen the health system and the capacity of the MOHFPSP to undertake its normative functions to ensure the delivery of critical health services. It is envisioned that significant progress will be made in: developing, disseminating, and effectively implementing norms, policies and guidelines, using data to generate and implement annual work plans; strengthening the pharmaceutical and health management system with a

---

<sup>7</sup> USAID/Madagascar Mission Strategy Statement can be found at:  
[http://pdf.usaid.gov/pdf\\_docs/PDACG992.pdf](http://pdf.usaid.gov/pdf_docs/PDACG992.pdf)

priority on maternal and child health (including malaria), family planning and HIV/AIDS commodities; improving donor coordination; better disbursement and tracking of health resources; and enhancing financial systems and improving governance and transparency. Professional development and training of health personnel within the system and those in pre-service training will improve clinical competence and performance in monitoring and surveillance of health activities; and expand essential health service broader and deeper into rural communities. Collaboration with civil society organizations, including CBOs, FBOs and NGOs will be critical to ensuring expansion of health services and products.

The achievement of the strategy will involve increasing demand for, quality of, and access to high-impact services and products for child, maternal, and adolescent health; family planning and reproductive health; HIV/AIDS; diarrheal diseases; and malaria prevention and control through technical assistance and other resources. Indicators of progress towards the objective include: increases in Diphtheria, Pertussis, and Tetanus (DPT3)<sup>8</sup> immunization rates; contraceptive prevalence rate; exclusive breastfeeding under age 6 months; Vitamin A supplementation; condom use with last non-regular partner; use of treated bed nets; appropriate treatment of malaria among children and mothers; reduced cases of diarrhea, and correct diagnosis and treatment of STIs.

Results will be achieved through the Core Program, which are the basic activities to be implemented under this contract, and the social marketing program, and the Expanded Program, which are activities that contribute to the overall strategy and are obligated through other mechanisms outside this contract. (See Annex A for a description of the Core and Expanded Programs.) USAID will select two organizations to implement the Core Program: one to undertake assistance primarily to the public sector (this contract) and one to manage the social marketing component. This contract, therefore, shall be the primary source of services under the Assistance Agreement with the GOM. However, the USAID/Madagascar Health program is tightly integrated and the Contractor shall work closely with and build on and reinforce the positive working relationships with the social marketing grantee and the USAID-funded implementing partners including PL480 Title II, child health grantees, and field support mechanisms that make up the Expanded Program, as well as with other USAID supported sector programs, other health and development assistance agencies and other donors.

The Contractor's primary clients shall be the MOHFP, National AIDS Control Committee (CNLS), the National Malaria Control Program, National Nutrition Council (CNN), WASH, Voahary Salama (an indigenous network of NGOs) CBOs, FBOs and NGOs and USAID/Madagascar. Key partners shall include the USAID-funded private sector social marketing activities, currently being implemented by Population Services International (PSI), other USAID-funded activities, the USAID Title II Food Security program, Madagascar World Bank, United Nations (UN) organizations, the European Union (EU), French cooperation, and other bilateral donors.

### **c) Complementarity with Government of Madagascar Strategies and Priorities**

A major objective of USAID/Madagascar's strategy is to support the government's priorities and to strengthen public sector governance and service delivery capacity to respond to the needs of its citizens. With this in mind, USAID has worked closely with the Minister of Health and Family

---

<sup>8</sup> Diphtheria, Pertussis, and Tetanus vaccine (DPT3) requires three injections and is used as a proxy for full vaccination.

Planning and civil society to develop the new interventions in the health program and to ensure that they are fully supportive of GOM priorities as outlined in the MAP 2007-2012.

As described above, the MAP is a bold, five-year action plan which establishes direction and priorities for the nation from 2007-2012. It states the commitments, strategies and actions that will ignite rapid growth, lead to the reduction of poverty, and ensure that the country develops in response to the challenges of globalization. Through the MAP, the President has also the reinforced commitment and vision of the GOM to achieve the UN Millennium Development Goals of eradicating poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and developing a global partnership for development. The MAP makes a special commitment to health, through expanding family planning services and increasing the contraceptive prevalence rate (CPR), improving maternal and child health, halting the spread of HIV/AIDS and malaria, and making safe drinking water more accessible through expansion of quality health services and products at the community and community health center levels. The Minister of Health and Family Planning developed a framework that supports the achievement of the MAP health goals, the "*Plan de Développement Sector Santé (PDSS) 2007-2011*". The PDSS describes the Ministry's new approach towards integration of health services and its strategy to deliver a basic minimum package of health services closer to the people.

To contribute to the GOM's strategies and plans, the USAID health strategy has identified the need to maintain and increase access to essential health services and products by progressively enhancing direct service delivery capacity at the commune level in both the public and private sector and strengthening public sector oversight of, and norm setting for, service provision. Areas of assistance will include:

- enhancing MOHFP executive and normative policy functions in service delivery to improve quality, accountability and transparency;
- strengthening the health information management system and use of data for programming and decision-making;
- reinforcing the pharmaceutical and commodity management system to assure access to quality products;
- expanding quality service delivery through the ASBCs, and the CSBs;
- strengthening IEC/BCC capabilities in the public sector and NGOs
- extending the reach of the private sector to deliver services and products through the social marketing program
- enhancing the role of civil society; i.e. CBOs, FBOs and local and international NGOs in extending services and products further into rural communities;
- strengthening public and private sector cooperation in quality service delivery; and
- improving pre-service training of primary health care professionals.

These priorities are completely consistent with and supportive of the priorities outlined in the MOHFP Sector Development Plan and the MAP.

#### 4. Other Donors in Health

The United States Government is the single largest bilateral donor in the health sector. Other key players include: the World Bank (WB), the United Nations Children's Fund (UNICEF), the World Health Organization (WHO), French Cooperation and the Japanese International Cooperation Agency (JICA). In the areas of child survival, the combined efforts of UNICEF and USAID have helped the MOHFP develop and implement a child health policy. WHO, WB and UNICEF are key partners in immunization campaigns. UNICEF and USAID worked together to launch oral rehydration salts (ORS). UNICEF, WHO and USAID are the main donors supporting the introduction of zinc as a treatment for diarrhea and the launch of community-based distribution of co-trimoxazole to treat acute respiratory infections in children. USAID implemented a number of activities with WHO, including the polio outbreak response, establishing a pharmacovigilance system and appropriate disposal of medical waste. USAID and WHO also collaborated in support of national policies such as the national child health policy and the national nutrition action plan. USAID collaborated actively with the World Food Program, UNICEF and WHO in nutrition and child health.

The World Bank and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) are the two largest HIV/AIDS donors. In addition, the African Development Bank (ADB), United Nations Agencies, French Cooperation, and the German Technical Cooperation (GTZ) have committed substantial resources since 2002 to assist the GOM in its fight against HIV/AIDS.

While all donors are providing substantial inputs to the national health system, little investment is being made to ensure adequate drugs and preventive health commodities are consistently available in appropriate quantities at the CSBs and the in the community. However, through *Santénet*, the current bilateral health program, USAID is providing technical assistance to the MOHFP and the Central Procurement Agency, SALAMA, to strengthen the national health commodity system to assure that essential drugs and contraceptives are available at the public health centers consistently in the quantity needed. In addition, USAID's social marketing program, in collaboration with Santénet and local NGOs, has expanded distribution networks to ensure that essential health commodities (family planning commodities, a water purification solution, insecticide treated bed nets for malaria and eventually ORS and zinc for diarrhea, antibiotics for ARI and ACT for malaria) are available in traditional and non-traditional commercial sectors as well as through the FBOs and NGOs and ASBCs at the household and community levels.

In addition to the international donors and USAID, other USG agencies actively participate in the health sector. The U.S. Department of Defense (DOD) supports the Malagasy Ministry of Defense in its HIV/AIDS testing and education programs. The Peace Corps works with communities in collaboration with USAID partners in STI/HIV prevention education, family planning, maternal and child health and nutrition.

## II. WORK REQUIREMENTS

### A. Technical Requirements

USAID/Madagascar authorizes investments to ***Expand Use of Selected Health Services and Products and Improve Health Practices In Madagascar***. USAID will deploy technical assistance and resources to increase demand for, quality of, and access to high-impact services and products for child, maternal, neonatal, and adolescent health, family planning and

reproductive health, HIV/AIDS, diarrhea diseases, and malaria prevention and control. Indicators of progress towards the objective include: increases in DPT3 immunization rates, contraceptive prevalence rate, exclusive breastfeeding under age six months, Vitamin A supplementation, condom use with last non-regular partner, use of treated bed nets, appropriate treatment of malaria among children and mothers, and diagnosis and treatment of STIs.

The objective will be reached through support to the GOM in strengthening specific aspects of the national health system, reinforcing efforts for decentralized management of the public sector health service, and expanding and deepening quality health services in rural areas through effective engagement of communes in improving the health and well being of the population. As noted above, USAID will support achievement of these results through this contract; Field Support mechanisms; maternal and child and reproductive health activities carried out under PL 480 Title II; and the Global Health/Child Survival and Health Grant Programs. Contractor activities shall complement these and other SO activities to ensure that the totality of activities serves to support achievement of results.

## **1. Vision**

USAID will consider this contract successful to the extent that:

- HPN indicators related to the main services, products, and practices entailed in this contract have shown measurable improvement, reaching established targets at national scale;
- The contract activities are perceived as an integral part of GOM and MOHFP activities and have been an effective complement to and partner with the GOM and other USAID activities (both HPN and non-HPN and the cross-cutting Title II program). The contract shall contribute to the overall success of MSS and MAP objectives;
- The capacity to plan, manage, and evaluate health activities is increasingly institutionalized within GOM and other host-country institutions, particularly coordination and management systems necessary to ensure access to health products and services;
- Activities at the community level have increased the access to and quality of health services and have improved practices, and these activities are more sustainable than before in terms of program management, service delivery and financial support (e.g., GOM allocations through MOHFP budget, local cost recovery, and ability to secure outside funding)
- Contract activities have contributed to specific improvements in policy that support MOHFP and MAP priorities and those of USAID
- Lessons learned from USAID-supported community mobilization and behavior change approaches, and integrated community-level actions in maternal and child health, family planning, food security and nutrition, water and sanitation, malaria control, and HIV prevention have been institutionalized centrally and reflected in communities more widely.

The specific contract results and performance indicators that could achieve this vision are outlined below in Section II.B.

## **2. Program Objective**

The purpose of this contract is to build on previous USAID/Madagascar HPN activities, expand services broader and deeper into communities to provide quality services to the poor, and to strengthen specific health systems and the capacity of the MOHFP to undertake its normative functions to ensure the delivery of critical health services. The achievement of this purpose will involve increasing demand for, quality of and access to high-impact services and products for child, maternal, and adolescent health; family planning and reproductive health; HIV/AIDS; diarrheal diseases; and malaria prevention and control through technical assistance and other resources. Contract resources will support activities at the local level through both the public sector and civil society organizations and at the central, national level through the MOHFP. At the end of this contract period, it is intended that the percentage of Malagasy people that have access to quality basic health services will increase to 65%.

## **3. Customers**

USAID-funded health activities will mainly target women and children (especially young mothers) and men of reproductive age and infants and children under age five. Adolescents between 15-24 years of age are a particular focus of the program with activities to assist them to delay onset of sexual debut, delay pregnancy and protect themselves from STIs, including HIV. Additional customers include populations that engage in high-risk sexual behavior such as commercial sex workers and their clients; men who have sex with men, and men in mobile occupations such as truck drivers and miners, as well as uniformed men who are particularly vulnerable to STI and HIV infection. As the program expands deeper into the countryside, potentially most of the estimated 3,300,000 households may be customers of at least some of the community-level services and/or health products of the program.

## **4. Technical Approach and Level of Focus**

The Contractor shall build upon the achievements of the past decade of USAID support, particularly in strengthened coordination and management of community-based and NGO networks and reinforcing the accompanying national health systems. A critical element of the new strategy will be a stronger and more pro-active role of the MOHFP to lead and provide technical oversight to NGO and donor activities for greater efficiency and community level results. In order to empower public sector leadership and build accountability within civil society, USAID's technical and financial support to the MOHFP will be increasingly performance-based.

The level of focus refers to the operational level at which activities are carried out. The HPN program aims to achieve nationwide impact on the use of select services and products. The contractor shall focus on improving the national health system at central, region, district, and health center level and expanding the commune empowerment model to improve health outcomes in more communities. National level investments are intended to complement and support activities at the commune and community level, and are aimed at those aspects of the national health system that most directly sustain local primary health care promotion and services, in concert with the GOM and MOHFP broader, longer-term development objectives and plans, and with the investments of other external assistance.

The new program will build on previous USAID investments in assisting the MOHFP at all levels to adapt to its revitalized role in policy development, articulation of technical norms and

standards, and standardization of program guidelines to manage, implement and supervise programs. In addition, the new program will continue supporting the MOHFP to establish a robust sustainable pharmaceutical and commodity management system and an active Health Information System used for decision making. The new program will be taking place within the context of decentralization/deconcentration which is articulated within the MAP and health strategy. As of 2007, several laws have been enacted to strengthen the communes, districts and regions and to decentralize resources to these levels. However, to date, policy making and budget decisions remain concentrated in the central government. The MAP plans to gradually decentralize resources by 2012. As the MOHFP moves forward on decentralization, it will be imperative that the Contractor shall assist the MOHFP to ensure that regional and community development plans and budgets include provision for health services. Furthermore, as the district medical officers and their staff are directly responsible for the supervision of the CSBs and assuring the MOHFP norms standards and procedures are implemented, the Contractor shall work with the DMOs that supervise the communes that are being supported by the project. Support to the MOHFP at all levels and NGOs will deepen public-private partnerships in the delivery of health services to underserved groups and will increase transparency and accountability in the delivery of critical services, while at the same time bringing government services closer to the people.

#### *National Level Activities*

The national level activities will result in nationwide improvements in key health indicators. These activities will have a broad reach throughout the country resulting in improved implementation of select norms and standards, strengthened pharmaceutical and commodity management, strengthened health information management system, improved use of data for programming and decision-making, increased access to products and services, and a higher quality of services delivered. Additionally, information, promising practices, and proven models for behavior change emerging from the community level activities shall be continuously fed back to the decision-makers at all levels to leverage support from other donors for replication and/or scale-up. The MOHFP recognizes the importance of the ASBC as the end point of service delivery. Efforts are currently underway by the MOHFP and partners to standardize the materials and training for the important outreach agents, and to design a more formalized system for reporting from the ASBC to the CSB and supervision from the CSB. Many of the ASBC are so well trained now that they can also create and run health outposts or satellite clinics with a minimum package of services.

The Contractor shall provide the technical assistance to strengthen national level agencies, mostly the Ministry of Health services (especially the NMCP); medical, paramedical, public health schools; SALAMA; WASH; ONN; and the CNLS. This technical assistance shall include health sector planning and coordination for consistency and cost-effective programming; support for analyses and advocacy for policies, development and validation of standards and guidelines to improve service delivery and cost recovery; development of standardized materials and training for ASBC and linking them to the health center; curricula development and strengthening medical and paramedical pre-service training; strengthening of health commodity logistics management and procurement systems, support for existing coordination mechanisms and other new mechanisms; improved collection and use of data; operations research; and strengthening of surveillance systems.

### *Commune/Community Level Activities*

At the commune and community levels, the Contractor shall build on lessons learned under the current program and continue to expand the successful *Kominina Mendrika*, Champion Community, approach (See Annex B for a description of the *Kominina Mendrika* (KM) approach as currently being implemented) in providing technical assistance, training, and selection of and funding for sub-contracts or grants. The KM approach has proven to be a successful one by which local communities participate in their own development. The KM approach helps commune leaders identify key health and development issues, establish “doable” short-term targets, and measure their success. The approach can be a useful good governance platform that integrates key development sectors to improve community well-being such as environmental protection agricultural production, health improvement, economic development, and education. Although this approach reflects the fact that development sectors are interdependent and that their integration produces the best possible synergy while promoting sustainable development, the Contractor shall focus on identified health interventions which fall within the scope of this contract. The contractor shall assist communities in identifying resources necessary to address priority development issues identified in the other sectors. The KM approach also has numerous steps that the community must traverse to succeed. To expand the approach to attain the needed health benefits, the Contractor shall rapidly identify ways to reduce the number of steps and to streamline the approach, reducing the cost with an eye to scaling up and sustaining the effort. The Contractor shall ensure the complementarity and continuity of this approach with other GOM efforts to support decentralization and good governance at the commune and fokatany levels, such as the Comité d’Appui aux Communes (Communal Support Committee—CAC).

At the Commune level, the contractor will assure that the ASBCs are closely linked to the CSB and that they have high-quality, standardized training and materials that will prepare them to provide education and home-based treatment in maternal, child and reproductive health, nutrition, community IMCI, and malaria prevention and control. The Contractor will build on existing materials, experiences and best practices to integrate literacy training at the commune level using key maternal, child and reproductive health, hygiene, and malaria prevention and control messages as the basis for the curriculum. Experience has shown that using CBOs, churches, scout groups, schools, farmer-to-farmer groups, rural radio and radio listening groups, and other media sources to complement the work of the ASBCs in the context of KM create an environment for community norm change.

### **5. Technical Focus**

The new program concentrates on the integrated implementation of high impact, proven reproductive and maternal and child health efforts that will have an ultimate impact on Madagascar’s high fertility, malnutrition, and under five and maternal mortality rates. To implement the HPN strategy described above, the Contractor, in concert with other USAID-funded activities, shall support both private and public sectors to achieve specific planned results at national and (selected) commune levels, building on previous USAID investments and expanding successful models. The contract purpose will be achieved through selected activities undertaken in five main Program Elements which are expected to lead to improvements in health status. The five main elements are:

- Maternal and Child Health
- Family Planning and Reproductive Health
- Malaria

- Water Supply and Sanitation
- HIV/AIDS

## 6. Geographic focus

As stated above, contract activities are national in scope. Nonetheless, they shall focus on communes within the regions. All contract activities shall address the cross-cutting concern of strengthening the role of civil society and mobilizing communities to action. Community-based NGOs, CBOs and FBOs play a unique role in advocating for the development of their communities and partnering with the public sector to sustain positive health impacts.

During the time period of this contract, through both national and community level activities, it is estimated that the total population of Madagascar (approximately 19 million people) will be reached at least to some degree through the health activities supported by USAID. National level activities will reach throughout the entire country, and community level activities will focus on more intensive activities in specific geographic areas. By working at both the national and community levels, USAID-funded health activities will have both the breadth and depth required to achieve results.

To take advantage of efficiencies of scale, create a tightly integrated program and to develop a critical mass among mobilized communities to affect broad based behavior and normative change in a given area, the geographic scope for the new HPN community level activities will for the most part build on and out from the *communes* and areas in which USAID has already been active in health with the goal towards reaching all of the communes in a given district. These areas include:

- HPN Phase III programs under the current prime bilateral contract,
- HPE activities,
- Title II program,
- Child survival grants,
- Other USAID-funded implementing partners (FHI, FBOs, Voahary Salama, etc.), and
- HIV/AIDS activities.

A map of the current USAID intervention areas as well as a listing of the participating communes in the different programs can be found by clicking on the link for background documents on the HPN page of the USAID/Madagascar web site:  
<http://www.usaid.gov/missions/mg/program/health.html>.

In addition to spreading out from existing HPN intervention areas, other, non-adjacent, communes may be chosen to participate in the program. The selection of these new communes may be based on epidemiological and other health and socio-economic indicators or because they link with other on-going USAID programs such as environment and agriculture. Communes in which USAID had worked previously (but is no longer present), especially districts on the vulnerable east coast, may also be considered. Final decisions on the focus communes shall be made in conjunction with the MOHFP, USAID, and the Contractor within the first 60 days of contract signature.

As the community health program advances, it is anticipated that in the second year of implementation, some communes that have reached a level of maturity and will have received five to six years of assistance (the criteria for which will be determined by USAID and the

Contractor in year one of the contract) will graduate from USAID assistance. Beginning in 2009, the program will target 500 new communes. (At the end of calendar Year 2009 it is estimated that around 400 of the 1,567 communes will have been reached, making services available to about 60% of the population.).

## **7. Grants Under Contract**

In an effort to provide innovative and flexible mechanisms to promote public-private partnerships, strengthen local NGOs, achieve rapid scale up of the KM approach and support local development goals, the Contractor shall develop and manage a small grants under contract (GUC) program. The Contractor shall award these grants on a competitive basis. This component is the mechanism by which the Contractor will be able to undertake community-level activities and expand the KM approach. This GUC program will be made available to coalitions of local CBOs, faith-based organizations (FBOs) and other civil society groups who are implementing their own programs, but who may wish to add a health component that supports the objectives of USAID-funded health activities and the MOHFP. Civil society organizations that have existing health programs and wish to extend these programs further into distant rural communities will also be eligible. These and similar civil society groups would be eligible to request funding under the GUC component. The Contractor shall develop criteria for these grants in collaboration with USAID. Preference shall be given to those proposals that linked the proposed health activities to USAID's other development programs. As a result of these small grants, coalitions of local stakeholders will have access to much needed funding to expand their activities or in some cases access seed money in pursuit of activities which support the goals of USAID and the MOHFP and target activities in geographic or priority areas. These strategic activities will provide a catalyst to achieve broader goals and serve to leverage or attract additional support. By giving local coalitions the ability to manage funds and participate directly in projects, ownership of the larger development process and objectives should increase among Malagasy citizens.

## **8. Gender Considerations**

USAID considers women's participation throughout: in health activities, in access to information and reproductive health products, in participation in decision-making, in access to resources for investments in family health, in sexual negotiation skills, and in opportunities for training and leadership in the public health field. Young women and adolescents between 15-24 years of age will be a particular focus of the program with activities to provide them with the necessary tools to allow them to delay the onset of sexual debut, delay pregnancy and protect themselves from STIs, including HIV. In addition, men's role in family health will be included, such as a father's participation in monitoring their children's growth and nutritional status, men's condom use, men's role in contraception, and men's roles in promoting community health. By actively engaging men and women in both their family and community health, sustainability will be enhanced in reproductive, maternal, and child health. Evidence world-wide demonstrates that improving maternal, child, and reproductive health will have positive impacts on women's productivity and quality of life. Public health survey data shall be disaggregated by sex to determine differences in use of health care, vaccine coverage, nutritional status, attitudes toward condom use, etc. Professional training opportunities shall emphasize female participation on an equal level with males.

In compliance with section H.22 of the Basic IQC approval by the Head of Contracting Activity to award and administer grants under this task order has been obtained.

## **9. Coordination with other USAID Implementation Partners**

As stated above, the HPN strategy will be implemented through a Core Program and Expanded Program. The Core Program includes the activities to support the public sector and communities to be implemented under this contract and the social marketing program. The Expanded Program includes other activities that contribute to the overall strategy and are obligated through other mechanisms outside this contract. Examples of this additional USAID/Madagascar and USAID/Washington support include Field Support, child survival, and reproductive health activities carried out under Title II, Child Survival and Health Grant Programs, the President's Malaria Initiative (PMI) and other initiatives. These activities support this contract and are critical to the success of the program, but are not the responsibility of the Contractor.

With USAID guidance and support, the Contractor shall work closely and create synergistic working relationships with the social marketing grantee and the other USAID-funded implementing partners that make up the Expanded Program. In addition, the Contractor will create collaborative working relationships with other sector programs where logical. Although each organization or mechanism will have its own results and reporting relationships, the Contractor shall work collaboratively with other implementers to ensure that all project activities are coordinated and support the USAID and GOM health programs.

USAID will directly procure MCH commodities, including contraceptives, for the program. Procurement of MCH commodities, including contraceptives, therefore, does not comprise a part of this contract. However, the Contractor shall provide technical assistance in commodities forecasting, logistics management of child survival, malaria and family planning supplies and their storage and distribution to central and district service delivery points. The Contractor shall coordinate closely with the social marketing grantee and any other service provider involved in the distribution of contraceptives and other health commodities.

### **B. Deliverables**

#### **1. Results by element**

The USAID health program reflects current needs in the health sector in Madagascar and the priorities spelled out by the MOHFP and the GOM and capitalizes on USAID's comparative advantage. The focus is on people-level impact in terms of "use of services" and "behavior change" at two levels. At the national level, the program will reach the entire Malagasy population through policy dialogue, institutional capacity development, social marketing, and media activities. At the commune level, intensive and fully-integrated health activities will improve the supply of and demand for quality health services and products among approximately 9 million people (half of Madagascar's total population). The program will identify successful interventions at the commune level and further institutionalize them at the national level, including the champion commune or KM approach, child-to-child program, literacy training using health messages in the curriculum, and behavior change activities designed to empower women and families as pro-active stakeholders and managers of their own healthcare needs.

USAID/Madagascar recognizes the importance of international short-term training. The Contractor shall support three appropriate short-term training programs per year for qualified Malagasy participants over the contract period. Participants will be chosen in collaboration with the MOHFP and USAID.

The USAID/Madagascar HPN program concentrates on the integrated implementation of proven, high impact reproductive, maternal and child health, essential nutrition, malaria control, safe water, and HIV prevention efforts that will have a positive impact on Madagascar's high fertility, malnutrition, and infant and maternal mortality rates.

The Contractor shall deliver the expected results within the broad results (program elements) listed below. Furthermore, the Contractor shall provide gender-disaggregated (where applicable) data for the indicators listed within each broad result area. There are two levels of indicators for each result: HPN PMP indicators and Operational Plan (OP) indicators (for malaria, there are also indicators drawn from the Malaria Operational Plan-MOP).

**Result One: Maternal and Child Health—Increase the availability and use of proven life-saving interventions that address the major killers of mothers and children and improve their health and nutrition status, including effective maternity care and management of obstetric complications; prevention services including newborn care, routine immunization, polio eradication, safe water and hygiene, and micronutrients; improved maternal, infant and young child feeding; and treatment of life-threatening childhood illnesses.**

**Summary:**

USAID investments in health over the past ten years have demonstrated impressive gains in child and maternal health. Madagascar continues to fully integrate nutrition, effectively linking micronutrients, community-based and clinic-based activities and breastfeeding by effectively using a variety of resources including PL480 assistance. Health interventions emphasized health worker training, community mobilization and health education and expansion of child and maternal health care delivery in the public and private sectors.

USAID-funded activities were pivotal in the successful development of the Integrated Management of Childhood Illnesses (IMCI). USAID also provided support to the National Immunization program which increased vaccination coverage in USAID-targeted zones to 91% of children 12-23 months old completely vaccinated, compared to the national average of 53%. This assistance coupled with support for expanded breastfeeding and Vitamin A distribution contributed to reducing child mortality from 164/1,000 in 1997 to 94/1,000 in FY 04. The neonatal mortality saw a less dramatic decrease from 40/1,000 in 1997 to 32/1,000 in 2003. These activities will be expanded to reach further into underserved rural areas as well as including greater emphasis on neonatal care, hygiene, malaria and diarrhea prevention, and home-based care for malaria, diarrhea, and ARI among children.

While substantial strides have been made in the area of safe motherhood (the maternal mortality rate has slightly decreased from 488/100,000 births in 1997 to 469 per 100,000 births in 2003/2004.<sup>9</sup>), elevated rates of teen pregnancy, unsafe abortions<sup>10</sup> and closely spaced pregnancies all contribute to unacceptably high maternal mortality rates. Despite these efforts, only 40% of pregnant women receive four prenatal consultations. Regrettably, 40% of deliveries still occur at home without medical assistance. There is also a lack of competencies

---

<sup>9</sup> Madagascar Demographic and Health Survey 2003-2004 Key Findings:  
<http://www.measuredhs.com/pubs/pdf/SR105/SR105MD03%2D04Eng%2Epdf>

<sup>10</sup> Abortions are illegal in Madagascar and little data exists on its prevalence.

among the staff at the CSBs to provide emergency obstetric care and no ability in the community to recognize the need for such care and make a referral plan.

The Contractor shall provide expertise at the central, service delivery, and community and household levels to further reduce maternal and child mortality and morbidity with increased vaccination coverage, expansion of essential nutrition actions and preventions as well as early detection and treatment of childhood diseases. Within HPN's integrated program the contract shall provide a full range of maternal health interventions, including family planning. A community-based literacy program using key maternal and child health and hygiene messages will be an important component. The Contractor shall initiate a pilot community-based emergency obstetrical care activity as an additional strategy to further reduce the maternal mortality rate. The Contractor shall support training and capacity-building at the national and district MOHFP levels to manage and implement successful vaccination programs. The expansion of the *Kominina Mendrika (KM)* or Champion Communities will allow CBOs and FBOS to extend their reach. This expansion will result in increased vaccination rates in the target communities, improved nutritional status (through nutritional supplementation including vitamin A and exclusive breastfeeding), reduced mortality resulting from malaria, diarrhea and pneumonia (through health education and provision of LLITNs, ACT, ORS/zinc and cotrimoxazole), and better management of childhood illnesses (through the introduction of community IMCI). The contractor shall also expand training of physicians and other health professionals in clinic-based IMCI. ASBCs will also educate women about the dangers of malaria in pregnancy and will have tools and materials to encourage pregnant women to go to the CSBs early in their pregnancy for their complete package of pre-natal care, including IPTp and an LLIN.

*Expected Results:*

- Key MCH (including malaria) indicators increase annually in USAID focus communes
- Community-based services that improve maternal and child health are expanded to 500 new communes, and they achieve and sustain champion commune status
- Nutrition of women and children under 5 is improved and the percentage of women exclusively breastfeeding up to six months and providing appropriate complementary feeding from six to nine months is increased
- Home-based management of childhood diseases (especially for diarrheal disease, Acute Respiratory Infections, and Malaria) is effectively implemented in focus communes;
- Focus Communes implement activities to delay the onset of sexual activity among youth, reduce unintended adolescent pregnancies and illegal abortion, and introduce community-based approach to emergency obstetric care activity
- Pre and in-service training of health professionals use State of the Art (SOTA) information for care of women and children;
- Guidelines are regularly up-dated and disseminated throughout the MOHFP system;
- SOTA guidelines in post-partum care are developed and disseminated; and
- Effective coordination and synergies with social marketing, PL480 Title II and other USAID funded programs as well as with the Ministry of Education, the Ministry of Decentralization, WASH and other partners increases the demand for and access to clean water and sanitation and improve practices.

**Indicators:**

*HPN PMP Indicators:*

- Proportion of infants under 6 months who are being exclusively breastfed. Exclusive breastfeeding is the practice of giving only breast milk to the infant, with no other solid or liquids, including water.
- Proportion of caretakers (of children aged 0-59 months) who can state at least two recommendations for home case management of diarrhea
- Number of communes in which the Implementing Partners with funding from the Public Sector bilateral project has signed a contract to achieve health objectives using KM approach
- Proportion of households with treated (including chlorine, boiling, filtering etc) water prior to consumption in the last 24 hours of the survey
- Threshold reached of proportion of CSBs in which main IMCI content areas noted on clinic patient form
- Threshold reached of proportion of CSBs with functional cold chain. Percentage of selected CSBs with a functioning cold chain during the last 6 months in USAID-assisted communes.

*OP Indicators:*

- Liters of drinking water disinfected with USG-supported point-of-use treatment products
- Number of cases of child diarrhea treated in USAID-assisted programs
- Number of children less than 12 months of age who received DPT3 from USG-supported programs
- Number of children under 5 years of age who received vitamin A from USG-supported programs
- Percentage of children between 12-23 months of age who received their third dose of DPT by age 12 months in USAID-focus communes
- Percentage of children in USAID-focus communes between 12-23 months of age who received vitamin A supplement during the last six months before the survey
- Number of people trained in child health and nutrition through USG-supported health areas programs
- Number of children reached by USG-supported nutrition programs

**Result Two: Family Planning and Reproductive Health—Expand access to high-quality voluntary family planning (FP) services and information, and reproductive health (RH) care thus reducing unintended pregnancy and promoting healthy reproductive behaviors of men and women, reducing abortion, and reducing maternal and child mortality and morbidity**

**Summary:** With USAID support, the family planning program is showing remarkable success. The 2006 HPN outcome survey in intervention in rural communes reveal a contraceptive prevalence rate (CPR) of 20.7% compared to the national CPR of 16% in rural areas. A 2006 national population based survey showed the CPR at 24% in 2006 while the same 2004 survey showed 18.8%. In 2006, the MOHFP increased the number of facilities providing family planning in the public sector from 80% to 89%. Further, the MOHFP developed a national communication strategy and media campaign along with innovative clinic and community level

communication packages. Best practices have been identified and piloted in a number of communes and the MOHFP has plans to expand these approaches nationally. In spite of this success much remains to be done to improve contraceptive security, extend quality family planning services to remote rural areas and vulnerable populations and meet the unmet need for family planning.

The USAID-supported family planning program includes a full range of support at the national, district and community levels. USAID-funded programs will continue to increase demand for and access to family planning services and products through a variety of initiatives. Special focus will be given to expanding social marketing activities deeper into rural communities in order to extend the reach of essential health products further into the countryside. USAID will also continue to strengthen the public sector commodity management and distribution system. USAID will also continue efforts to take proven best practices to scale including the pregnancy check list, systematic screening, and community-based distribution of Depo-Provera. Technical assistance will be provided to the MOHFP to ensure that family planning remains a national priority, including strengthening the capacity of the MOHFP to develop, implement and evaluate programs.

USAID will continue to support and strengthen civil society organizations and faith-based organizations involved in family planning and maternal health service delivery, as well as those organizations which would like to begin offering these services to its constituents. Interventions with these groups will enable USAID to build upon ongoing, successful relationships with both the non-profit and for-profit Malagasy private sector and may provide opportunities to develop Global Development Alliance (GDA) initiatives to improve the health and well-being of Madagascar's poorest communities.

The Contractor shall provide technical assistance to the MOHFP to improve quality of services through competency-based approaches in pre-service training institutions and in-service training opportunities and revising norms, standards and guidelines as new information and techniques become available to ensure programs continue to offer quality services. To reduce the high reported unmet need for contraceptives, the Contractor shall implement activities that reach the non-served population to increase demand for and access to services and products by this group. The Contractor shall work with selected District Medical Officers (DMOs) who are interested in trying innovative means to deliver family planning services, e.g. identifying outstanding ASBCs who could, with additional training, manage satellite service posts and/or supervise other ASBCs, thus extending family planning services further into rural communities. The Contractor will build on existing materials, experiences and best practices to integrate literacy training at the commune level using key Family planning, maternal, and reproductive health, messages in the curriculum to reinforce the other community-based efforts. The Contractor shall introduce a pilot community-based emergency obstetrical care activity as an additional strategy to further reduce the maternal mortality rate.

With more than 60% of the population under 24, and teenage pregnancies on the rise, a special effort is required to reach adolescent men and women in rural areas. The contractor shall implement activities that reach out to rural youth in their communities and address their reproductive needs and concerns. The Contractor shall coordinate with the USAID-funded social marketing project's program that addresses concerns of urban youth and enables ASBCs to sell family planning and other health products as part of their community health activities.

The Contractor shall extend and link its community outreach and system strengthening activities to achieve results for this Element with those of PSI, PL-480 Title II, Voahary Salama and other

field support activities. This will require close coordination in both planning and implementation. Finally, some of the sites selected for community level activities will be joint sites for health and environmental activities that will build on and improve activities with Voahary Salama, and conservation partners.

*Expected Results:*

- Nationally, and in USAID focus communes, contraceptive prevalence is increased to 34% by 2011 and unmet need is decreased by 15%
- Stock out of depo-provera and other contraceptives and supplies is reduced (or maintain current 2%) at public sector service sites;
- Effective coordination with the USAID social marketing program expands the distribution and marketing of socially-marketed products in focus communes ;
- Community-based family planning and reproductive health services are expanded to *fokontany* in 500 communes that achieve champion commune (KM) status.
- MOHFP focuses on competency-based approaches in pre-service and in-service training
- MOHFP develops and disseminates policies, norms, guidelines and standards as necessary
- Capacity of the MOHFP to develop, implement and evaluate programs strengthened
- Community-based obstetric and neo-natal care activities implemented in selected communes

***Indicators:***

*HPN PMP Indicators:*

- Proportion of women in union age 15-49 who are using (or partner using) a modern method of contraception. Modern methods include oral contraceptives, injectables, implants, male condoms, IUD, male and female sterilization, vaginal foaming tablets (CPR)
- Effectiveness of the Public Sector and CS programs in ensuring a sufficient stock of injectable contraceptives (Depo Provera) in supported facilities over the 12 months (NB. Contractor only responsible for public sector portion of this indicator)
- Threshold reached of proportion of CSB with Health Care Providers (HCP) who appropriately cite the main FP counseling steps.

*OP Indicators:*

- Couple years of protection (CYP) in USG-supported programs
- Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs
- Percent of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs

**Result Three: Malaria—Reduce malaria related mortality through support for implementation of PMI, related malaria control programs and malaria research activities**

**Summary:** Malaria is a major cause of morbidity and mortality in Madagascar and the government considers control of malaria one of its highest priorities. Madagascar is the

recipient of three malaria grants with a total of \$53 million from the GFATM, most of which has been dispersed. With support from WHO, UNICEF, and other national and international partners, a scaling up of malaria prevention and control interventions has already started and considerable progress has been made.

In December 2006, Madagascar was selected as one of eight countries to begin receiving funding during the third year of the President's Malaria Initiative (PMI). The objective of this initiative is to assist African countries, in collaboration with other partners, to rapidly scale up to 85% coverage of vulnerable groups with four highly effective interventions: artemisinin-based combination therapy (ACT), intermittent preventive treatment for malaria in pregnancy (IPTp), insecticide-treated mosquito nets (ITNs), and indoor spraying with residual insecticides (IRS).

This contract plays a key role in the implementation of the Malaria Operational Plan<sup>11</sup> (MOP) for Madagascar and the Contractor is a key partner of the GOM in malaria control. The Contractor shall extend commune-based malaria control activities. These activities shall be tightly integrated with the KM approach and expanded through ASBCs, NGOS and local organizations. In addition the Contractor shall work in collaboration with CDC and other USAID programs to strengthen the NMCP in the areas of M&E, surveillance and supportive supervision. In conjunction with CDC and other PMI programs, the Contractor shall provide support to 12 RBM indicator sentinel sites. The Contractor shall play a key role in promoting positive behaviors at the national and community levels by taking the lead in harmonizing IEC/BCC messages and implementing community-based prevention and care (especially within the KM approach and grants under contract program).

Furthermore, the Contractor will assist the government by assuring the implementation of ACTs through training and supportive supervision at all levels. In all aspects of implementation, the Contractor shall coordinate and collaborate closely with all other PMI implementation partners as well as with other Roll Back Malaria partners including the principal recipients of the GFATM malaria grants.

*Expected Results:*

- Increased percent of pregnant women and children under 5 who slept under an ITN the previous night
- Increased percent of pregnant women that receive their second dose of sulfadoxine-pyrimethamine (SP) to prevent malaria in pregnancy
- Children under five years of age with suspected malaria receive treatment with ACT within 24 hours of onset of their illness at a MOHFP facility
- High quality appropriate community/household-based malaria prevention and care is extended to communities in 500 communes.
- Increased number of ASBCs are providing quality malaria prevention and care education and services using approved packet of materials;
- ACTs and RDTs are consistently available at community level and in government health facilities for treatment of uncomplicated malaria
- Stock-outs of ACTs, SP and RDTs at 2% or less in public sector health facilities
- Twelve sentinel sites functioning correctly and providing quality, timely information to NMCP

---

<sup>11</sup> The MOP for Madagascar can be found at [http://www.fightingmalaria.gov/countries/madagascar\\_mop-fy08.pdf](http://www.fightingmalaria.gov/countries/madagascar_mop-fy08.pdf)

- NMCP M&E system providing timely information to MOHFP and all PMI partners
- Effective coordination with RBM partners and with USAID-funded programs expands demand and access to malaria prevention and care at the community and health center level.

**Indicators:**

*HPN PMP Indicators:*

- Proportion of pregnant women sleeping under an ITN the previous night
- Proportion of children under five sleeping under an ITN the previous night

*OP Indicators:*

- Number of ITNs distributed that were purchased or subsidized with USG support
- Number of people trained in malaria treatment or prevention with USG funds
- Number of Insecticide Treated Nets (ITNs) distributed or sold

*MOP Indicators:*

- Proportion of pregnant women receiving 2 doses of IPTp
- Proportion of households with at least one ITN
- Proportion of pregnant women sleeping under an ITN the previous night
- Proportion of children under five sleeping under an ITN the previous night
- Proportion of government health facilities that have ACTs available for treatment of uncomplicated malaria
- Proportion of children under five with fever in previous 2 weeks treated with ACT within 24 hours of onset of symptoms

**Result Four: Water Supply and Sanitation—Ensure broadly accessible, reliable and economically sustainable water and sanitation services for health, security, and prosperity.**

**Summary:** Diarrheal diseases are the primary causes of mortality and morbidity among children under five years of age in Madagascar. Ensuring sufficient quantities of water for domestic use, the safety of water quality to be used for drinking and food preparation, effective sanitation, and improved hygiene practices are critical to reducing diarrhea. Diarrheal disease takes its greatest toll in rural areas, where 88% of the population lack access to potable water, and for most households, the water supply is a river, lake, or pond. Nationwide, 52% of households get their drinking water from surface sources and 14.2% from non-protected wells. Increasing access to clean water is a national priority under the MAP. Even in those parts of Madagascar with ample annual rainfall, seasonal fluctuations and inadequate contamination protection of source water can lead to periodic shortfalls in water supply.

USAID's comparative advantage in this sector lies in demonstrating effective approaches, leveraging additional resources, and providing limited direct support for improved water, sanitation, and hygiene promotion at the local level. At the national level, USAID works at creating synergies among the various ministries and WASH partners with responsibilities for provision of clean water and hygienic infrastructure. The Contractor shall develop and

implement a plan to enhance cooperation among these ministries to ensure effective implementation of the WASH strategy. The Contractor shall address this issue at the local level through its community mobilization activities, KM approach, community norm change, and hygiene promotion activities. The Contractor will build on existing materials, experiences and best practices to integrate literacy training at the commune level using key maternal, child health, and hygiene messages to reinforce the other community-based education. USAID Development Assistance funds to increase access to water and sanitation, if available, will be used to support infrastructure (wells, and latrines) in the USAID focus communes. To the extent possible, the Contractor shall work closely with other donors that are building water and hygiene infrastructure (Unicef, EU, BAD) to create synergies so that communities are also exposed to hygiene education and behavior change interventions where they are also benefiting from the infrastructure. Also, USAID's Title II program works with CBOs, FBOs and NGOs to rehabilitate existing community irrigation systems, install wells and dams, build latrines at schools and reinforce hygiene at the community level. Therefore, the contractor shall plan activities under this element in consultation with the Mission's Title II program recipients. In addition, the contractor shall provide technical assistance to regional WASH activities through training, planning, and support of hygiene improvement (safe water, sanitation, and hand washing promotion) for both local governmental bodies as well as NGOs.

*Expected Results:*

- Plan to enhance cooperation between MOHFP, other relevant ministries such as Education, Energy and Mines and Decentralization and other WASH partners for the implementation of the WASH Strategy developed and executed
- Enhanced availability of water for household and personal consumption and hygiene in target communities through effective coordination with USAID AG/Trade and Title II activities
- Collaboration with local and international NGOs and CBOs to promote and implement the national behavior change strategy leading to the adoption of hygienic and sanitation practices by local communities
- WASH-friendly structures such as CSBs, schools and markets promoted and implemented

***Indicators:***

*HPN PMP Indicators:*

None.

*OP Indicators:*

- Number of people in target areas with access to improved drinking water supply as a result of USG assistance
- Number of people in target areas with access to improved sanitation facilities as a result of USG assistance

**Result Five: HIV/AIDS—Reduce the transmission and impact of HIV/AIDS through support for prevention, care and treatment programs.**

**Summary:** Madagascar has an advantage over other countries in Sub-Saharan Africa in that all indications are that it remains in the early stages of the epidemic. Prevalence is estimated to be less than 1% in the general population, signaling that the primary focus must remain on prevention efforts among high risk groups<sup>12</sup>. USAID will build on previous Mission achievements and its comparative advantage in targeted behavior change interventions and behavior change communications, community mobilization, capacity-building and improved collection and use of data for decision-making. The focus will be on identifying creative opportunities to reach out further to high-risk populations that may be underserved. USAID will continue to support the National HIV/AIDS Strategic Framework to ensure that the high-risk populations have appropriate knowledge and access to high-quality and effective services for prevention and care of STIs and HIV.

Youth will continue to be a particularly important focus for STI/HIV prevention efforts in Madagascar, where more than 60 per cent of the population is under the age of 24. Most HIV infections occur among youth in their teens and twenties. For this group, USAID assistance will emphasize making it important to establish a norm of safe behavior among adolescents which includes delay of sexual debut as well as safe sex behavior, including reduction of partners and correct and consistent use of condoms. Targeted BCC initiatives will address youth in their communities through the efforts of the CSBs, the ASBCs, schools, youth clubs, churches and CBOs and will build on successful programs, such as the Ankoay Scout, School and Sports program and the associated Red Card campaign (see Annex C for background on these programs).

Targeted BCC activities for high risk populations, increased public awareness about STIs, and improved availability of quality STI services and products in rural areas will also need to be increased to reach the at-risk adult population. As with the adolescents, the program will work through the CNLS, MOHFP, Ministry of Education, other ministries, churches, the media, CBOs and FBOs emphasizing reduced number of partners and safe sex practices. Public sector capacity-building at the national, district and community levels will also be key to reducing risk and preventing infection.

The Contractor's major interventions shall be based on strategic approaches that take into account CNLS and MOHFP policy, cultural and institutional constraints. The Contractor shall provide targeted technical and organizational support to the CNLS. The Contractor shall improve HIV surveillance and data collection, monitoring and evaluation at the national and district levels and assist the CNLS to use the best data available, including USAID-funded operations research, World Bank assessments, and other surveys, as well as surveillance data to improve program performance. The Contractor shall provide technical assistance for the implementation of a strong STI control program and will support the integration of HIV/STI prevention activities into FP, VCT, PMTCT, MCH and PMI programs. The Contractor shall scale up the on-going collaborative efforts with the private sector, such as mining and oil companies and private physicians.

---

<sup>12</sup> While HIV prevalence is still relatively low among high risk groups, such as sex workers, it is more than double that of pregnant women. These groups also have significantly higher rates of STI infection (syphilis is almost three times more prevalent among sex workers than pregnant women).

*Expected results*

- Increased in the age of first sexual encounter – more youth reporting delaying the onset of sexual activity;
- Increased numbers of sexually active youth and target groups that report not having sex with a non-regular, occasional partner in the last 12 months
- Increased numbers of sexually active youth and high risk groups that report having used a condom with their last occasional partner
- Churches and FBOs have established community advocacy programs and education programs with community leaders promoting positive health behaviors with respect to STI/HIV prevention and reproductive health.;
- Innovative behavior change programs such as ANKOAY, Red card and others are scaled up nationally
- Strategic linkages built with the social marketing program to further extend STI prevention and control in rural areas to lower STI incidence rate among youth and other vulnerable groups;
- Increased number of women in focus areas are tested early in their pregnancies for STIs; and
- Pre and in-service health training institutions continue to up-date curricula to include latest findings and strategies to combat STIs and HIV/AIDS
- Reduced stock-out of key STI/HIV drugs and commodities;
- STI/HIV prevention is effectively integrated with family planning programs
- The CNLS and MOHFP effectively use data to improve STI/HIV control programs;

**Indicators:**

*HPN PMP Indicators:*

- Percentage of people in USAID-focus communes who report not having had sex with a non-regular, occasional partner in the last 12 months
- Percentage of people in USAID-focus communes who report having used a condom in their last sexual relation with a non-regular partner

*OP Indicators:*

- Percentage of people in USAID-focus communes who report not having had sex with a non-regular, occasional partner in the last 12 months
- Percentage of people in USAID-focus communes who report having used a condom in their last sexual relation with a non-regular partner
- Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful
- Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
- Number of individuals reached through community outreach that promotes STI/HIV/AIDS prevention through abstinence and/or being faithful
- Number of individuals reached through community outreach that promotes STI/HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

### **III. SUPPORTING INFORMATION**

#### **Roles and Responsibilities of the Parties**

##### **1. Contractor's Roles and Responsibilities**

###### **a) Overall project management**

As mentioned above, the program is divided into a Core Program and an Expanded Program. (See Annex A) Under the Core Program, the Contractor shall implement the activities described in the Statement of Work.

The Contractor shall be responsible for managing and coordinating the different grantees/partners to ensure efficient use of USAID resources. The Contractor shall be responsible for ensuring that all contract staff create and maintain effective working relations with host country counterpart agencies, partner institutions, international and national NGOs, donor organizations, and USAID; work in a collaborative and inclusive team oriented manner; and interact effectively with others in the accomplishment of tasks. The Contractor's performance will be assessed on its ability to develop partnerships and promote teamwork that ensures a more effective contribution to the attainment of results related to the Core program elements and activities.

###### **b) Staffing Requirements**

###### **(1) Long-term staff and Key Personnel**

The Contractor shall provide local technical, administrative, and logistical staff required for the effective implementation of this program. This contract is limited to four (4) international positions. Of the four international positions, Chief of Party and Head Finance/Administrative Officer are Key Personnel and mandatory positions.

###### ***Chief of Party***

The Chief of Party (COP) will be authorized to represent the Contractor in all matters pertaining to the execution of all contract activities, with the possible exception of contract issues and amendments, for which authority shall be delegated according to the discretion of the Contractor. The COP shall serve as the Contractor's representative in Madagascar for all purposes of the contract, and shall be responsible for the activities of all long- and short-term personnel under the contract. The COP shall work with the USAID Mission to respond to any contractual questions and formal contractual obligations. The COP shall be responsible for the overall planning, implementation and management of the project and to establish the administrative framework to monitor and assure progress toward the achievement of the goals and objectives of the project.

### **Head Administrative/Financial Officer**

The Head Administrative/Financial Officer is a full-time position. S/he shall oversee logistical and administrative management for the contract. In addition, s/he shall be responsible for the overall management of the Grants Under Contract component and any local sub-contracts that arise in conjunction with this solicitation. The Head Administrative/Financial Officer shall be responsible for the budgeting process, procurement, inventory, forecasting and financial reporting. S/he shall work directly with the COP to ensure that the Contractor's organization functions efficiently in all financial and administrative matters and that adequate internal control is maintained.

#### **(2) Short-Term technical assistance**

The Contractor shall provide professional short-term TA as necessary for successful performance under the contract.

#### **(3) Home Office Support**

The Contractor shall provide for corporate headquarters supervision, support, and quality control efforts under the contract including the provision for sourcing information and technical expertise to support the field team.

#### **c) Partnership, Coordination and Collaboration**

The Contractor will work closely with the key Malagasy and international agencies to ensure that all activities are collaboratively programmed as part of the overall USAID Health-funded program. It is essential that the Contractor specifically collaborate and coordinate closely with the agencies of the GOM, local and international NGOs, international donors, and specifically other Expanded Health Program implementing partners. The Contractor shall work closely with these organizations to assure achievement of the activities under the specific Program Elements.

**Linkages and Leveraging with Other Donors:** The USAID program is also integrated within the overall context of the Ministry of Health's Sector Development Plan and the CNLS's National HIV Strategic Plan. The World Bank's health program support to the MOH, nutrition program, and multi-sectoral AIDS project (PMPS) are important resources as well as the Global Fund to Fight AIDS, TB, and Malaria. UNICEF, WHO, UNAIDS, UNFPA, and World Food Program are some key partners. The EU, French, German, and Japanese Cooperation will also be providing support to the health sector. Contractors shall link their activities to these other Donor programs to assure synergy and complementarity of activities. The ability to leverage additional funds will be important to the overall program success in achieving impacts on a larger scale.

**Integration with Government of Madagascar Programs and Priorities:** This program should be viewed as a support mechanism for GOM and other health programs in Madagascar, as well as an integral component of the overall HPN program, and not as a stand-alone USAID "mega-project."

#### **d) Procurement of Commodities**

The Contractor will be responsible for the procurement of any and all equipment, office space and commodities necessary to implement the contract and which are not elsewhere specified as USAID procurement. To the extent practical, the Contractor will utilize the existing project equipment, vehicles and office space. All procurement of goods shall be executed in accordance with USAID regulations. Also, the Contractor shall be responsible for proper warehousing, inventory, and reporting requirements for all commodities under the contract. USAID has limited, fairly old household furniture and appliances for the authorized expatriate staff under their contracts; the Contractor shall be responsible for the procurement of any new furniture or appliances they deem needed. Lists of available equipment and furnishings can be found by clicking on the link for background documents on the HPN page of the USAID/Madagascar web site: <http://www.usaid.gov/missions/mg/program/health.html>.

### **2. USAID Responsibilities**

#### **a) USAID-funded Health Program Coordination**

USAID/Madagascar assumes the responsibility for overall coordination of USAID-funded health activities. Collaboration among the Contractor and other USAID-funded implementing partners, and other activities of relevance to the health program, will be fostered through:

- Active participation in coordination mechanisms established by the MOHFP and GOM;
- A regular coordination forum in which all USAID implementing partners come together to share progress and problems, discuss issues of common concern, identify areas for joint action, and update action plans;
- Joint, local level planning, implementation, and monitoring of USAID implementing partners and other Mission Teams, Contractors and partners; and
- Communication and sharing of information among partners.

Management of the contract will be the responsibility of the Health Team Leader. The Team Leader, plus other Health Team members as needed, will assist the Contractor's staff in program implementation. This assistance will include processing matters through USAID for decision, and assisting implementing partners (and USAID) to obtain compatibility in information and reporting requirements. USAID will help facilitate the Contractor's relationship with the GOM and relevant donor institutions other than USAID.

#### **b) Logistical and Administrative Support for Long-Term TA Staff**

USAID will obtain necessary paper work for customs clearance and visas for the Contractor's personnel as they are required to be covered under the USAID bilateral agreement. Specifically, USAID will:

- Assist in customs clearance and entry into Madagascar of all commodities as well as household effects and personal vehicles for long-term TA staff; and
- Obtain long-term residence and exit visas for long-term technical advisors and their dependents.

### 3. GOM Responsibilities

The Ministry of Finance and Budget (MFB) will continue to be responsible for the overall coordination of activities under this contract. The MFB will be responsible for assuring that performance criteria are met. The MOHFP will have primary responsibility for oversight of health-related activities implementation. The MOHFP, the National AIDS Coordinating Committee (CNLS), Medical, Public Health, Nursing, and paramedical schools, National Reference Laboratory, the National Malaria Campaign Program, Voahary Salama and SALAMA will be the key health partners.

USAID and the Contractor will participate in the annual programming processes with both the MOHFP and the CNLS at the national, regional, and local levels, and in joint donor program reviews where appropriate. The GOM has the following mechanisms to ensure oversight, monitoring, and coordination of the activities under the bi-lateral Assistance Agreement:

- *The Ministry of Health and Family Planning* will lead the overall coordination of activities under the bi-lateral Assistance Agreement and will have overall program coordination responsibility for primary health care, maternal, child, and reproductive health, family planning, infectious diseases, surveillance, and certain HIV/AIDS activities. The MOHFP leads the national population related activities including demand creation and coordination for all local and international NGOs. The MOHFP will organize meetings with USAID Health Team to review technical progress. The MOHFP will also ensure active leadership of, and participation by, concerned partners in key technical working groups (Roll Back Malaria, Interagency Coordination Committee, Intersectoral Nutrition Action Group, Reproductive Health Commodity Security, and others). The MOHFP will also facilitate and coordinate national performance and evaluation activities with all partners and donors. MOHFP will also actively participate in the TAC. It is expected that the MOHFP will also provide authority and capital to the Centralized Procurement Organization "SALAMA" to ensure the functionality of SALAMA for essential drug management and distribution.
- *The CNLS* is chaired by the President of the Republic with the Minister of Health and Family Planning as the Vice President and the Executive Secretary as the Operational Manager. CNLS is made up of GOM, National Assembly, NGO, civil society, and private sector participants responsible for providing high-level policy and strategic guidance for the program. CNLS will have overall program coordination responsibilities for National HIV/AIDS prevention program.
- *Ministry of Youth* is also an important GOM ministry critical to USAID Health Team activities, especially work in adolescent reproductive health and HIV/AIDS prevention. The Ministry of Youth should be an active TAC participant and facilitate and coordinate nation-wide activities with youth organizations.
- *Ministry of Education* will facilitate and coordinate national child-to-child and child-to-community activities with implementing partners and donors. The Ministry will also coordinate the WASH activities, the Ankoay program and Red Card campaign.
- *Ministry of Energy* houses the multi-sectoral National WASH Committee; their Potable Water and Sanitation Department (DEPA) is responsible for the development and construction of water pumps and latrines

- *Voahary Salama* is a network of indigenous civil society (CBOs, FBOs and NGOs) charged with the responsibility of advocating for the integration of health, population and environment activities. It is becoming a strong advocacy group which articulates the integrated development needs of local communities to the GOM.

## **Annex A Core and Expanded Program**

The achievement of the HPN Health Program results will be accomplished through a variety of instruments. The following provides an illustration of the support that may be provided through the Core and Expanded Program in support of the total HPN Program. The Public Sector Support Prime Contractor under the Core Program will support the integrated nature of the health activities and create effective linkages with the Social Marketing grantee and the Expanded Program activities, as well as with other elements of USAID's development program.

### **A. Core Program**

#### ***Public Sector Support***

One prime contractor will be selected to implement activities for achievement of the activities outlined in the Statement of Work described in the body of this document. The new bi-lateral contractor will be USAID's primary support to the GOM under the new Bi-Lateral Assistance Agreement. The contractor will implement a full range of integrated, proven reproductive and maternal and child health efforts that will have an ultimate impact on Madagascar's high fertility, malnutrition, and children under 5 and maternal mortality rates. Through this support, USAID will deploy technical assistance and funds to increase demand, quality, and availability of high-impact services and products for child, maternal, and adolescent health, family planning and reproductive health, HIV/AIDS, diarrhea diseases, and malaria prevention and control. Key approaches will be implemented on the national and community levels. Primary partners will include MOH, SALAMA, CNLS, the National Malaria Control Program, Voahary Salama and select communes and indigenous CBOs, FBOs and NGOs.

#### ***Social Marketing***

USAID currently has a social marketing grantee that carries out social marketing and promotion activities of select health products, subsidized commercial retail sales and community-based distribution. These activities will be continued under a new USAID Cooperative Agreement. The Social Marketing products include contraceptives, condoms, pre-packaged treatment kits for malaria and sexually transmitted infections, insecticide-treated mosquito nets, and water treatment solution. The successful model of a franchised network of private medical practitioner promoting and providing reproductive health services for youth may be expanded under the new Cooperative Agreement.

### **B. Expanded Program**

A variety of contractors and cooperating agencies will be selected to implement additional programs and activities that complement the Core Program. These activities are designed to be complementary, mutually reinforcing and non-duplicative.

#### **1. U.S. Food Aid Programs (Title II and Disaster Assistance)**

Once the Title II Food Aid programs for October 1, 2009-September 30, 2013 have been approved, USAID intends that significant resources additional to the Operational Year Budget will be invested to support the health program from the Title II program. The health segment of

Title II activities contributes to the achievement of the HPN Objective. These activities will be implemented through two mechanisms. The first mechanism is the direct transfer of food commodities; the second mechanism is the monetization of food commodities to generate local currency to implement health, agriculture, and disaster response food security projects.

## **2. Field Support Activities**

### ***Procurement of Health Commodities and Contraceptives***

USAID, over the past five years, has provided 80% of the public sector contraceptives with UNFPA supporting the remaining contraceptives. In 2007 the GOM allocated, for the first time, significant funds from its own budget for family planning commodities. USAID has also provided 100% of the socially marketed contraceptive products. The GOM, other partners and USAID are working together to develop multi-year contraceptive procurement plans. Subject to the availability of funds, USAID will continue to procure some of the contraceptives for the public sector and for sales through social marketing in order to increase access and availability to family planning and help achieve GOM and USAID/Madagascar's family planning objectives. It is anticipated that the MOHFP and other donors will increasingly support the contraceptive procurement as the contraceptive prevalence rate increases.

### ***Surveillance and Data for Decision Making***

Polio surveillance activities are supported in collaboration with the CDC. USAID may also provide short-term technical assistance to improve and reinforce Expanded Program of Immunization, malaria, and HIV/AIDS surveillance. This assistance may also support public and private sectors in managing and utilizing data for rapid and responsive decision making, including technical assistance for complementary analysis of existing and emerging data from national surveillance reports and surveys (i.e. 2005 census, 2003 and 2008 DHS, and 2005 Multiple Indicator Cluster Survey).

### ***Hygiene Improvement Project (HIP)***

HIP (Hygiene Improvement Project) Madagascar is a USAID-funded, three-year project (2005-2008) whose goal is to bring about sustainable improvement in three key hygiene practices that are shown to be effective at reducing diarrheal diseases: hand washing, safe feces disposal and safe storage and treatment of water at Point-of-Use (POU). Scale is reached when substantial numbers of people in an area adopt and sustain these key hygiene practices. Working in collaboration with the Madagascar National WASH (Water Sanitation and Hygiene) committee, HIP developed a community-based Behavior Change Strategy, a PAFI (Small Doable Important Actions) guide with illustrations, and training modules for a range of partners and audiences. HIP also compiled a catalogue of Behavior Change approaches and materials for water sanitation and hygiene products used and available in Madagascar. In partnership with WASH members and to contribute to the MAP (Madagascar Action Plan) goals, HIP is scaling up the "WASH friendly" school concept and is developing the "WASH friendly" health center concept (CSB Amis de WASH).

### ***Reproductive Health Grant Solicitation Mechanism (GSM)***

The Reproductive Health GSM (also called the Flexible Fund) supports community-based family planning activities that serve marginalized populations and strengthen the capacity of PVO/NGOs to implement effective family planning programming. To achieve the purposes, the

GSM has established a grant program that supports PVO/NGO programs that increase family planning use and improve FP/RH practices in communities. These community-based family planning programs:

- contribute to the reduction of unintended and mistimed pregnancies among women of reproductive age
- address the family planning needs of clients throughout their reproductive years (not only addressing the needs of women to delay the next pregnancy for only a short time following birth)
- provide a variety of methods and refer clients to providers for additional methods or services, and
- provide clients with information on all methods

### ***BASICS***

BASICS provides technical assistance to the MOHFP and the child health partners, including UNICEF and WHO, for community case management of diarrhea, introduction of zinc in the treatment of diarrhea, and integration of nutrition and management of childhood illness. Specifically, BASICS supports the development and implementation of approaches and tools to introduce community case management of pneumonia, diarrhea diseases and malaria, for the introduction of zinc in the treatment of diarrhea in health facilities, and for improved effectiveness of growth promotion interventions. BASICS, working with partners such as RPM+, will continue to build in-country capacity at the central level by working with a group of nationals from various departments of MOH, training institutions and cooperating partners, including NGOs.

### ***The President's Malaria Initiative (PMI)***

A myriad of Cooperating Agencies (CAs) have been selected to participate in the implementation of the PMI. These will provide technical assistance, procurement of LLINs for the private sector, operations research, strengthen the entomology capabilities of the NMCP, procurement of RDTs, and monitoring of drug quality. These activities are in addition to the activities described under Result 2 of the Statement of Work.

## **3. USAID Globally Funded Programs**

### ***Child Survival and Health Grants Program***

USAID Global Health child survival grants, subject to the availability of funds, may be able to continue to provide support for community-based health improvements. Communities that may be selected will serve as sites from which to expand services to surrounding communities.

### ***Reproductive Health "Repositioning" Family Planning Funds***

USAID/Washington has created a Reproductive Health Fund to support the government efforts to position FP as a national priority and extend community-based family planning and reproductive health interventions. This activity complements the Mission's approach to high-impact health interventions. USAID/Madagascar has had success in extending FP to poor, remote, bio-diverse areas.

***Support for Health, Population and Environment (HPE) Approach***

Three U.S. conservation organizations have received funding to implement reproductive health, family planning, and child survival activities in bio-diverse regions of Madagascar. These activities complement and support achievement of the health program, particularly in the area of creating “demand for family planning and health services in bio-diverse areas expanded.” Should funds continue to be available, USAID will explore continuing to use this mechanism.

**Annex B**  
**Kominina Mendrika Approach**  
**SantéNet**

The Government of Madagascar is currently implementing a rapid and sustainable development policy that is in line with the national Poverty Reduction Strategy Paper (PRSP) that aims at directly benefiting local communities. At the community level, innovative partnerships between the public and private sectors are being formed to carry out important efforts in community mobilization.

One example of a dynamic public-private partnership is the Champion Community approach which is used to mobilize community leaders, groups and individuals in a community that will lead to positive social, economic, and cultural development.

***The Champion Community Approach is a platform for all sectors of development***

The Champion Community Approach seeks to integrate four key development sectors to improve community well-being: 1) environmental protection, 2) health improvement, 3) economic development, and 4) good governance.

Development sectors are completely interdependent and need to be integrated to produce the best possible synergy while promoting rapid and sustainable development. The development of the rural economy, for example, is highly dependent on the availability and sound management of human and natural resources. In turn, the population needs to be healthy to be productive and natural resources rely on rational management to ensure availability and quality. At the same time, good governance in a community ensures commitment to and investment in natural resource management and health services.

The Champion Community Approach serves as a platform for the integration of these crucial development sectors. It calls for close collaboration between local and international partners and stakeholders to reach as many communities as possible throughout Madagascar.

**Mobilizing all actors in the community**

Finding solutions to development challenges in a community requires the engagement of all key actors. The Champion Community Approach seeks to mobilize all community actors to achieve common goals and common objectives. An ACTOR is an individual or a group of individuals that voluntarily commits itself to carry out actions for achieving pre-defined objectives to become a Champion Community.

***Achieving common development objectives in the community***

Champion Community actions are defined through a participatory process which establishes development objectives and corresponding indicators, based on needs identified by the community and on the analysis of data available at the community level. The set of objectives and indicators that serve as Champion Commune criteria are negotiated directly with the community by local partners. These must be specific, realistic, and achievable. The key is to define OBJECTIVES that require a significant but also reasonable level of effort from the community.

### **Changing behaviors through Important-Doable-Actions**

The approach is based on important-doable-actions with tangible and measurable results which foster sustainable behavioral change. An ACTION is any form of participation by an individual or a group that facilitates, supports or promotes the achievement of the predefined objectives.

*A community becomes a Champion Community when it demonstrates that it has achieved the predefined objectives by implementing important, doable and measurable actions.*

### **Implementation cycle of the Champion Community Approach**

The approach is implemented through a 10-step cycle with a variable timeframe based on the development sector:

- Step1: Introduction of the approach in the community and definition of the indicators and objectives;
- Step2: Signature of the commitment contract with the community;
- Step 3: Training of community-based agents and launch of community-based activities;
- Step 4: Monitoring of activities round 1;
- Step 5: Supervision and technical/organizational support round 2;
- Step 6: Monitoring of activities round 2;
- Step 7: Supervision and technical/organizational support round 3,
- Step 8: Monitoring of activities round 3;
- Step 9: Evaluation of community performance against their pre-defined objectives; and
- Step 10: Festival to award the Champion Community status and prize (if they met their objectives).

### ***Champion Community's four-star system encourages multi-sectoral development***

At the end of this implementation cycle, the Community is awarded the Champion Community status if it has achieved the objectives in the development sectors targeted during the cycle. This earns it the status of "One-Star Champion Community." The community can then continue or expand its activities to a different sector, using the same approach to define objectives relative to the sector. Upon realizing these objectives, the community may continue its activities and earn stars from the remaining sectors, eventually becoming a "Four-Star Champion Community". Each star is given a specific color to represent the corresponding development sector: green for environmental protection, blue for health improvement, gold for economic development, and white for good governance

### ***The Champion Community Approach tools***

Three toolkits are available to implementing partners for community-based activities:

- ***The Marketing kit:*** includes print materials that increase visibility of the approach in the community, to motivate community-based agents and to facilitate the approach's implementation.
- ***The Mass Media Communication kit:*** includes audio materials like songs, fables, sketches and promotional spots targeting local radio to support community mobilization and awareness-raising activities and to reinforce key messages.
- ***The Interpersonal Communication kit:*** includes materials to assist trainers and community-based agents to facilitate introductory activities, negotiate objectives with local

communities, conduct training sessions, awareness-raising campaigns, behavior change communication activities and monitoring and evaluation activities.

## **Annex C HIV Youth Prevention Activities**

### ***Ankoay***

In cooperation with the President's Emergency Plan for AIDS Relief, USAID/Madagascar is funding an initiative to curb the trend of high-risk behavior among Malagasy youth. Known as the *Ankoay* or eagle initiative, the program educates youth about HIV/AIDS and teaches them how to become community leaders in HIV/AIDS prevention by promoting behaviors such as abstinence. To encourage participation among young people, groups compete as teams to earn the distinction of Ankoay status. The teams are required to complete a series of life skill exercises, a peer education program, and community outreach activities.

The Ankoay initiative incorporates a diverse mix of educational methods, which speak to a variety of learning styles and personality types. To successfully complete the program, youth groups work through twenty highly participatory activities, developing skills such as decision-making, goal-setting, and effective communication. One of these activities is designed to promote individual reflection — the "Youth Passport" includes a role play kit containing scenarios of typical situations youth encounter. As youth act out the dramas included in the booklet, they connect emotionally to vital issues in a safe environment. Once a youth group reaches Ankoay status, it assumes a role of community leadership in the fight against AIDS and celebrates its success with a festival. Media broadcast the news around the country, generating enthusiasm for the program.

The program was designed for youth between the ages of 15 and 18. Originally launched in 2005 through the federation of Malagasy scout troops, the program has expanded to include other youth groups, sports teams, and schools. The Ankoay project is now considered a HIV prevention model for youth by Madagascar's National AIDS Committee.

### ***Red Card Campaign***

A new initiative, called the 'Red Card' campaign, was made possible by the success of the Ankoay Scout, School and Sport programs. In this initiative, girls are given red cards and encouraged to use them to say 'stop' in risky situations, and to start conversations about normally taboo subjects. The Red Card is a low-cost, easily scalable AIDS prevention tool. Launched in October 2006, the Red Card campaign has attracted enormous support and interest among young women. Lessons learned and additional insights gained during the first eight months of the Red Card campaign have contributed to a greater understanding of the card's potential. A part of the Ankoay peer education component, the campaign was supported by mass media; four Red card TV spots were aired on three Malagasy TV stations. The spots created a huge "buzz" around in the country as indicated by the national AIDS hotline now receiving 70–80 calls a day requesting Red cards. Trainings are continuing around the country. The National AIDS Prevention committee has requested that the Health Communication Partnership, which assisted with the Red Card launch submit a grant request to print one million cards. Due to the success of the program, it has leveraged financial support from other partners such as UNICEF, WB MAP project and the African Development Bank.

**END OF SECTION C**

## **SECTION D – PACKAGING AND MARKING**

### **D.1 AIDAR 752.7009 MARKING (JAN 1993)**

(a) It is USAID policy that USAID-financed commodities and shipping containers, and project construction sites and other project locations be suitably marked with the USAID emblem. Shipping containers are also to be marked with the last five digits of the USAID financing document number. As a general rule, marking is not required for raw materials shipped in bulk (such as coal, grain, etc.), or for semifinished products which are not packaged.

(b) Specific guidance on marking requirements should be obtained prior to procurement of commodities to be shipped, and as early as possible for project construction sites and other project locations. This guidance will be provided through the cognizant technical office indicated on the cover page of this contract, or by the Mission Director in the Cooperating Country to which commodities are being shipped, or in which the project site is located.

(c) Authority to waive marking requirements is vested with the Regional Assistant Administrators, and with Mission Directors.

(d) A copy of any specific marking instructions or waivers from marking requirements is to be sent to the Contracting Officer; the original should be retained by the Contractor.

### **D.2 BRANDING**

The Contractor shall comply with the requirements of the USAID “Graphic Standards Manual” available at [www.usaid.gov/branding](http://www.usaid.gov/branding), or any successor branding policy.

As required under ADS 320.3.2.2, The Contractor must comply with the attached approved Branding implementation plan and marking plan.

**END OF SECTION D**

## **SECTION E - INSPECTION AND ACCEPTANCE**

### **E.1 TASK ORDER PERFORMANCE EVALUATION**

Task order performance evaluation shall be performed in accordance with Population, Health, and Nutrition Technical Assistance and Support Contract (TASC 3 – Global Health) IQC, Section E.2

**END OF SECTION E**

## **SECTION F – DELIVERIES OR PERFORMANCE**

### **F.1 PERIOD OF PERFORMANCE**

This task order is effective from July 25, 2008 through July 24, 2013.

### **F.2. DELIVERABLES**

See Section C for full information and definitive listing. All of the evaluation findings, conclusions, and recommendations shall be documented in the Final Report. All written deliverables shall also be submitted electronically to the CTO. Bound/color printed deliverables may also be required, as directed by the CTO.

### **F.3 TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS**

*Victoria D. Ghent*  
Supervisory Regional Contracting Officer  
U.S. Agency for International Development  
*USAID/Souther Africa*

Telephone: 27-12-452-2166  
Fax: 27-12-452-2399  
Email: VGhent@usaid.gov

The Cognizant Technical Officer (CTO) will be designated separately.

The CTO address is:

Health Population and Nutrition Office (HPN)  
USAID/Madagascar  
B.P. 5253  
6<sup>th</sup> Floor Zital Tower  
ZI Taloumis, Ankorondrano  
Antananarivo 101  
Madagascar

### **F.4 PLACE OF PERFORMANCE**

The place of performance under this Task Order is Madagascar, as specified in the Statement of Work.

### **F.5 AUTHORIZED WORK DAY / WEEK**

No overtime or premium pay is authorized under this Task Order.

6 day workweek for short-term assignments is authorized.

## **F.6 REPORTS AND DELIVERABLES OR OUTPUTS**

In addition to the requirements set forth for submission of reports in Sections I and J, and in accordance with AIDAR clause 752.242-70, Periodic Progress Reports, the Contractor shall submit reports, deliverables or outputs as further described below to the CTO (referenced in Sections F.2 and G). All reports and other deliverables shall be in the English language, unless otherwise specified by the CTO.

### **4. Reports and Work plans**

#### **a) Monitoring and Evaluation Plan**

The Contractor shall develop and implement a Monitoring and Evaluation (M&E) Plan which supports the Mission Monitoring and Evaluation System. The monitoring and evaluation plan for each program element shall provide qualitative and quantitative performance measure on specific results, processes, and health and behavior changes.

The M&E plan shall be submitted to the USAID TOCTO within 30 days of the approval of the workplan in a format to be provided by USAID/HPN. To the extent possible the M&E plan will be integrated into, and enhance, existing MOHFP management systems. The M&E plan shall be updated and revised as appropriate in collaboration with USAID. USAID implementing partners, Contractors, and Malagasy counterpart agencies will work together to achieve the results using the performance measures and other appropriate measures as determined. All performance measures shall contribute to monitoring the overall impact of activities and results for achieving the strategic objective.

The Contractor, in collaboration with USAID Expanded Program implementing partners and local counterpart agencies, shall work together to achieve the results using available scientifically sound methodologies and techniques, so that reported information respond to reliable criteria and universally accepted data quality standards. This monitoring system (indicators and planned targets) shall be finalized based on discussions between the Contractor and USAID.

#### **b) Annual Implementation Plans**

The Contractor shall submit detailed Annual Implementation Plans, with detailed cost information to the TOCTO for approval. These plans shall be consistent with the USAID/HPN Strategy. Annual Implementation Plans shall include, at a minimum, the following:

- A table of activities to be implemented organized by the four Program Objectives;
- An indication of USAID and GOM partners to be involved in the planning or execution of activities;
- The timeframe for activities by quarter;
- The pipeline and expenditures information to date and projected expenditures for the coming period.

The first Annual Implementation Plan will cover the period October 2008 - September 2009 and is due 60 calendar days after award. The subsequent Annual Implementation Plans will cover the period October - September and are due by August 31.

### **c) Program Reporting**

Monitoring/Performance reports will be required on a semi-annual basis to coincide with USAID's fiscal year calendar. The first semi-annual report will cover the period from the signature of the Task Order till September 2008. Subsequent semi-annual reports will cover the six-month period ending in March. Semi-annual reports are due 30 calendar days after the reporting period. The first Annual Performance Report will cover the period October 2008-September 2009, and subsequent reports will cover the twelve-month periods ending in September. Annual Performance Reports are due 60 calendar days after the reporting period.

The Final Performance Report will cover the entire period of the award. The Final Performance Report is due 90 calendar days after the expiration or termination of the award.

#### **(1) Semi-annual Performance Reports**

The Contractor shall submit an original and two copies of the Semi-annual Performance Reports in English and an original and two copies in French to the Task Order Cognizant Technical Officer (TOCTO), with a diskette or CD of the report and annexes in Microsoft Word and/or Excel. The Contractor shall also submit one copy of the Semi-annual report to the TO Contracting Officer. The Semi-annual reports shall contain information on the following:

- A summary of actual activities and results during the reporting period compared with the plan established for the reporting period (may be presented in table format);
- An explanation of why results were not achieved, or were surpassed, and of why activities were delayed or not carried out during the reporting period, if appropriate;
- Information on participant training, as specified below in Participant Training Reports;
- Success stories, if any, including examples of synergy and collaboration with partners;
- Activities planned, indicating expected results for each Result specified (may be presented in table format);
- Unit cost information developed by relating financial data to performance data whenever practical. The reported information shall include, on an accrual basis, a comparison of outlays with budgeted amounts; and
- Other pertinent information related to program progress.

The TOCTO will acknowledge receipt of and provide verbal or written feedback, within 30 days after receipt, on all Semi-annual Performance Reports. If the TOCTO deems necessary, the TOCTO will schedule a meeting with the Contractor to discuss the contents of Semi-annual Performance Reports.

#### **(2) Annual Performance Reports**

The Contractor shall submit an original and two copies in English and an original and two copies in French of the Annual Performance Report to the Task Order Cognizant Technical Officer with a diskette or CD of both versions of the report and annexes in Microsoft Word and/or Excel. The Contractor shall also submit one copy of the annual report in English to the TO Contracting Officer and one electronic copy in English to the USAID Development Experience Clearinghouse. The Contractor is also required to send the TOCTO proof of **receipt** by CDIE of the submitted document within 10 calendar days of submission. The Contractor shall follow-up with CDIE and confirm that CDIE has received the document. Annual Performance Reports replace the last Quarterly Performance Report of each fiscal year.

The annual reports shall contain the following information:

- A summary of activities and results achieved during the year compared with the activities and results planned for the year (may be presented in table format);
- An explanation of why targets were not achieved or were surpassed and of why activities were delayed or not carried out during the year.
- Progress made toward achieving targets for achievement indicators (based on valid data collection and analysis);
- Success stories, if any, including examples of synergy and collaboration with partners.
- An annual budget indicating anticipated expenditures, the actual funding situation, and required funding for the year ahead;
- Unit cost information developed by relating financial data to performance data whenever practical. The reported information shall be an expansion of the details provided in block 12. "Remarks" of the SF 269 "Financial Status Report" to include, on an accrual basis, a comparison of outlays with budgeted amounts; and
- Other pertinent information related to program progress and results.

The TOCTO will acknowledge receipt of and provide written feedback, within 30 days after receipt, on all Annual Performance Reports. In addition, the TOCTO will organize a meeting with the Contractor to discuss the contents of the Annual Performance Report.

### **(3) Final Performance Report**

The Contractor shall submit an original and two copies in English and an original and two copies in French of the Final Performance Report to the Task Order Cognizant Technical Officer with a diskette or CD of both versions of the report and annexes in Microsoft Word and/or Excel. The Contractor shall also submit one copy of the final report in English to the Contracting Officer and one electronic copy in English to the USAID Development Experience Clearinghouse. The Contractor is also required to send the TOCTO proof of **receipt** by CDIE of the submitted document within 10 calendar days of submission. The Contractor shall follow-up with CDIE and confirm that CDIE has received the document. The Final Performance Report replaces the last Annual Performance Report and shall contain the following information:

- A comparison of actual activities and results with the plan established for the life of the program (may be presented in table format);
- Reasons why targets were not achieved or surpassed and why activities were delayed or not carried out, if appropriate;
- Success stories, if any, including examples of synergy and collaboration with partners.
- A summary of progress made in achieving indicator targets during the program (based on valid data collection and analysis);
- Unit cost information developed by relating financial data to performance data whenever practical. The reported information shall be an expansion of the details provided in block 12. "Remarks" of the SF 269 "Financial Status Report" to include, on an accrual basis, a comparison of outlays with budgeted amounts; and
- Other pertinent information, including recommendations and lessons learned, related to overall program results.

#### **d) Research, Studies, and Survey Documents**

The Contractor shall submit an original and two copies in English of the terms of reference and of the reports for all research, studies and survey documents to the Task Order Cognizant Technical Officer (TOCTO). An original and two copies in French of the same documentation should be submitted when determined necessary by the TOCTO. After receiving written acceptance from the TOCTO, the Contractor shall also submit one electronic copy of the reports in English to the USAID Development Experience Clearinghouse. This should be done within 30 calendar days of receiving written acceptance from the CTO. The Contractor is also required to send the TOCTO proof of **receipt** by CDIE of the submitted document within 10 calendar days of submission. The Contractor shall follow-up with CDIE and confirm that CDIE has received the document.

#### **e) Participant Training Reports**

The Contractor shall collect information on all participant training financed under this contract. This includes training data for any in-country training program or sub-program of more than 3 consecutive class days in duration, or more than 15 contact hours scheduled intermittently. This training data must be recorded using the web-based "TraiNet" reporting system. The training data must be consolidated according to training program or sub-program and must identify the following:

- (1) subject area of training;
- (2) total trainees per participant group, with gender breakdown;
- (3) total cost of training for each program; and
- (4) direct training costs (program costs, not overhead/fees).

The Contractor shall enter and submit the participant training information on a semi-annual basis as part of the Semi-annual Performance Report, specified above in "Semi-annual Performance Report." Simultaneously, the Contractor shall also submit one copy of the participant training information on a diskette or CD directly to the Mission Program Officer. Contact the Mission Program Officer for further information about site registration and use of TrainNet.

### **F.7 AIDAR 752.7005 SUBMISSION REQUIREMENTS FOR DEVELOPMENT EXPERIENCE DOCUMENTS (JAN 2004) (AAPD 04-06)**

(a) Contract Reports and Information/Intellectual Products.

(1) The Contractor shall submit to USAID's Development Experience Clearinghouse (DEC) copies of reports and information products which describe, communicate or organize program/project development assistance activities, methods, technologies, management, research, results and experience as outlined in the Agency's ADS Chapter 540. Information may be obtained from the Cognizant Technical Officer (CTO). These reports include: assessments, evaluations, studies, development experience documents, technical reports and annual reports. The Contractor shall also submit to copies of information products including training materials, publications, databases, computer software programs, videos and other intellectual deliverable materials required under the Contract Schedule. Time-sensitive materials such as newsletters,

brochures, bulletins or periodic reports covering periods of less than a year are not to be submitted.

(2) Upon contract completion, the Contractor shall submit to DEC an index of all reports and information/intellectual products referenced in paragraph (a)(1) of this clause.

(b) Submission requirements.

(1) Distribution.

(i) At the same time submission is made to the CTO, the Contractor shall submit, one copy each, of contract reports and information/intellectual products (referenced in paragraph (a)(1) of this clause) in either electronic(preferred) or paper form to one of the following:

(A) Via E-mail: [docsubmit@dec.cdie.org](mailto:docsubmit@dec.cdie.org);

(B) Via U.S. Postal Service: Development Experience Clearinghouse, 8403 Colesville Road, Suite 210, Silver Spring, MD 20910, USA;

(C) Via Fax: (301) 588-7787; or

(D) Online: <http://www.dec.org/index.cfm?fuseaction=docSubmit.home>

(ii) The Contractor shall submit the reports index referenced in paragraph (a)(2) of this clause and any reports referenced in paragraph (a)(1) of this clause that have not been previously submitted to DEC, within 30 days after completion of the contract to one of the address cited in paragraph (b)(1)(i) of this clause.

(2) Format.

(i) Descriptive information is required for all Contractor products submitted. The title page of all reports and information products shall include the contract number(s), Contractor name(s), name of the USAID cognizant technical office, the publication or issuance date of the document, document title, author name(s), and strategic objective or activity title and associated number. In addition, all materials submitted in accordance with this clause shall have attached on a separate coversheet the name, organization, address, telephone number, fax number, and Internet address of the submitting party.

(ii) The report in paper form shall be prepared using non-glossy paper (preferably recycled and white or off-white using black ink. Elaborate art work, multicolor printing and expensive bindings are not to be used. Whenever possible, pages shall be printed on both sides.

(iii) The electronic document submitted shall consist of only one electronic file which comprises the complete and final equivalent of the paper copy.

(iv) Acceptable software formats for electronic documents include WordPerfect, Microsoft Word, and Portable Document Format (PDF). Submission in PDF is encouraged.

(v) The electronic document submission shall include the following descriptive information:

(A) Name and version of the application software used to create the file, e.g., MSWord6.0 or Acrobat Version 5.0.

(B) The format for any graphic and/or image file submitted, e.g., TIFF-compatible.

(C) Any other necessary information, e.g. special backup or data compression routines, software used for storing/retrieving submitted data or program installation instructions.

## **F.8. ENVIRONMENTAL COMPLIANCE**

As part of its initial Work Plan, and all Annual Work Plans thereafter, the Contractor, in collaboration with the USAID Cognizant Technical Officer and Mission Environmental Officer or Bureau Environmental Officer, as appropriate, shall review all ongoing and planned activities under this Contract to determine if they are within the scope of the approved Regulation 216 environmental documentation.

If the Contractor plans any new activities outside the scope of the approved Regulation 216 environmental documentation, it shall prepare an amendment to the documentation for USAID review and approval. No such new activities shall be undertaken prior to receiving written USAID approval of environmental documentation amendments.

Any ongoing activities found to be outside the scope of the approved Regulation 216 environmental documentation shall be halted until an amendment to the documentation is submitted and written approval is received from USAID.

When the approved Regulation 216 documentation is (1) an IEE that contains one or more Negative Determinations with conditions and/or (2) an EA, the Contractor shall:

- a) Unless the approved Regulation 216 documentation contains a complete environmental mitigation and monitoring plan (EMMP) or a project mitigation and monitoring (M&M) plan, the Contractor shall prepare an EMMP or M&M Plan describing how the Contractor will, in specific terms, implement all IEE and/or EA conditions that apply to proposed project activities within the scope of the award. The EMMP or M&M Plan shall include monitoring the implementation of the conditions and their effectiveness.
- b) Integrate a completed EMMP or M&M Plan into the initial work plan.
- c) Integrate an EMMP or M&M Plan into subsequent Annual Work Plans, making any necessary adjustments to activity implementation in order to minimize adverse impacts to the environment.

A provision for sub-grants/contract is included under this award; therefore, the Contractor will be required to use an Environmental Review Form (ERF) or Environmental Review (ER) checklist using impact assessment tools to screen grant proposals to ensure the funded proposals will result in no adverse environmental impact, to develop mitigation measures, as necessary, and to specify monitoring and reporting. Use of the ERF or ER checklist is called for when the nature of the grant proposals to be funded is not well enough known to make an informed decision about their potential environmental impacts, yet due to the type and extent of activities to be funded, any adverse impacts are expected to be easily mitigated. Implementation of sub-grant activities cannot go forward until the ERF or ER checklist is completed and approved by USAID. Contractor is responsible for ensuring that mitigation measures specified by the ERF or ER checklist process are implemented.

The Contractor will be responsible for periodic reporting to the USAID Cognizant Technical Officer, as specified in the Schedule/Program Description of this award.

**END OF SECTION F**

## **SECTION G – TASK ORDER ADMINISTRATION DATA**

### **G.1 CONTRACTING OFFICER'S AUTHORITY**

The Contracting Officer is the only person authorized to make or approve any changes in the requirements of this task order and notwithstanding any provisions contained elsewhere in this task order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other than the Contracting Officer, the change shall be considered to have been made without authority and no adjustment shall be made in the contract terms and conditions, including price.

### **G.2 TECHNICAL DIRECTION**

Health Population and Nutrition Office (HPN) shall provide technical oversight to the Contractor through the designated CTO. The contracting officer shall issue a letter appointing the CTO for the task order and provide a copy of the designation letter to the contractor.

### **G.3 ACCEPTANCE AND APPROVAL**

In order to receive payment, all deliverables must be accepted and approved by the CTO.

### **G.4 INVOICES**

One (1) original of each invoice shall be submitted on an SF-1034 Public Voucher for Purchases and Services Other Than Personal to the Controller Office, USAID/Madagascar and a copy to the CTO.

Claims for reimbursement or payment under this Purchase Order/Contract must be submitted to the Controller's Office. The Contractor must submit the SF-1034 Public Voucher for Purchases and Services Other Than Personal and SF-1034A continuation, if necessary, Attached. Each voucher shall be identified by:

- (a) Name of the vendor/contractor;
- (b) Date and invoice number;
- (c) USAID Purchase Order/Contract number;
- (d) Description, price, quantity, period of goods and services rendered;
- (e) Contact name, telephone and fax number;
- (f) Other substantiating documentation or information required by the Purchase Order/Contract. Original invoice is required.

Invoice with required supporting documents may be submitted either through paper or electronic in a Portable Document File (PDF) format through an electronic mailbox. The mailbox address is [antan-invoices@usaid.gov](mailto:antan-invoices@usaid.gov). Electronic submission (PDF format) are encouraged and do not require subsequent transmittal of original paper invoice.

The SF-1034 must be signed, and it must be submitted along with the invoice and any other documentation in Adobe.

Paper Invoices shall be sent to the following address:

Controller Office  
USAID/Madagascar  
6<sup>th</sup> Floor ZITAL Tower  
ZI Taloumis, Ankorondrano  
Antananarivo 101  
Madagascar

**END OF SECTION G**

## **SECTION H – SPECIAL TASK ORDER REQUIREMENTS**

### **H.1 KEY PERSONNEL**

The contractor shall provide the following key personnel for the performance of this task order:

- [REDACTED]
- [REDACTED]

USAID reserves the right to adjust the level of key personnel during the performance of this task order. The personnel specified above are considered to be essential to the work being performed hereunder. Unless otherwise agreed to in writing by the Contracting Officer, the contractor shall be responsible for providing such personnel for performance during the entire life of the award at the level of effort. Failure to provide key personnel may be considered nonperformance by the contractor unless such failure is beyond the control, and through no fault or negligence of the contractor. No replacement of key personnel shall be made by the contractor without the written consent of the Contracting Officer whether provided in advance or by ratification. Prior to replacing any of the specified individuals, the Contractor shall immediately notify both the Contracting Officer and USAID Cognizant Technical Officer reasonably in advance and shall submit written justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the program.

### **H.2 AUTHORIZED GEOGRAPHIC CODE**

The authorized geographic code for procurement of services under this order is 935. The Contractor must comply with the source and origin requirement for the procurement of goods.

### **H.3 LANGUAGE REQUIREMENTS**

All deliverables shall be produced in English and French. Ability to hire French and local language expertise are required when necessary for the completion of field support tasks.

### **H.4 GOVERNMENT FURNISHED FACILITIES OR PROPERTY**

The Contractor and any employee or consultant of the Contractor is prohibited from using U.S. Government facilities (such as office space or equipment) or U.S. Government clerical or technical personnel in the performance of the services specified in the Task Order unless the use of Government facilities or personnel is specifically authorized in the Task Order or is authorized in advance, in writing, by the CTO.

### **H.5 CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY**

All reports generated and data collected during this project shall be considered the property of USAID and shall not be reproduced, disseminated or discussed in open forum, other than for the purposes of completing the tasks described in this document, without the express written approval of a duly-authorized representative of USAID. All findings, conclusions and recommendations shall be considered confidential and proprietary.

## **H.6 CONTRACTOR'S STAFF SUPPORT, AND ADMINISTRATIVE AND LOGISTICS ARRANGEMENTS**

The Contractor shall be responsible for all administrative support and logistics required to fulfill the requirements of this task order. These shall include all travel arrangements, appointment scheduling, secretarial services, report preparations services, printing, and duplicating.

## **H.7 EXECUTIVE ORDER ON TERRORISM FINANCING**

The Contractor is reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the contractor/recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts/subawards issued under this contract.

## **H.8 REPORTING ON TAXATION OF U.S. FOREIGN ASSISTANCE**

(a) Reporting of Foreign Taxes. The contractor must annually submit a final report by April 16 of the next year.

(b) Contents of Report. The reports must contain:

(i) Contractor name.

(ii) Contact name with phone, fax and e-mail.

(iii) Agreement number(s).

(iv) Amount of foreign taxes assessed by a foreign government [each foreign government must be listed separately] on commodity purchase transactions valued at \$500 or more financed with U.S. foreign assistance funds under this agreement during the prior U.S. fiscal year.

(v) Only foreign taxes assessed by the foreign government in the country receiving U.S. assistance is to be reported. Foreign taxes by a third party foreign government are not to be reported. For example, if an assistance program for Lesotho involves the purchase of commodities in South Africa using foreign assistance funds, any taxes imposed by South Africa would not be reported in the report for Lesotho (or South Africa).

(vi) Any reimbursements received by the Contractor during the period in (iv) regardless of when the foreign tax was assessed plus, for the interim report, any reimbursements on the taxes reported in (iv) received by the contractor through October 31 and for the final report, any reimbursements on the taxes reported in (iv) received through March 31.

(vii) The final report is an updated cumulative report of the interim report.

(viii) Reports are required even if the contractor did not pay any taxes during the report period.

(ix) Cumulative reports may be provided if the contractor is implementing more than one program in a foreign country.

(c) Definitions. For purposes of this clause:

(i) "Agreement" includes USAID direct and country contracts, grants, cooperative agreements and interagency agreements.

(ii) "Commodity" means any material, article, supply, goods, or equipment.

(iii) "Foreign government" includes any foreign governmental entity.

(iv) "Foreign taxes" means value-added taxes and custom duties assessed by a foreign government on a commodity. It does not include foreign sales taxes.

(d) Where. Submit the reports to: Cognizant Technical Officer with a copy to the Controller.

(e) Subagreements. The contractor must include this reporting requirement in all applicable subcontracts, subgrants and other subagreements.

(f) For further information see <http://www.state.gov/m/rm/c10443.htm>.

#### **H.9 USAID DISABILITY POLICY - ACQUISITION (DECEMBER 2004)**

(a) The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website:

<http://www.usaid.gov/about/disability/DISABPOL.FIN.html>.

(b) USAID therefore requires that the contractor not discriminate against people with disabilities in the implementation of USAID programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing this contract. To that end and within the scope of the contract, the contractor's actions must demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

**END OF SECTION H**

**SECTION I – CONTRACT CLAUSES**

**Reference** *TASC3 – Global Health IQC.*

**END OF SECTION I**

**SECTION J – LIST OF DOCUMENTS EXHIBITS AND OTHER ATTACHEMENTS**

**SECTION J - LIST OF ATTACHMENTS**

<b>Attachment Number</b>	<b>Title</b>
J.1	List of available equipment
J.2	Approved Branding Implementation Plan and Marking Plan

END OF SECTION J

---

**TASK ORDER No. GHS-I-01-07-00005-00**

**RESEARCH TRIANGLE INSTITUTE**

**RTI**

**ATTACHMENT J.1.**

**LIST OF AVAILABLE EQUIPMENT**

---



**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Box spring, twin		\$176,49
Box spring, twin-791-505-T		\$176,49
Boxspring, Q		\$257,58
Boxspring, Q		\$257,58
Buffet a glass		\$1,314.94
Can garbage	1993	\$32.95
Can garbage		\$32.95
Carpet		\$65.00
Carpet		\$65.00
Carpet		\$65.00
Carpet pad		\$109.99
Carpet with pad		\$109.99
Carpet with pad		\$109.99
Ceiling, fan		\$75.55
Ceiling, fan		\$75.55
Chair	1993	\$437,89
Chair		\$437,89
Chair		\$450,00
Chair		\$450,00
Chair		\$437,89
Chair		\$437,89
Chair		\$437,89
Chair		\$450,00
Chair		\$437,89
Chair		\$450,00
Chair		\$450,00
Chair	1993	\$437,89
CHAIR		\$437,89
Chair		\$437,89
Chair		\$450,00
Chair		\$450,00
Chair		\$437,89



**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Chair, occasionnal		\$205,82
Chair, patio	1993	\$209.00
Chair, patio		\$209.00
Chair, patio - Code Bar 50253		\$209.00
Chair, porch		\$55.95
Chair, prestataire	1993	\$99.99
Chair, prestataire		\$99.99
Chair, secretarial		\$89.00
Chair, side	1993	\$175,36



**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Chair, side		\$175,36
Chair, student		\$80,99
CHAIR,SIDE		\$175,36
CHAIR,SIDE		\$175,36
CHAIR,SIDE 965-811		\$175,36
Chaise prestataire		\$99,99
Chest	1993	\$334,00
Chest		\$334,00
Chest 5 drawers	1993	\$403,66
Chest 5 drawers		\$403,66
Chest 5 drawers		\$403,66
Chest 5 drawers		\$403,66
Chest bachelor 3 drawers		\$137,14
Chest bachelor 3 drawers		\$137,14
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$137,14
Chest bachelor 3 drawers		\$137,14
Chest bachelor 3 drawers		\$137,14
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$260,86
Chest bachelor 3 drawers		\$137,14
Chest, 3 drawers		\$137,14
Chest, TV		\$452,73



**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Freezer		\$187.84
Garden pavilion		\$1,462.99
Head board, queen		\$211.66
Head board, queen		\$211.66
Head board, queen		\$211.66
Head board, twin		\$159.79
HEADBOARD TWIN 950-111		\$159.79
Headboard, Q		\$211.66
Headboard, Q		\$211.66
Heater, space		\$81.93
HUTCH		\$182.46
HUTCH		\$143.10
HUTCH		\$143.10
HUTCH		\$182.46
HUTCH		\$182.46
HUTCH		\$182.46
HUTCH		\$120.00
HUTCH		\$143.10
Ladder (6")		\$39.95
Lamp	1993	\$79.18
Lamp		\$79.18

**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Lamp		\$79.18
Lamp, floor		\$49,49
Lamp, floor		\$41.50
Lamp, table		\$41,14
Lamp, table		\$41,14
Lamp, table		\$41,14
Lamp, table		\$34,50
Lamp, table		\$34,50
Lamp, table		\$24,00
Lamp, table		\$24,00
Lamp, table		\$41,14
Lamp, table		\$34,50
Lamp, table		\$34,50
Lamp, table		\$41,14
Lamp, table		\$41,14
Lamp, table		\$34,50
Lamp, table		\$24,00
Lamp, table		\$34,50
Lamp, table		\$24,00
Lamp, table		\$34,50
Lamp, table		\$24,00
Lamp, table		\$24,00
Lamp, table		\$34,50
Lamp, table		\$34,50
LAMP,DESK		\$75.39

**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
LAMP, DESK 115A-PMM		\$75.36
Love seat		\$829.86
Manual lawn mower	17-Oct-02	\$24.45
Matress queen		\$326.82
Matress queen		Incl. In Box spring cost
Matress queen		Incl. In Box spring cost
Matress queen		Incl. In Box spring cost
Matress queen		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin	1993	Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
Matress twin		Incl. In Box spring cost
MATRESS TWIN 791-505T		Incl. In Box spring cost
Mattress, Q		Incl. In Box spring cost
Mattress, Q		Incl. In Box spring cost
Mirror		\$104.94
Mirror		\$104.94
Mirror		\$97.55
Mirror		\$97.55
Mirror		\$97.55
Mirror		\$104.94
Mirror		\$104.94
Mirror		\$97.55
Mirror		\$97.55
Mirror		\$104.94

**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Mirror		\$104,94
Mirror		\$97,55
Mirror		\$104,94
Mirror		\$97,55
Night stand	1993	\$156,23
Night stand		\$180,00
Night stand		\$180,00
Night stand		\$156,23
Night stand		\$156,23
Night stand		\$180,00
Night stand		\$156,23
Night stand		\$180,00
Night stand		\$156,23
Night stand		\$180,00
Night stand		\$180,00
Night stand		\$156,23
Night stand		\$156,23
Nightstand		\$156,23
Nightstand		\$156,23
Nightstand		\$180,00
Nightstand		\$180,00
Ottoman	1993	\$194,38
Ottoman		\$194,38
Ottoman		\$194,38
OTTOMAN		\$194,38

## HOUSEHOLD FURNITURE

Item Description	Acquisition Date (if available)	Amount \$
Ottoman		\$194,38
Pedestal		\$75.59
Radiator		\$49.95
Radiator		\$49.95
Radiator (space heater)		\$79.95
Range, electric	2001	\$665.00
Range, electric - GE		\$665.00
Range, gaz - SN 991400681		\$623.03
Recliner, chair		\$313.62
Refrigerator		\$900.00
Refrigerator		\$900.00
Refrigerator - AMANA		\$900.00
Refrigerator - SN FG94EI6Y	2000	\$594,76
Refrigerator (SN : HZ 537122)		\$594,76
Refrigerator 150L		\$600.00
Refrigerator 150L		\$600.00
Sofa	1993	\$913,38
Sofa		\$913,38
Sofa		\$913,38
Sofa		\$765.93
Sofa		\$765.93
Sofa		\$765.93
Sofa		\$913,38
Sofa - Code Bar 50259		\$913,38
Sofa : Love seat		\$829,86
Space Heater		\$81.93
Space Heater		\$81.93
Space, heater		\$81.93
Step ladder		\$39.95

**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Step ladder		\$39.95
Step ladder		\$39.95
Step ladder		\$39.95
Stove		\$55.00
Stove		\$55.00
Stove, electric (SN : DZ 19622030)		\$116.10
Table		\$83.00
Table computer - Pinewood		\$138.00
Table garden		\$34.99
Table prestataire		\$154.99
Table prestataire		\$154.99
Table prestataire		\$154.99
TABLE, COCKTAIL	1993	\$353.25
Table, coffee		\$279.64
Table, corner		\$206,60
Table, Desk		\$286,20
Table, dining		\$657,96
Table, dining		\$657,96
Table, dining		\$657,96
Table, dining		\$657,93
Table, dining (w/ 2 leaves)		\$657,96
Table, end	1993	\$170,89
Table, end		\$170,89

**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Table, end		\$170,89
Table, folding		\$149,00
Table, folding		\$149,00
Table, folding		\$149,00
Table, lamp (rond with glass)		\$201,53
Table, lamp (rond with glass)		\$201,53
Table, lamp (rond with glass)		\$201,53
Table, occasional	1993	\$109,71
Table, occasional		\$109,71
Table, patio		\$249,00
Table, patio		\$249,00
Table, patio		\$249,00
Table, round		\$229,99
Table, sofa	1993	\$271,89
Table, sofa		\$271,89
Table, sofa		\$271,89
Table, Sofa		\$228,00
Table, Sofa		\$271,89
Table, sofa		\$271,89
Table, sofa		\$271,89
TABLE,ACCESSORY 4000-87		\$204,74
TABLE,ROUND W/GLASS TOP		\$305,00
Transformer		\$131,00

**HOUSEHOLD FURNITURE**

Item Description	Acquisition Date (if available)	Amount \$
Transformer		\$131.00
Transformer 783		\$156.00
Wardrobe in pine		\$85.00
Wardrobe in pine		\$85.00
WASHER	2001	\$450.00
WASHER - SN CJ3011413		\$450.00
Washing machine		\$264.95
Water filter		\$24.99
Water filter		\$24.99
Water filter		\$24.99
Water filter DOM'EAU		\$89.92
Water heater		\$154.80
Wheelbarrow		\$29.99



**OFFICE MATERIAL AND EQUIPMENT**

Item Description	Acquisition date	AMOUNT \$	AMOUNT FMG
Vidéo Projecteur INFOCUS	3/27/2006	\$2,808.55	25,277.000
Video projector + Remote control	8/14/2004	\$1,209.00	
Video projector TOSHIBA TDPS -20	8/14/2004	\$1,209.00	
Video projector TOSHIBA TDPS -20	10/31/2004	\$1,209.00	
Filing cabinet métallique 4t - HON 4D*106*43/135		\$508.00	
Filing cabinet métallique 4t - HON 4D*106*43/135		\$508.00	
Filing cabinet métallique 5t - HON		\$1,041.00	
Filing cabinet métallique 5t - HON		\$1,041.00	
Filing cabinet métallique 5t - HON		\$1,041.00	
Filing cabinet métallique 5t - HON		\$1,040.00	
Laptop CPX DELL	HWRC20J	\$3,609.07	
Printer HP Laserjet 1100	FRH997025	\$523.07	
Refrigerator - G.E - TBE25PASK -TL579141		\$529.00	
Vehicle Ford		\$22,860.00	
Vehicle Ford Cherokee		\$21,000.00	
Vehicle Mitsubishi Rosa		\$25,000.00	

**TASK ORDER No. GHS-I-01-07-00005-00**

**RESEARCH TRIANGLE INSTITUTE**

**RTI**

**ATTACHMENT J.2.**

**BRANDING IMPLEMENTATION PLAN AND MARKING PLAN**

---

## **Annex 6: Branding Implementation Plan and Marking Plan**

---

The following Branding Implementation Plan (BIP) illustrates how RTI International will promote activities under the USAID/EZAKA Mendrika Program and describes how this new program will be named, positioned, promoted, and communicated to beneficiaries and host-country citizens to guarantee that program activity funds are appropriately understood to be “from the American people.”

### **1. Positioning**

#### **1.1 Program Name**

The formal name of this program is the *Expanding the Use of Selected Health Services and Products and Improving Health Practices in Madagascar*. If approved by USAID, the project name will be USAID/EZAKA Mendrika Program. Funding acknowledgments associated with the project name will use the phrase “from the American people” next to the USAID identity, translated into local languages of the targeted geographic regions as appropriate.

#### **1.2 Types of Branding**

Activities under this program will be implemented by RTI and its partners PSI; IntraHealth, Inc.; CARE; CRS; and DRV. The program will use full branding and the USAID tagline “from the American people,” translated into French and Malagasy as appropriate, when a product, publication, or event is positioned as exclusively from the USAID/EZAKA Mendrika Program. Placement of the USAID/Madagascar logo will follow branding guidelines to consistently mark component activities with the USAID/Madagascar identity equal in size to government partners (e.g., MOH), cofunding U.S. Government (USG) and non-USG development partners (when appropriate), and non-USG bilateral development agencies (where appropriate or applicable). Service-delivery points will follow the same marking plan, showcasing the USAID logo with the tagline “from the American people” as a co-brand to the service being delivered, in equal size as logos of Ministry partners and co-funding development agencies.

Project documents will not use the RTI logo, but will acknowledge that the document was prepared for USAID by the USAID/EZAKA Mendrika Program. In addition to USAID branding, RTI may, where applicable, also acknowledge the cooperation and participation of Malagasy private and public institutions, including Malagasy government institutions.

#### **1.3 Translation of the Branding**

The USAID identity will be used on all reports and printed materials. Program branding will carry the tagline “*du peuple américain*” in French project materials and products. The English tagline will be used for all products requiring English translation.

The RTI team will ensure that grant recipients incorporate the message that the assistance is from the American people into the narrative of all program materials targeting secondary and tertiary audiences.

## 1.4 Key Milestones to Generate Awareness that the Program Is from the American People

Illustrative milestones through which RTI could increase awareness that the American people support this program include

- Scale up of the champion commune approach in regions previously not reached by USAID assistance;
- Publishing reports or studies;
- Spotlighting innovative applications of program models and approaches;
- Highlighting success stories;
- Featuring beneficiaries as spokespeople;
- Securing endorsements from ministry or local organizations;
- Promoting final or interim reports; and
- Communicating program impact/overall results.

## 1.5 Presumptive Exceptions

Deliverable	Presumptive Exception	Rationale
All materials and activities, including interpersonal communications; participatory interpersonal behavior change communication (BCC) materials; print materials; condom social marketing materials; Internet-based communications; maps and brochures for voluntary counseling and testing (VCT)/sexually transmitted infection (STI) referrals, and print and electronic service directories that counsel target audiences on sexual behaviors or conduct.	Requested under <ul style="list-style-type: none"> <li>• ADS 320.3.2.5.c: where branding may undercut host-country government “ownership” of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, PSAs, or other communications are better positioned as “by” or “from” a cooperating country ministry, organization, or government official; and</li> <li>• ADS 320.3.2.5.f: where branding may offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities.</li> </ul>	Due to the nature of some project activities and objectives, RTI and its partners believe there may be cases where USAID will be best served by omitting the USAID identity on materials. These decisions will be made on a case-by-case basis in close collaboration with USAID/Madagascar.

---

## ***Marking Plan***

---

Proposed Marking Plan for the USAID/EZAKA Mendrika Program.

Submitted to:

Submitted by:

---

---

---

---

## 1. Proposed Marking Plan

This marking plan will include all print materials, including print advertising; press releases; promotional materials; packaging; research reports; training protocols; event banners; etc. Adjusting for nonprint materials, all broadcast media, including speeches; radio; television; and press events, will acknowledge USAID support directly, with the statement “made possible by USAID, with the generous support of the American people.”

### 1.1 Budget for Marking Plan

For the life of the project, not more than 1 percent of funds allocated to the USAID/EZAKA Mendrika Program budget will be earmarked for costs to comply with the final Marking Plan, as approved by USAID.

### 1.2 Public Communications, Commodities, and Project Materials that Will Be Marked

The following public communications, commodities, and project materials will be produced as part of activities implemented under the USAID/EZAKA Mendrika Program and will visibly bear the USAID identity, as indicated in *Exhibit 6-1*. This list is not comprehensive; new types of communications and project materials may be needed and, when prepared, will be marked in a manner consistent with that proposed below for similar materials. The USAID identity will be equal in size and prominence to any other logos present upon the material (as detailed in the BIP), discounting the white frame of the USAID identity.

#### Exhibit 6-1. Labeling of Public Communications, Commodities, and Project Materials that Will Be Marked with the USAID Identity

Description of Communications, Commodities, and Project Materials	How Labeled	Where Labeled	Comments on Labeling
<b>1. Public Relations Events</b>			
Press releases	USAID identity	Bottom-left	Where appropriate and agreed upon with the USAID/Madagascar and/or partnering agency (USG, non-USG, etc.), USAID identity and agency logo will be of equal prominence
Handouts	USAID identity	Bottom-left	Where appropriate and agreed upon with the USAID/Madagascar and/or partnering agency (USG, non-USG, etc.), USAID identity and agency logo will be of equal prominence
Speeches	Introductions will include the statement: “This Project was made possible with the generous support of the American people through the U.S. Agency for International Development”		

Description of Communications, Commodities, and Project Materials	How Labeled	Where Labeled	Comments on Labeling
<b>2. Media Campaigns</b>			
Fact sheets and other handouts	USAID identity	Bottom-left	Where appropriate and agreed upon with the USAID/Madagascar and/or partnering agency (USG, non-USG, etc.), USAID identity and agency logo will be of equal prominence
	Partner <sup>1</sup> logo(s) (if applicable)	Bottom-right	
Paid newspaper advertisements (e.g., “open calls” for response to RFA)	USAID identity	Bottom-left	
Posters	USAID identity	See note in next column	Posters always will be marked, but exact placement will vary by activity (e.g., will depend on the number of partners/logos, photos, and other design factors)
	Partner logo(s) (if applicable)		
TV spots	USAID identity; audio tagline, “This activity is made possible by USAID”	Audio tagline at the end of the spot; also see note in next column	TV spots always will be marked, but exact placement will vary depending on the subject and the design
Radio spots	Audio tagline, “This activity is made possible by USAID”	At the end of the spot	Where appropriate and agreed upon with the USAID/Madagascar and/or partnering agency (USG, non-USG, etc.), USAID identity and agency logo will be of equal prominence
CDs and CD labels	USAID identity	Printed on left side of label or CD face	Space may not allow for the full project title on this item
DVDs and DVD labels	USAID identity	Printed on left side of label or DVD face and within the video	Videos always will be marked, but exact placement will vary depending on the subject and design. Designers will negotiate marking for videos on a case-by-case basis. Space may not allow for the full project title on some DVDs
<b>3. Workshops for Organizations Involved in Training</b>			
Invitations to events	USAID identity	Bottom-left	Where appropriate and agreed upon with the USAID/Madagascar and/or partnering agency (USG, non-USG, etc.), USAID identity and agency logo will be of equal prominence
	Partner logo(s) (if applicable)	Bottom-right	
Banners	USAID identity	Top-left, large, above project title	For reasons of space, photo placement, or aesthetics, designers may need to negotiate placement on a case-by-case basis. Both USAID identity and partner logos will have equal prominence
	Partner logo(s) (if applicable)	Top-right, large, above project title	

<sup>1</sup> “Partner” refers to other donors or entities that either have approved branding and marking (B&M) implementation plan from USAID or contributed technically and/or financially to the completion of the activities.

<b>Description of Communications, Commodities, and Project Materials</b>	<b>How Labeled</b>	<b>Where Labeled</b>	<b>Comments on Labeling</b>
<b>Handouts and training instructions</b>	USAID identity	Bottom-left on front of handout	For reasons of space, photo placement, or aesthetics, designers may need to negotiate placement on a case-by-case basis
	Partner logo(s) (if applicable)	Bottom-right on front of handout	
<b>Certificates</b>	USAID identity	Bottom-left on front of certificate	For reasons of space or aesthetics, designers may need to negotiate placement on a case-by-case basis
	Partner logo(s) (if applicable)	Bottom-right on front of certificate	
<b>4. Partner Public Recognition and Award Ceremonies</b>			
<b>Invitations to events</b>	USAID identity	Bottom-left	For reasons of space or aesthetics, designers may need to negotiate placement on a case-by-case basis
	Partner logo(s) (if applicable)	Bottom-right or bottom-center	
<b>Banners</b>	USAID identity	Top-left, large, above project title	For reasons of space, photo placement, or aesthetics, designers may need to negotiate placement on a case-by-case basis
	Partner logo(s) (if applicable)	Bottom-right or bottom-center	
<b>Certificates</b>	USAID identity	Bottom-left on front of certificate	For reasons of space or aesthetics, designers may need to negotiate placement on a case-by-case basis
	Partner logo(s) (if applicable)	Bottom-right on front of certificate	
<b>5. Partner-produced materials (e.g., newspaper publications, banners, textbooks for education programs, teacher training materials, and community health training materials)</b>	USAID identity Partner logos	All items produced with USAID funding will be marked, with placement to be determined on a case-by-case basis	USAID may determine that marking is not appropriate for some partner-produced materials. In general, co-branding will appear at the bottom of printed public documents and at the end of any TV or radio messages. For items that receive USAID funding, the project and USAID will review and approve all final copy, including marking placement, before printing/final production
<b>6. Equipment</b>	Sticker: USAID identity	Placement will depend on the item. The sticker will be featured prominently on equipment. Stickers will be added to any unmarked equipment that is transferred to USAID/EZAKA Mendrika Program from other USAID projects	As negotiated with USAID, items of very small value will not be marked (e.g., if the cost of the stickers and the labor to apply them would exceed the cost of the item). Stickers also will not be applied if not practicable (e.g., would not adhere, would be destroyed by heat or water, etc.)

Description of Communications, Commodities, and Project Materials	How Labeled	Where Labeled	Comments on Labeling
7. Project sites where health, nutrition, or education activities are conducted with USAID funding	USAID identity Partner logo(s)	Sign, banner, or plaque prominently displayed outside building or room. Size will be determined based on location. Placement of relevant logos will be negotiated on a case-by-case basis, based on the number of partners involved and the size of the sign, banner, or plaque	

### 1.3 Project Deliverables That Will Be Marked

The following project deliverables will be produced as part of this TASC3 task order and will visibly bear the USAID identity, as indicated in *Exhibit 6-2*.

**Exhibit 6-2. Labeling of Project Deliverables Marked with the USAID Identity**

Project Deliverables	How Labeled	Where Labeled	Comments on Labeling
Project reporting documents	USAID identity	Top-left corner of the cover of each report. The reports also will bear the appropriate disclaimer for partner-produced materials	
Technical reports for external distribution (partners and alliance members)	USAID identity Partner logo(s) (if applicable)	All items will be marked, with placement to be determined on a case-by-case because of potential variations in the number of logos. The project and USAID will review and approve all final copy, including marking placement, before printing/final production. The reports also will bear the appropriate disclaimers for partner-produced materials	USAID may determine that marking is not appropriated for some partner-produced materials
Equipment associated with grants (if any)	Sticker: USAID identity	Placement will depend on the item. The sticker will be featured prominently on equipment	Consumable items and items of very low monetary value (as negotiated with USAID) will not be marked
Training materials at workshops	USAID identity Partner logo(s) (if applicable)	Bottom-left on front of materials Bottom-right on front of materials	For reasons of space, photo placement, or aesthetics, designers may need to negotiate placement locations on a case-by-case basis

Project Deliverables	How Labeled	Where Labeled	Comments on Labeling
Public announcements at workshops	Verbal acknowledgment, translation of “Made possible with the generous support of the American people through the U.S. Agency for International Development in partnership with ____ (i.e., government organization, donor partner, etc.)”	At the beginning and end of each workshop	