ANNUAL PROGRAM STATEMENT (APS) NUMBER : APS-386-13-000006

HEALTH SYSTEMS STRENGTHENING, QUALITY IMPROVEMENT, AND RMNCH+A SCALE-UP

Issuance Date of Draft APS:	May 22, 2013
Deadline for Questions:	June 05, 2013
Concept Papers Due:	June 26, 2013 midnight, India time
Full Applications Requested:	July 19, 2013 (by invitation only)
Full Applications Due:	August 31, 2013 midnight, India time

This program is authorized in accordance with Part I of the Foreign Assistance Act of 1961, as amended

The United States Agency for International Development Mission India (USAID/India) seeks applications from *local organizations*[1] registered in India that are eligible to receive funding directly from USAID for "Health Systems Strengthening, Quality Improvement, And RMNCH+A Scale-Up" Projects. This APS provides prospective Applicants an opportunity to submit applications to USAID/India for a range of programs and services for vulnerable populations especially women and children.

This Annual Program Statement (APS) will be open for a period of up to 12 months from the issuance date of **May 22, 2013,** until such time as funding identified for this APS has been fully obligated. USAID/India invites eligible organizations to submit brief concept papers of no more than five (5) pages, including an illustrative budget of no more than one (1) page, that demonstrate innovative approaches to addressing one or more of the following program areas: 1) Human Resources for Health; 2) Health Care Financing; 3) Engaging the Private Sector in Reproductive, Maternal, New-born, Child, and Reproductive Health (RMNCH+A) Care; 4) Quality Data for Decision Making; 5) Scaling Up Interventions in Reproductive, Maternal, Neonatal, Child, and Adolescent Health; 6) Increased quality of RMNCH+A and tuberculosis services.

Applicants are welcome to submit more than one concept paper for each program area of the application for which they have programmatic expertise as described in Section B. Each concept

[1] *Be organized under the laws of the recipient country;*
- *Have its principal place of business in the recipient country;*
- *Be majority owned by individuals who are citizens or lawful permanent residents of the recipient country or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of a recipient country; and*
- *Not be controlled by a foreign entity or by an individual or individuals who are not citizens or permanent residents of the recipient country.*

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paper must stand alone and only address one program area. However if an applicant wishes to combine two or more program areas into one concept paper this must also be a stand-alone concept paper in addition to the individual concept paper(s) for the individual program areas. Concept papers must be received by the closing date and time specified in this cover letter. **Facsimile submissions are not authorized and will not be accepted.** Concept papers must be received by the closing date and time specified in this cover letter. **Facsimile submissions are not authorized and will not be accepted.**

The application process is comprised of two steps: (1) concept papers are sought from prospective Applicants; and (2) full applications are requested from those Applicants with the most highly evaluated concept papers. A Cooperative Agreement will be awarded to each successful applicant.

Pursuant to 22 CFR 226.81, it is USAID policy to not award fee or profit under assistance instruments. As such, any for-profit organization receiving an award under this APS will not be eligible for fee or profit; however, all reasonable, allocable, and allowable expenses, both direct and indirect, that are related to the grant program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organizations, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations) may be recognized.

USAID reserves the right to make a single award, make multiple awards, fund parts of an application, or not to make any awards at all. Issuance of this APS does not constitute an award commitment on the part of the U.S. Government (USG), nor does it constitute a commitment to pay for costs incurred in the preparation and submission of an application. In addition, final award of any resultant Agreement cannot be made until funds have been fully appropriated, allocated, committed and obligated through internal USAID procedures, on which condition this APS is issued. While it is anticipated that these procedures will be successfully completed, potential Applicants are hereby notified of these requirements and conditions for award and that Applicants will not be compensated for any proposal preparation and submission costs. The USG reserves the right to reject any or all applications received. This APS may be amended at the discretion of USAID.

The preferred method of distribution of USAID procurement information is via www.Grants.gov on the World Wide Web (www). This APS and any future amendments can be downloaded from the Agency website. To access the Agency website from Grants.gov: Click "Find Grant Opportunities," then click "Browse by Agency" and choose "Agency for International Development." If you have difficulty registering or accessing the Grants.gov website, please contact the Grants.gov Contact Center at 1-800-518-4726 or via e-mail at support@grants.gov for technical assistance. Receipt of this APS through Grants.gov must be confirmed by written notification to the contact person noted below. It is the responsibility of the recipient of the application document to ensure that it has been received from Grants.gov in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion processes.

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TABLE OF CONTENTS

SECTION I
PROGRAM DESCRIPTION

A. BACKGROUND

A.1 Overview of Health Systems Challenges and Opportunities in India

India is a country of contrasts. As a rising economy, it has become a defining force in geopolitics and the global economy, and is South Asia's dominant regional power. It has the world's fourth largest economy in purchasing power parity terms, helping to lift millions of Indians out of poverty. Yet, there are many significant development challenges on the horizon for India. With one-sixth of the world's population and one-third of the world's poor, equitable economic and social progress in India is critical to achieving the Millennium Development Goals (MDGs). Despite India's sufficient food grain stocks, it ranks 65th out of 79 countries in the Global Hunger Index[2]. And, while the economy continues to grow, human rights and the ability of vulnerable populations to access services continues to be weak.

Approximately 1.9 million children die before their fifth birthday every year in India. The sex ratio at birth and gender differential in under-five mortality continues to be skewed against girls. About 67,000 mothers die each year due to complications during pregnancy and childbirth. About 30 million couples have an unmet need for contraception. Nearly half of all Indian children are undernourished. Tuberculosis (TB) remains the most common disease in India, killing more than 1,000 people a day. India's urban poor are exceptionally vulnerable to many health risks as a consequence of appalling living conditions, which lead to poor health indicators. Some of the children who are particularly vulnerable in the Indian context are the approximately four million children affected by HIV/AIDS.

There have been some notable areas of progress in particular areas of reproductive, maternal, newborn, and child health (RMNCH); particularly increasing the proportion of institutional-based deliveries through demand-side financing, and also in reducing the incidence of polio, having completed a second year without a single case of polio after being one of the major contributors to the global polio case count. In spite of these significant achievements, India still faces significant challenges in achieving MDGs 4 and 5, related to maternal and child health. The major challenge pertains to reducing the Infant Mortality Rate (IMR) from 44 (SRS 2011) to less than 30 and the Maternal Mortality Ratio (MMR) from 212 (SRS 2007–2009) to less than 100 by 2015.

The size and magnitude of India's health problems make partnerships with Indian organizations to end preventable maternal and child deaths and create an AIDS-free generation, critical U.S. Agency for International Development (USAID)/India priorities. These priorities are also core goals for the Government of India (GOI) as outlined in initiatives such as the National Rural Health Mission (NRHM). The original focus of the NRHM on rural populations has resulted in strengthening program management structures and implementation of new activities and schemes at the state and district levels. In addition to this, numerous civil society and private sector

[2] The Global Hunger Index (GHI) is a multidimensional statistical tool that describes the state of countries' hunger situation. The 2012 GHI was calculated for 120 developing countries and countries in transition. 79 countries were ranked and their food security situation was compared to 1990 levels. The remaining 41 countries had a 2012 GHI of under 5 ("low hunger") and were not included in the ranking.

organizations have intensified their efforts for developing and implementing innovative health pilots, some of them demonstrating impressive success, albeit at a limited scale at which most of these are implemented. The limited impact of these interventions can be attributed to the fact that pilots are often not scaled up to their full potential. The GOI faces numerous challenges in scaling up proven high-impact RMNCH interventions[3] due to variable capacity of states, districts, blocks and facilities in planning and implementation. For the private sector to scale up high-impact RMNCH interventions, commercial viability is a pre-requisite. Civil society networks cover a very small proportion of women and children and many lack resources or incentives for scaling up. And, the success of these interventions to be implemented at scale meeting desired quality standards is largely dependent on important health systems components, such as an effective health workforce, appropriate engagement of the private sector, financial access to healthcare, and use of reliable data for decision making at all levels.

B. GOAL, OVERALL APPROACH, AND RESULTS

B.1 USAID/India's Health Sector Priorities

The health system in India is highly complex and is at a cross-road. On the one hand, India's health system continues to respond to preventable infections, pregnancy and childbirth, and under-nutrition, while on the other hand, it increasingly must address the enormous burden of non-communicable diseases such as heart diseases, diabetes, and mental illness. The focus of USAID/India's support is to catalyze India's effort to complete the primary and preventive health care agenda and reduce morbidity and mortality in support of India's efforts toward Millennium Development Goals (MDGs) 1, 4, 5, 6 and 7. This Annual Program Statement (APS) is USAID/India's invitation to local Indian organizations to identify and suggest ways to catalyze, facilitate, and support interventions, development solutions, innovations, and partnerships to support improvements in the health of vulnerable populations in India. Specifically, this APS is to improve specific critical elements of the health system to increase access to and quality of priority reproductive, maternal, new-born and child health (RMNCH) services at scale to respond to: 1) the Government of India's Call for Action Child Survival and Development to accelerate child survival and development, and, 2) USAID's global goals to end preventable maternal and child deaths.

Activities funded under this APS will support system improvements to make substantial contributions to:

Maternal Health

- Reduction in maternal mortality ratio
- Reduction in anemia among girls (15-19 years)

Child and Newborn Health

- Reduction in under-5 mortality rate

[3] *Proven, high-impact RMNCH interventions are many, for example including a mix of adolescent girl and maternal health, newborn health, child health, family planning, and cross-cutting facility-based interventions. These might include, but are not limited to, basic and comprehensive emergency obstetric and newborn care, immediate essential new born care, newborn resuscitation, management of preterm/low birth weight newborns, newborn screening and management, case management of pneumonia and diarrhea, post-partum family planning spacing methods, and prevention and management of healthcare-acquired infections.*

- Reduction in infant mortality rate
- Reduction in neo-natal mortality rate
- Reduction in stunting among children under three years of age

Family Planning / Reproductive Health
- Reduction in total fertility rate (TFR)
- Reduction in percentage of women 15-49 years who had first sexual intercourse by 15 years
- Reduction in percentage of pregnant women aged 15-49 who are anemic

Tuberculosis (TB)
- Prevalence rate associated with TB
- Mortality rate associated with TB

More immediate objectives that activities under this APS are expected to contribute to include, but are not limited to:

Maternal Health
- Births assisted by doctor/nurse/Lady Health Visitor (LHV)/Auxiliary Nurse Midwife (ANM)
- Percentage women who had four or more antenatal care visits
- Mothers who received postnatal visits within 10 days of delivery

Child and Newborn Health
- Children 12-23 months fully immunized (BCG, measles, and 3 doses each of polio/DPT)
- Children exclusively breastfed till six months of age
- Newborns receiving three or more post natal checkups within 10 days after birth
- Children (<five years) with diarrhea in the last 2 weeks who received Oral Rehydration Salts (ORS) packets
- Children (<five years) who had symptoms of acute respiratory infection in preceding two weeks received antibiotics
- Children (<five years) who had symptoms of acute respiratory infection in the last two weeks for whom treatment was sought from a health facility or provider (excluding pharmacy, shop, and traditional practitioner)

Family Planning/ Reproductive Health
- Currently married women (15-49 years) using any modern methods of contraception
- Currently married women (15-49 years) with unmet need (total) for family planning
- Currently married women (15-49 years) with unmet need (spacing) for family planning
- Women (15-19 years) receiving Iron Folic Acid (IFA)
- Women delivering in previous 12 months consumed 100 or more IFA during pregnancy

Target Population

This APS targets India's vulnerable, marginalized, and underserved populations spread across rural areas, urban slums, and tribal pockets – including those currently outside the realm of effective service provision for reasons related to economics, gender, and social inclusion (notably females across the life cycle). Specific target populations are identified for each of the Program Components outlined in Section C.

Geographic Focus

It is envisaged that for the six Program Components outlined under this APS, the successful applicant(s) will work at both the national level and in a minimum of 30 districts spread over at least six states.

B.2. USAID/India's Strategic Direction and Overall Approaches

USAID India's Country Development Cooperation Strategy (CDCS) for the period 2012- 2017 recasts the USAID-India relationship from a traditional donor-recipient relationship to a peer-to-peer partnership for addressing Indian and global development challenges. USAID recognizes that different solutions and approaches are needed to truly effect the significant magnitude of change required to meet the challenges outlined above in a cost-effective and sustainable manner. These might include:

Building Locally-Led Alliances and Multi-Stakeholder Platforms: Locally-led alliances and multi-stakeholder platforms have the potential to enable public and private sector partners to collaborate and contribute significant shared resources to identify, diffuse, and scale-up "game-changing," proven, high-impact interventions. Successful scale up will be measured by widespread improvements in health outcomes that can only be achieved by significant, widespread uptake of key services and interventions.

Establishing Linkages with Priority National Programs: USAID seeks to further the goals and objectives of national programs implemented and funded by the GOI, for example the National Health Mission and National AIDS Control Program.

Promoting Game-Changing Innovations and Proven High Impact Solutions: USAID defines innovations as those interventions that introduce novel business or organizational models; operational or production processes; or products or services that lead to dramatic (not incremental) improvements in addressing health challenges. Innovation could help produce significant health outcomes more effectively, more cheaply, more sustainably, reaching more beneficiaries, and in a shorter period of time.

Strengthening Health Systems: Capitalizing on opportunities to promote innovations and implementation of proven high-impact interventions at scale will have lasting health impact. Success will depend, in part, on strong health systems. The program components outlined under this APS directly contribute to the health systems strengthening assistance objective and the five intermediate results outlined in Health Partnership Program Agreement that was signed between the Governments of India and the United States of America on September 30, 2010. The five intermediate results include: i) Increased access to quality services; ii) Strengthened policy and regulatory environment; iii) Increased healthy behaviors, iv) Increased use of data for decision making; and; v) Increased private sector engagement in quality health services.

Utilizing Appropriate Frameworks and Tools for Reaching Scale: Successful applicant/s will function primarily as "intermediary organizations," meaning that they will work closely with national and selected state governments and private sector partners to: 1) identify potentially effective and scalable approaches, global best practices, technologies, etc., and 2) develop and implement scale-up plan(s) in selected districts and states, partly by establishing pre-conditions for scale up, building capacity for scale up and facilitating implementation of scale up by public and/or private sector partners. Successful applicant/s must demonstrate the use of robust internationally

recognized and appropriate tools and frameworks or approaches to facilitate the scale up of proven, high-impact interventions through the public and/or private health care systems. Some examples of proven approaches include: 1) the Scaling-Up Management (SUM) Framework developed and field-tested by Management Services International (MSI), 2) the positive deviance approach that can help communities to discover desired behaviors demonstrated by a few within the community and promoting their adoption by all, and 3) market shaping approaches and tools to create sustainable health markets to deliver appropriate, high quality, and affordable health outcomes at scale.

C. PROGRAM AREAS

PROGRAM AREA #1: Human Resources for Health (HRH)	
Value of Awards	Up to $ 12 million (in total)
Implementation Period:	4 years

Health service provision in India, especially for priority RMNCH and tuberculosis services is seriously affected by a shortage of health care providers. There is also a serious problem with geographic distribution, as there is little incentive for health providers to work in rural areas, where housing, schools, and general infrastructure are unsatisfactory. According to recent studies, 75% of doctors work in urban areas, catering to 25% of the population. The GOI has introduced wide-ranging measures to promote greater availability of human resources especially in rural and underserved areas. However, the government at both the national and state levels continues to face numerous challenges associated with the HRH shortfall, including needs for successful recruitment, effective performance monitoring, long term retention, and greater productivity.

Program Area Goal: Increased access to priority RMNCH+A and tuberculosis services by ensuring availability of health workers.

Program Purpose: Facilitate implementation of proven high impact RMNCH+A and tuberculosis interventions by skilled providers to serve India's rural and urban poor.

Result 1: Enhanced institutional capacity at national and state level to accelerate adoption and scale up of HRH interventions for recruitment, performance management, retention, and productivity of doctors, nurses, auxiliary nurse midwives (ANMs), and ASHAs in rural and underserved areas.

There are several specific HRH challenges that need to be addressed. The first is recruiting new health care providers; second is effectively deploying staff to health facilities that address large unmet need for health services in rural and underserved areas; third is ensuring health care providers are motivated to perform their roles and responsibilities; fourth is developing a real-time human resource information system for effective workforce planning and management; and fifth is establishing a system for performance monitoring for optimum productivity. There are several potential HRH approaches and interventions that are being implemented albeit on a small scale in different states. However, there is a need to map and evaluate these existing HRH approaches and interventions for effectiveness as well as potential scale, either within the originating state or across states in India.

The applicant shall provide a credible plan to assess, adapt, promote and facilitate scale up of proven high impact HRH interventions in the areas of recruitment, performance management, retention, and productivity of health workers, especially in rural and underserved areas for

improved RMNCH and tuberculosis outcomes and impact. As part of the plan, the applicant shall propose strategic and creative approaches, partnerships to work with national and select state governments and other relevant stakeholders. The applicant shall function primarily as an 'intermediary organization and utilize appropriate frameworks and tools for reaching scale. The adoption and scale up of HRH interventions is expected to reduce vacancies and improve retention, reduce absenteeism and increase productivity of health personnel in rural and underserved areas. The successful applicant may be provided with time-bound international technical assistance through other USAID Projects.

Result 2: Effective technical assistance provided at national and select state level on HRH planning and management to support implementation of the GOI's RMNCH+A strategic approach with a focus on strengthening the nursing and midwifery cadre.

The GOI's RMNCH+A strategic approach lays emphasis on augmentation of human resources and HRH policy reforms to ensure adequate skilled human resources. The strategy outlines broad range of actions needed to address challenges related to recruitment, strengthening sub-centers through additional human resources, rational deployment of available human resources, multi-skilling of the health workforce, creation of public health cadre, task-shifting, development of career pathways, performance appraisal, strengthening of pre-service education and training, competency based internship and certification and strengthening of training institutions. The GOI has also initiated a national program, currently being implemented in 10 high focus states of Madhya Pradesh, Jharkhand, Bihar, Rajasthan, Uttar Pradesh, Uttarakhand, Chhatisgarh, Orissa, Assam and Jammu and Kashmir for strengthening the quality of pre-service education at the General Nurse Midwifery (GNM) schools and ANM training centers. It has brought out operational guidelines for strengthening pre-service education for the nursing and midwifery cadre in India.

While the technical and management capacity of personnel who plan and manage RMNCH program is increasing, there are still gaps. Development and implementation of a robust need-based technical assistance plan to support implementation of the RMNCH+A strategy with a focus on nurses and midwives will provide critical assistance in facilitating the scale up of effective HRH interventions.

The applicant shall provide a credible plan to provide technical assistance at national and state level on HRH policy, planning and management challenges for nurses and midwives to address recruitment, rational deployment, task shifting, performance management systems, creation of new cadres and career development pathways. As part of the plan, strategic and creative approaches to meet the gaps and scale-up high impact interventions, partnerships to work with national and select state governments, private sector and civil society partners and other relevant stakeholders are needed. It is important to avoid duplication of technical support, and put in place a robust capacity transfer and sustainability plan. Provision of technical support is expected to support the GOI's efforts to empower the nursing and midwifery workforce, thereby contributing towards improved RMNCH+A outcomes and impact. The successful applicant may be provided with international technical assistance through other USAID Projects.

PROGRAM AREA #2: Health Care Financing	
Value of Awards	Up to $ 8 million (in total)
Implementation Period:	4 years

Making the health care system more accessible and responsive to the needs of vulnerable populations requires that they have access to health financing. India's health indicators mask inequities in service utilization and resulting health outcomes across income quintiles. For example, children from the poorest communities are three times more likely to die before they reach the age of five than those from high income groups.

In India, Government funding for health remains comparatively low at 1.04 percent of the Gross Domestic Product (GDP). The lack of adequately funded public sector health services pushes large numbers of people to incur heavy out-of-pocket expenditures on services purchased from the private sector, placing a very high financial burden on families who experience severe illness. Private out-of-pocket expenditures on health are among the highest in the world. High out-of-pocket spending is a major barrier to accessing quality health care by the rural and urban poor; it is also a major cause of indebtedness and impoverishment.

Better data on health expenditure and utilization will be key to designing and funding comprehensive and sustainable health care financing programs for vulnerable populations.

Program Area Goal: Increased access to health financing for priority RMNCH+A and tuberculosis related services among India's rural and urban poor.

Program Purpose: To identify and expand coverage of equitable, evidence-based, and cost-effective health financing for the urban and rural poor, especially women, infants and children.

Result 1: Systems for generating health expenditure and other health financing data to better inform programs and policies for the rural and urban poor.

Analyses of health care spending and sources of financing are critical for making equitable and efficient allocation of health resources. National Health Accounts (NHA) are standard international tools used to track financial resources from the government, households, employers, and donors to health care service providers.

India has done two rounds of NHA - one in 2001-02 and another in 2004-05. The NHA is of limited use for policy making because: (a) it is not comprehensive; and (b) it is not produced on a regular and systematic basis. A comprehensive NHA should be able to answer questions such as: What is the current level of funding for child health? What is out-of-pocket spending on child health by income quintiles? How much money households from the poorest quintile spend on preventive care and curative care? What is the break-down between drug, inpatient and outpatient services? There is a strong need for regular production of NHA that is comprehensive and aligned with the international standards to strengthen information and research-based decision making and implementation in the government.

There is need to provide technical support to the Ministry of Health and Family Welfare (MoHFW) to: (a) Develop a system for routinely generating the NHA using the internationally accepted health accounting framework; and (b) Analyze the health expenditure data and develop and disseminate evidence-based policy relevant briefs. In addition, the successful applicant will also promote actionable research on health economics topics such as health care costs and inflation, and efficiency, effectiveness, value and behavior in the production and consumption of health care.

Result 2: Health financing schemes identified, adapted, tested, scaled-up and integrated into the mainstream health system.

Most of the current health financing schemes, targeted at India's rural and urban poor, focus on in-patient secondary and tertiary care. For example, in the absence of any child-specific and cashless health financing schemes for preventive and primary care, the parents of newborns from vulnerable populations tend to access health services from the informal sector (including self-medication, tradition healers, and quacks). For these parents, out-of-pocket spending is often the only source of financing. This deters families from seeking timely health care and has serious implications on child morbidity and mortality.

The successful applicant will identify financing schemes that already exists and adapt and harmonize these to make them more comprehensive and user-friendly for the rural and urban poor to improve maternal, child, and tuberculosis health outcomes. The local organization will work within selected states to build capacity in the entire gamut of health financing functional areas such as mobilization and pooling of financial resources, purchasing of quality health care services, monitoring and evaluation to scale-up these schemes. The lowering of financial barriers to accessing health care is expected to increase the utilization of maternal and child health services, reduce out-of-pocket payments for accessing these services, and result in improved health outcomes for the rural and urban poor.

PROGRAM AREA #3: Engaging the Private Sector in Reproductive, Maternal, New-born, Child, and Adolescent Health (RMNCH+A) Care	
Value of Awards	Up to $ 5 million (in total)
Implementation Period:	4 years

In its twelfth Five-year Plan 2012-2017, the Government of India (GOI) has set an ambitious goal to ensure universal access to healthcare, particularly for impacting India's maternal and child health indicators. Global evidence indicates that broader coverage and improvements in these indicators are possible by partnering with the private sector. Engagement of private sector is now being seen as an important opportunity to improve access to quality, proven high impact RMNCH+A services for the rural and urban poor. Yet, the GOI's experience in engaging the private sector in this area has shown that the GOI's capacity to design, negotiate and manage these partnerships could be more effective.

Program Area Goal: GOI's engagement with India's private sector increased access to RMNCH+A services for the urban and rural poor.

Program Purpose: To strengthen Governmental stewardship capacities for successful engagement of the private sector in RMNCH+A care.

Result 1: Strengthened knowledge management of proven private sector engagement in health programs.

National and state governments have in the past engaged the private sector for supporting critical health priorities. These partnerships have mostly focused on contracting the private sector for mobile health, diagnostic services, emergency transportation, health care financing, and support services such as laundry and catering services. Currently, there are no dedicated systems to periodically assess, document and disseminate the success, experiences, challenges, lessons, and

management expertise of engaging private sector in prevention and primary care. This information will provide important insights for policy makers and the public sector to engage the private sector in preventive and primary care. There are needs to: a) develop an inventory of major private sector initiatives in RMNCH+A care; b) periodically evaluate, document and disseminate private sector efforts in RMNCH+A care; c) constitute high-level private sector partnership working groups to develop white papers, policy briefs on private sector engagement in RMNCH+A care; and d) provide guidance on scaling-up proven private sector initiatives in RMNCH+A care.

Result 2: Robust due-diligence and rational costing systems for private sector partnerships in RMNCH+A programs established.

Limited promotion of private sector partnership opportunities; inadequate consultations with private sector on costing and incentive schemes; and lack of standardized tools and systems to assess due diligence of partnering private sector organizations have influenced the success and number of private sector partnerships in RMNCH+A care. There are needs to: a) develop outreach strategies to promote RMNCH+A care opportunities to the private sector; b) analyze costs of different RMNCH+A care services in private and public health care settings; c) evolve rationale and market-based incentive structures for the private sector to provide a range of RMNCH+A care services to rural and urban poor; d) administer standardized tools and guidelines on due diligence for partnering with private sector organizations in select states; and e) evaluate the impact of due-diligence and rationale costing, incentive structures on program outcomes and on continuity of partnerships by the private sector.

Result 3: Strengthened national and state systems for public sector stewardship of private sector engagement in RMNCH+A care.

The lack of dedicated management systems at national and state level to, a) conceptualize opportunities for private sector participation in RMNCH+A care; b) systematically dialogue and engage with the private sector; c) adapt existing schemes and develop new models of private sector participation; and d) provide supportive supervision for private sector engagement in RMNCH+A care, is a major gap, and has impacted private sector partnerships in RMNCH+A programs. Few states have engaged an interface agency to help coordinate logistics and supplies, demand creation, capacity building, quality assurance, reporting and incentive management functions for effective engagement of the private sector. In most states there are no dedicated staff for overseeing private sector partnerships in RMNCH+A care.

There are needs to: a) develop a leadership forum at the national and state levels to provide strategic roadmaps for engaging the private sector in RMNCH+A care; b) assess effectiveness of interface agencies and dedicated public-private partnership units/staff; c) establish systems for periodic government and private sector dialogue on RMNCH+A care; d) develop systems to promote and manage private sector partnerships in RMNCH+A care; and e) strengthen capacities of public sector officials to design, implement, regulate and effectively monitor private sector programs in RMNCH+A care.

PROGRAM AREA #4: Quality Data for Decision Making (QDDM)	
Value of Award	Up to $ 9 million (in total)
Implementation Period	4 years

The Ministry of Health and Family Welfare (MOHFW) is committed to enhancing the use of quality data to improve the status of RMNCH+A. In 2005, along with the launch of the National Rural Health Mission, a need was felt to strengthen the health management information systems (HMIS) to facilitate availability of good quality data for efficient program planning. In recent years, a great deal of effort has been made to improve the quality and use of HMIS data. During the Call to Action for Child Survival and Development, the GOI established a system to track progress at the national and state level through a National Child Survival and Development Score Card and a National Dashboard (developed using HMIS and survey data respectively) for key RMNCH+A health indicators along the continuum of care – pre-pregnancy, pregnancy, childbirth, postnatal, early childhood, and adolescence. States are encouraged to introduce State Dashboards to monitor health in districts. In the past, various policy and planning documents (Working Group Papers, Records of Proceedings, Program Implementation Plans, District Health Action Plans, etc.) have used data (HMIS, survey, surveillance, Sample Registration System, Census, etc.) for planning purposes but such use of data is yet not optimum.

Evidently, HMIS data quality and use has improved over the years, however, both the quality and use especially at district and facility level has scope for improvement. MOHFW intends to strengthen health information systems and enhance use of good quality data (from various sources) to inform program planning. Specifically, validity and accuracy of HMIS data needs to be improved.

Program Goal: Increased access to quality, proven high impact RMNCH+A services by improving data quality and enhancing evidence-based decision-making.

Program Purpose: To facilitate evidence-based decision-making using improved quality of and use of data.

Result 1: Quality of HMIS data and maternal and child health tracking system (MCTS) improved in minimum 30 high priority districts across select states.

The quality of HMIS data and MCTS has not been assessed. There is need to: a) use internationally recognized standardized tool to assess HMIS data quality and MCTS system; b) develop a roadmap for improvement of data quality especially the validity of the HMIS data, and strategies to strengthen the MCTS system, c) help establish annual targets for data quality improvement, d) provide support to implement the road-map for data quality improvement, and, e) develop and implement strategies for replication and scale-up.

Result 2: Evidence-based decision-making enhanced in minimum 30 high priority districts across select states.

HMIS data as well as data from various other sources needs to be used for program planning, budgeting, prioritization, monitoring, and evaluation. There is need to: a) assess use of data for evidence-based decision-making in various policies and planning documents at national, state, and district level; b) develop plans to effectively use data from various sources to improve evidence-based decision-making at various levels including district specific Child Survival and Development Score Card and Dashboards; c) demonstrate enhancement in evidence-based decision-making; and; d) develop and implement strategies for replication and scale-up.

One of the important tools that has been recently introduced is the Maternal and Child Health Tracking System (MCTS). This could potentially have a substantial impact on improving

utilization of key maternal and child health services. The selected organization will work in select districts to assess the current implementation of MCTS and will help in strengthening the maternal and child health tracking.

PROGRAM AREA #5: Scaling Up Interventions in Reproductive, Maternal, Neonatal, Child, and Adolescent Health	
Value of Awards:	Minimum US $10 million and Maximum $25 million
Implementation Period:	4 years
Geographic Priorities:	National level and specifically at least 30 priority districts in selected states

While there have been several efforts to expand activities aimed at improving coverage of RMNCH+A services nationally and in the high burden states, the scale has not been enough to demonstrate impact in several priority areas. The institutional delivery rate has increased remarkably through the Janani Suraksha Yojana, yet the exclusive breast feeding rates continue to be less than 30 percent in most places. Rates of immunization coverage vary from 70 percent to 30 percent across districts. On the other hand, India has not seen a new case of Polio for over two years. The Infant Mortality Rates have unacceptably high variance ranging from rates comparable to developed countries (19 per thousand live births) in some districts of India to being among the lowest in the world (103 per thousand live births) in others. The use of simple solutions of reducing child mortality such as use of oral rehydration salts during diarrhea ranges from 18 percent to 94 percent and zinc usage is very low.

A credible plan to implement and scale up proven high-impact RMNCH+A interventions that have been tested and demonstrated globally/nationally to demonstrate improved health outcomes and impact is needed. Strategic and creative approaches, unconventional partnerships, to both create and strengthening platforms to work with the Government and the private sector - the two main providers of health services - to scale up proven RMNCH interventions will be required.

Program Goal: Effective RMNCH+A solutions, scaled to achieve significant reductions in preventable morbidity and mortality among women and children.

Purpose: GOI and private sector scale up proven high-impact RMNCH+A interventions.

Result 1: Enhanced institutional capacity of GOI and private sector networks to scale up proven high-impact RMNCH+A interventions.

There are several factors which impede the scale up of RMNCH+A services in India. There is variable capacity of the states both in terms of technical capacity and absorptive capacity of the funds, systemic inefficiencies, frequent changes in the leadership, delays in procurements and several others. The private sector although interested in the public good, must ensure that the scale up is commercially viable for them. There are issues related to co-financing between the public and private sector. The health impact will be seen if there is scale-up of RMNCH services both by the public and the private sector.

Result 2: Effective technical assistance provided though a national technical support unit and quick response team.

India is a large and complex country with specific state specific issues including those which affect RMNCH+A outcomes. While the technical and management capacity of personnel who plan and manage RMNCH+A programs is increasing, still there are technical gaps. Development and implementation of a robust and need based technical assistance plan to the Public and private sector will provide critical assistance in facilitating the scale up of programs. It is important to demonstrate that the technical support is not duplicative, has a robust capacity transfer and sustainability plan.

PROGRAM AREA # 6 : Increased quality of RMNCH+A and tuberculosis services	
Value of Awards:	Up to $15 million (in total)
Implementation Period:	4 years

While the National Rural Health Mission (NRHM) has made considerable investments in the last few years to upgrade public sector health facilities, a lack of adoption of standard quality frameworks and continuous quality improvement (QI) efforts, has meant that investments have not led to significant improvements in quality of services. The Government of India (GOI) is keen to enhance the quality of health services at all levels. Despite the availability of evidence-based, simple, and high-impact interventions capable of saving mothers and children's lives, many children and their mothers are not benefiting from them, partly because of poor quality in their delivery. The inadequate quality of care is evident through various parameters such as efficiency, patient-centeredness, equity, accessibility, and timeliness showing deficiencies in both the public and private sector facilities. The private sector health care delivery poses additional challenge as the private sector is fragmented and largely unregulated though it provides 70 to 80% of health care in India.

Goal: Improved quality of RMNCH+A and tuberculosis services.

Purpose: To institutionalize quality improvement systems for RMNCH+A and tuberculosis care in both the public and private health sector.

Result 1: Effective systems for quality improvement identified and assessed for potential scale-up.

This activity will strive to scale up successful quality improvement interventions to accelerate RMNCH+A and tuberculosis outcomes. In this context there is need to: a) identify potential high impact quality improvement systems and practices in primary healthcare in the public sector and the private sector (including civil society) ; b) assess the identified interventions to determine health impact, feasibility for scaling-up and cost-effectiveness; c) supplement available data on key parameters, if sufficient data is unavailable; d) develop a road-map for quality improvement at the national level, and selected states and districts; and e) provide technical support for implementation of the plan. The road-map will recognize that the context within which quality improvement activities are implemented is variable. Thus, no single approach can be successful for sustained quality improvement and an adaptive approach is more likely to have positive outcomes.

Result 2: Evidence-based schemes support quality improvement in public and private health facilities.

The quality improvement activity requires change in established practices of healthcare providers. Even though in the short-term the healthcare providers find making measurable improvements in the care of their patients to be rewarding, there is insufficient understanding of how to make

quality improvement approaches sustain over the long-term. There is need to understand both the provider and client side interventions that can lead to sustained quality improvement efforts. The role that specific incentives may play for improvements in quality of care for the healthcare providers as well as the role that client information and demand for improved quality of care from the clients needs further understanding. The applicant shall identify, assess, and support the implementation of evidence based approaches in the public and private health care delivery system for sustaining quality improvement efforts.

D. GENDER

Pursuant to ADS 201.3.12.6, proposals/concept paper should clearly state the respondents' gender mainstreaming expertise and capacity, and propose meaningful approaches to address gender, clearly answering the following three questions:
(1) Are women, including girls, and men involved and benefiting equally at different levels (effort, decision-making, etc.) or affected differently by the proposed intervention?
(2) Do the opportunity costs of participation differ between men and women (including girls)?

- If either (1) or (2) are affirmative, what is the difference and magnitude and how will the proposed intervention mitigate these differences to ensure sustainable and appropriate program impact?

SECTION II:
APPLICATION AND SUBMISSION INFORMATION FOR CONCEPT PAPERS

A. INSTRUCTIONS TO APPLICANTS

A.1 Eligibility

USAID seeks applications from "local Organizations". Organizations registered in India, including non-governmental organizations,[4] civil society organizations, universities or institutes, para-statal organizations, or for-profit organizations. A "local organization" must,

• Be organized under the laws of the recipient country;

• Have its principal place of business in the recipient country;

• Be majority owned by individuals who are citizens or lawful permanent residents of the recipient country or be managed by a governing body, the majority of whom are citizens or lawful permanent residents of a recipient country; and

• Not be *controlled by* a *foreign entity* or by an individual or individuals who are not citizens or permanent residents of the recipient country.

The term "*controlled by*" means a majority ownership or beneficiary interest as defined above, or the power, either directly or indirectly, whether exercised or exercisable, to control the election, appointment, or tenure of the organization's managers or a majority of the organization's governing body by any means, e.g., ownership, contract, or operation of law. "*Foreign entity*" means an organization that fails to meet any part of the "local organization" definition. Government controlled and government owned organizations in which the recipient government owns a majority interest or in which the majority of a governing body are government employees, are included in the above definition of local organization. Support for government owned or controlled organizations will be subject to applicable USAID rules.

Illustrative Indian organizations may include, but not be limited to:

- non-government organizations (NGOs) including any non-profit or voluntary organizations
- faith-based groups
- labor unions
- academic institutions
- consulting firms
- research institutions
- For-profit private companies

Indian organizations should meet the following criteria:

- Have a minimum of 3 years of experience implementing programs of similar scope and complexity
    - Organizations with less than 3 years of experience **<u>may apply</u>** but will need to demonstrate capacity to implement an activity of the proposed scope and complexity.

[4] NGOs include any non-profit or voluntary organizations, organized on a local or national level, duly registered with stated goals to improve the lives of Indians.

- Demonstrate institutional/management capacity to manage donor funds, for example:
  - Board of directors
  - Mission statement
  - Personnel, procurement and administrative systems
  - Financial management capacity utilizing an accounting system
  - Appropriate infrastructure to implement proposed program
- Have in place monitoring and evaluation systems (capacity to collect, enter, store, and report on program data)
- Demonstrate linkages to local networks

An Indian applicant may propose an international sub-partner if the partner is providing technical assistance (TA), and;

- It is critical to the activity's success
- For a minimal period of time (a rare occurrence and time bound),
- Clearly demonstrates specific rationale and role
- Is less than 20% in the activity and budget
- Assistance represents real value for the money

While both for profit, as well as not-for-profit organizations are eligible to submit applications under this Annual Program Statement (APS); for-profit institutions will not be eligible for fee or profit.
USAID will not accept applications from individuals. All applicants must be legally recognized organizational entities under applicable law.

A.2 Program Duration

This APS will be open for a period of up to one year or 12 months from the issuance date, which should be approximately **May 21, 2014**, or until such time as funding identified for this APS has been fully allocated. The duration of any proposed program implementation (life of project) may not exceed four (4) years. USAID reserves the right to incrementally fund activities over the duration of the program, if necessary, depending on program length, performance against approved program indicators, and availability of funds. Depending on the availability of funds , the APS may be extended, revised or re-issued.

A.3 Anticipated Number of Awards

Under this APS, USAID reserves the right to make a single award, make multiple awards, fund parts of an application, or not to make any awards at all. Issuance of this APS does not constitute an award commitment on the part of the U.S. Government, nor does it commit the U.S. Government to pay for any costs incurred in the preparation and submission of any application.

A.4 Substantial Involvement

USAID anticipates that grant(s) in the form of Cooperative Agreement(s) will be awarded as a result of this APS. Under a Cooperative Agreement, USAID may be substantially involved in the following areas:

- USAID approval of the recipient's Annual Work/Implementation Plans

- USAID approval of key personnel funded under the agreement (limited to five positions) USAID approval of the program's Monitoring and Evaluation (M&E) Plans, including indicators
- USAID approval of sub-recipients (sub-grants/sub-awards) and corresponding activities

A.5 Official Source Documents

This APS is the official source document for the application. Oral explanations of the Applications will not be evaluated or considered; only written applications will be evaluated. Applicants should retain for their records a copy of the application and all attachments or enclosures that accompany their application. USAID will only consider applications conforming to the prescribed format. Explanations or instructions given before award of a Cooperative Agreement will not be binding. Any information given to a prospective Applicant concerning this APS will be furnished promptly, via www.grants.gov, to all other prospective Applicants as an amendment of this APS.

B.1 Cost Share

While not mandatory, cost share is expected. It is expected that the proposed budget will be generated from both USG funding plus non-USG funding through cost share from the applicants for the proposed program. The cost share may be a combination of cash and in-kind. Actual and/or expected sources and amounts of the cost-share amount from all sources (other donors, community members, business, etc.) must be stipulated. Criteria for acceptance and allowability for the non-U.S. federal contributions are set forth in 22 CFR 226 (Copies of 22 CFR 226 may be obtained from http://transition.usaid.gov/policy/ads/cfr.html

B.2 Authorized Geographic Code

Geographic Code : 937

B.3 Branding and Marking Plan

It is a federal statutory and regulatory requirement that all USAID programs, projects, activities, public communications, and commodities that USAID partially or fully funds under a USAID grant or cooperative agreement or other assistance award or sub-award, must be marked appropriately overseas with the USAID Identity. See Section 641, Foreign Assistance Act of 1961, as amended; 22 CFR 226.91. Under the regulation, USAID requires the submission of a Branding Strategy and a Marking Plan, but only by the "apparent successful Recipient," as defined in the regulation. The apparent successful Recipient's proposed Marking Plan may include a request for approval of one or more exceptions to marking requirements established in 22 CFR 226.91. The Agreement Officer is responsible for evaluating and approving the Branding Strategy and a Marking Plan (including any request for exceptions) of the apparently successful Recipient, consistent with the provisions "Branding Strategy," "Marking Plan," and "Marking of USAID-funded Assistance Awards" contained in AAPD 05-11 and in 22 CFR 226.91. Please note that in contrast to "exceptions" to marking requirements, waivers based on circumstances in the host country must be approved by Mission Directors or other USAID Principal Officers, see 22 CFR 226.91(j). Branding and marking under this Cooperative Agreement will be carried out in accordance with AAPD 05-11
http://www.usaid.gov/business/business_opportunities/cib/pdf/aapd05_11.pdf

C. APPLICATION PROCESS

As stated at the beginning of this APS,USAID/India invites eligible organizations to submit brief concept papers of no more than five (5) pages, including an illustrative budget of no more than one (1) page, that demonstrate innovative approaches to addressing one or more of the following program areas: 1) Human Resources for Health; 2) Health Care Financing; 3) Engaging the Private Sector in Reproductive, Maternal, New-born, Child, and Reproductive Health (RMNCH+A) Care; 4) Quality Data for Decision Making; 5) Scaling Up Interventions in Reproductive, Maternal, Neonatal, Child, and Adolescent Health; 6) Increased quality of RMNCH+A and tuberculosis services.

Applicants are welcome to submit more than one concept paper for each program area of the application for which they have programmatic expertise as described in Section B. Each concept paper must stand alone and only address one program area. However if an applicant wishes to combine the two or more program areas into one concept paper this must also be a stand-alone concept paper in addition to the individual concept paper(s) for the individual program areas.

This is a two-stage process. Applicants are required to submit short concept papers per the instructions below; concept papers need not be in the format or detail of a full proposal. The submitted concept papers will be reviewed using the criteria set forth below. The most highly rated Applicants will be invited to participate in the second stage through the submission of Full Applications per the instructions in Section III.

Deadline for Submission of Concept Paper: Concept papers for the first round of awards submitted after the **June 26, 2013 deadline** will not be considered.

Applicants interested in being considered for funding should submit their a concept paper(s) via e-mail to indiarco@usaid.gov Only those concept papers that are received by the deadlines specified above will be reviewed for responsiveness to the requirements set forth in this APS.

Applicants will be notified via email if USAID will request them to expand the concept paper into a full application. **Applicants should not prepare full applications unless specifically requested to do so by USAID/India's Office of Procurement.**

D. CONCEPT PAPER FORMAT

The concept papers must be written in English and formatted on standard A4 paper, with single space, 12 point font Times New Roman with margins no less than one inch on each border, and each page numbered consecutively. The concept paper should include three sections and total submission **should not exceed 5 pages total, including cover page, technical narrative, budget and notes**. ***Any materials beyond 5 pages will not be reviewed or considered.*** The concept papers are to be presented in the following format:

1. **Cover Page (one page)**. The cover page must include
    - The APS number,
    - The names of the organization(s) involved (with the name of the lead or primary Applicant clearly identified),
    - Authorized representatives name for the primary Applicant, title or position with the organization, mailing address, email address, telephone numbers. Application

should be signed by the authorized representative who has the authority to negotiate both program issues and budget on behalf of the Applicant.
- Type of organization and cost share, if any.

2. **Technical Narrative.** A narrative of **not more than three (3) pages** should outline the following:

- Goals – Describe the goals of the program.
- Define the problem or issues and provide analysis of the context that demonstrates understanding of the needs, the complexity of the current situation, and the challenges of programming and/or service provision in the identified geographic area and/or for the targeted audience.
    - Describe the technical approach to be used to achieve the goal, purpose and results with the program area in line with USAID's new strategic direction and assistance approaches, general sequencing, and roles and responsibilities of partners and stakeholders. Describe how activities will link into and complement existing programs. Explain how or why the proposed approach will be more successful or effective than other approaches and be appropriate to effective scale up. If the Applicant is proposing capacity building of Indian organizations, describe what areas are targeted (i.e. strategic planning, business development, quality assurance, etc.) and how the capacity building will be delivered.
- Sustainability – Describe how ownership, leadership and program management will build on existing programs and resources and will be sustained, post-USAID funding. The technical discussion should include proposed partners and arrangements for effective and complimentary operations among partner organizations, including linkages to existing networks, structures, and resources.
- Expected Results – Outline the expected results and how results will be measured (including mechanisms of measurement) for progress, benchmark achievements, and greater sustainability. Results must be measureable on an annual basis as well as over the life of the award.
- Organizational Capacity – Describe technical, senior management and capacity-building expertise and capabilities with regards to project implementation and quality assurance. If applicable, describe how the approach will strengthen the capability of the Applicant.

3. **Budget.** Provide a **one page** budget that clearly identifies the major cost line items, such as personnel, travel, training, program activities, sub-awards, commodities, etc., by year, for the full program period. Applicants are encouraged to focus resources on project implementation rather than salaries, equipment and supplies and must demonstrate growing cost-effectiveness over the life of the award. The proposed costs and budget aspects of applications will be reviewed for cost realism to evaluate the relationship between the proposed costs and proposed program as well as the likelihood for success. Cost share contribution if any, should also be reflected separately. Cost-share could contribute to the achievement of the results of this funding opportunity and is highly encouraged

E. TECHNICAL EVALUATION CRITERIA FOR CONCEPT PAPERS (Step 1)

For all concept papers meeting the basic eligibility requirements, a technical evaluation panel will evaluate the concept paper to determine the application's relevance to improving either: 1) Human Resources for Health; 2) Health Care Financing; 3) Engaging the Private Sector in Reproductive, Maternal, New-born, Child, and Reproductive Health (RMNCH+A) Care; 4) Quality Data for

Decision Making; 5) Scaling Up Interventions in Reproductive, Maternal, Neonatal, Child, and Adolescent Health; 6) Increased quality of RMNCH+A and tuberculosis services. In addition, the panel will determine whether the approach described reflects the new strategic direction of USAID and its health programs. Those concept papers which pass this review will be shortlisted for full application and will move on to Step 2, where the full application will be requested, submitted and evaluated. ***Concept papers that are not shortlisted will not move on to Step 2. In these cases, the full applications will not be requested or evaluated***.

All concept papers shortlisted after Step 1 will then be move to Step 2, where the full application will be requested, submitted and evaluated based on the following technical evaluation criteria. The relative scoring weights of the criteria are listed below, so that applicants will know which areas require emphasis in the preparation of information

SECTION III
APPLICATION AND SUBMISSION INFORMATION FOR FULL APPLICATIONS

A. TECHNICAL EVALUATION CRITERIA FOR FULL APPLICATION(S) (Step 2)

The criteria presented below have been tailored to the requirements of this APS. Applicants should note that these criteria serve to: (a) identify the significant matters which applicants should address in their applications and (b) set the standard against which all applications will be evaluated. To facilitate the review of applications, applicants are requested to organize the narrative sections of technical applications according to the technical application format set forth below.

The specific evaluation criteria are as follows:

1. Technical Evaluation:

	EVALUATION CRITERIA	MAXIMUM SCORE
i.	Technical Approach	35
ii.	Key Personnel	30
iii.	Management Plan	15
iv.	Past Experience	10
v.	Past Performance	10
	TOTAL SCORE	**100**

i. Technical Approach 35 points

A technical approach that is well-conceived, technically sound, result-oriented, feasible, and sustainable, which demonstrates a clear understanding of the key issues identified in the Program Description.

ii. Key Personnel 30 points

Individuals proposed as key personnel will be evaluated based on their sector specific qualifications, professional competence, relevant academic background, demonstrated success in carrying out proposed activities, experience.

iii. Management Plan 15 points

The Management Plan will be evaluated based on its ability to support the achievement of results. The Management Plan must consist of a clear and concise description of how internal management plans, organizational structures, lines of communication and authority, and partnerships are conducive to effective project implementation.

iv. Past Experience 10 points

Past experience managing or implementing similar programs or partnerships that involved elements of strategic partnership and advocacy; supporting and scaling successful and innovative education projects; and knowledge management.

v. Past Performance 10 points

USAID will evaluate the quality of the applicant's past performance. The assessment of the applicant's past performance will be used to evaluate the relative capability of the applicant to successfully carryout the program. Past performance of significant and critical subs and other types of partnership in applications will be considered to the extent warranted by their involvement in the proposed effort.

Applicants will be evaluated for demonstrated successful past Performance in previous and/or existing projects for the following:
a. The overall quality of the product /services provided
b. Cost control performance,
c. timeliness of performance,
d. End-user /customer satisfaction with the performance; and
e. Performance of key personnel.

2. **Cost Evaluation:**

Points will not be awarded for cost. Cost will primarily be evaluated for reasonableness, realism, allowability and the applicant's understanding of the work to be performed. Effective cost saving measures to improve cost efficiency of the program will also be considered. Given the nature of this activity, USAID/India will weigh carefully potential benefits from the proposed staffing plans and level of effort**.**

[Note: Applications that do not present realistic costs may risk not being considered for award.]

B. REVIEW AND EVALUATION PROCESS

Application(s) which are deemed to offer the best overall value and meet USAID objectives will be selected for award(s). The Technical Evaluation Committee (TEC) will evaluate the technical/programmatic merit of each application as measured against the evaluation criteria mentioned above.

Once an "apparent successful applicant" is identified, additional information and discussion may occur between the applicant and USAID Agreement Officer, before the final funding decision is made. The "apparent successful applicant" means the applicant recommended for an award of a component after evaluation, but who has not yet been awarded a grant, cooperative agreement or other assistance award by the Agreement Officer. "Apparently successful applicant" status confers no right and constitutes no USAID commitment to an award.

The recommendation or selection of an application for award does not in any way guarantee an award. The USAID Agreement Officer must be fully satisfied that the applicant has the capacity to adequately perform in accordance with standards established by USAID and the Office of Management and Budget (OMB). This issue of organizational capability is generally referred to as a pre-award "responsibility determination." The Agreement Officer must also complete any other necessary pre-award arrangements.

Details on USAID pre-award responsibility determination policy and procedure can be found on our agency website, in its automated directive system (ADS) chapter 303, section 303.3.9:

http://www.usaid.gov/policy/ads/300/303.pdf.

USAID/India may make awards without any discussion(s)/negotiation(s). To the extent that they are necessary, /discussions(s)/negotiation(s) will be conducted with the applicant(s) whose application(s), has or have a reasonable chance of being selected for award. The final award decision(s) will be made by the Agreement Officer, with consideration of the Technical Evaluation Committee recommendations.

Other areas of review and discussion will vary according to the circumstances pertaining to the application. The following areas commonly require discussion and agreement prior to award:

A. Branding Strategy and Marking Plan. In accordance with ADS 303.3.6.3.f and 22 CFR 226.91, the apparently successful applicant must submit a Branding Strategy and a Marking Plan for evaluation and approval by the Agreement Officer before an award under this solicitation will be made. "Marking Plan" and "Marking of USAID-funded Assistance Awards" are contained in **AAPD 05-11** and in **22 CFR 226.91**. Please note that in contrast to "exceptions" to marking requirements, waivers based on circumstances in the host country must be approved by Mission Directors or other USAID Principal Officers, see **22 CFR 226.91(j)**. USAID approved Branding Strategy and Marking Plan is required for award execution.

B. Final program and budget plans.

C. Payment terms.

D. Procedures concerning administrative reporting and logistical requirements for program including training components.

E. Other award terms including audit, special provisions and/or special award conditions.

All other factors being technically equal, USAID/India reserves the right to ensure geographic diversity in applications selected for award.