Issue Date:	**June 15, 2015**
Deadline for Questions:	**July 2, 2015 16:00 Local (Maputo) Time**
Application Submission Deadline:	**July 20, 2015 16:00 Local (Maputo) Time**
E-mail address for questions and applications	**ifpp.rfa@usaid.gov**

Subject: **Notice of Funding Opportunity (NFO) Number RFA-656-15-000009**

Program Title: **Integrated Family Planning Program (IFPP)**

Ladies/Gentlemen:

The United States Agency for International Development (USAID) is seeking applications for a cooperative agreement from all U.S. and non-U.S. qualified organizations (other than those from foreign policy restricted countries) for funding to support a program entitled **Integrated Family Planning Program (IFPP)**. The authority for this NFO is found in the Foreign Assistance Act of 1961, as amended.

Subject to the availability of funds, an award will be made to that responsible applicant(s) whose application(s) best meets the objectives of this funding opportunity and the selection criteria contained herein. While one award is anticipated as a result of this notice of funding opportunity (NFO), USAID reserves the right to fund any or none of the applications submitted.

For the purposes of this NFO, the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer". Eligible organizations interested in submitting an application are encouraged to read this funding opportunity thoroughly to understand the type of program sought, application submission requirements and evaluation process.

To be eligible for award, the applicant must provide all information as required in this NFO and meet eligibility standards in Section III of this NFO. This funding opportunity is posted on www.grants.gov, and may be amended. Potential applicants should regularly check the website to ensure they have the latest information pertaining to this notice of funding opportunity. Applicants will need to have available or download Adobe program to their computers in order to view and save the Adobe forms properly. It is the responsibility of the applicant to ensure that the entire NFO has been received from the Internet in its entirety and USAID bears no responsibility for data errors resulting from transmission or conversion process. If you have difficulty registering on www.grants.gov

or accessing the NFO, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via e-mail at support@grants.gov for technical assistance.

The successful Applicant will be responsible for ensuring the achievement of the program objectives. Please read each section of the NFO.

Please send any questions to the point(s) of contact identified in Section IV. The deadline for questions is shown above. Responses to questions received prior to the deadline will be furnished to all potential applicants through an amendment to this notice posted to www.grants.gov.

Issuance of this notice of funding opportunity does not constitute an award commitment on the part of the Government nor does it commit the Government to pay for any costs incurred in preparation or submission of comments/suggestions or an application. Applications are submitted at the risk of the applicant. All preparation and submission costs are at the applicant's expense.

Thank you for your interest in supporting USAID/Mozambique programs.

Sincerely,

Adam Cox
Agreement Officer
Office of Acquisition & Assistance
USAID/Mozambique

U.S. Agency for International Development
JAT Complex
Rua 1231, n.º 41
P.O.Box 783
Maputo, Mozambique

Tel: (258) 21 35 20 00
Fax (258) 21 35 21 00
www.usaid.gov/mz

U.S.A. Postal Address
2330 Maputo Place
U.S. Department of State
Washington, D.C. 20521-2330

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SECTION I: FUNDING OPPORTUNITY DESCRIPTION

I.1. Overview:

The purpose of this program is to implement an integrated family planning (FP) program in all, or a subset of four, provinces in Mozambique (key provinces are Nampula, Sofala, and Cabo Delgado).

The goal of the FP Integrated Project is to increase use of modern contraceptive methods by target populations. This project's target populations, defined below, have a high unmet need for family planning.[1] The project goal supports the Government of the Republic of Mozambique (GRM) and Ministry of Health (MISAU) priorities related to improving the health of Mozambicans by increasing access to and use of voluntary family planning and contraceptive methods. The FP Integrated Project will prioritize the implementation and scale-up of evidence-based, high impact FP service delivery interventions and other effective FP practices. It will also contribute to the policy environment, address sociocultural issues and norms, and support health systems improvements to ensure sustainability of service delivery interventions. Strategic integration with maternal and child health (MCH), HIV/AIDS, reproductive health (RH), and non-health platforms will be at the forefront of this project to ensure that investments are maximized and services are provided in the most effective and cost-efficient ways.

This project aims to achieve three Intermediate Results:

IR 1: Increased access to a wide range of modern contraceptive methods and quality FP/RH services;
IR 2: Increased demand for modern contraceptive methods and quality FP/RH services; and
IR 3: Strengthened FP/RH health systems[2].

The FP Integrated Project is expected to be funded at $7 million/year for 5 years. The award will be a cooperative agreement and will be managed by the USAID Integrated Health Office's MCH Team. The project will be funded with USAID PEPFAR and Other Health funds and will be eligible for other funds from a variety of accounts.

USAID is seeking applications that describe how the proposed program will increase access to modern contraceptive methods and quality FP/RH services by integrating FP into, or linking FP with, clinical and community MCH, HIV/AIDS, and other health and non-health programs and organizations, to achieve maximum service coverage as quickly and effectively as possible. Strong applications will clearly identify high-impact and

[1] Unmet need for family planning is defined as the percentage of women who are not currently using a method of contraception yet want to delay or end childbearing.

[2] This NFO refers to modern contraceptive methods, in addition to family planning, to emphasize that youth are an important target group. Unmarried, sexually-active adolescents are more likely to want to obtain contraceptives to avoid unwanted pregnancy than to plan their families.

other effective practices that will be used to reach key target populations having high unmet need for FP.[3] These populations include postpartum women, HIV-positive women, adolescents, including Orphans and Other Vulnerable Children (OVCs), high-parity women, and post abortion care women. Pregnancies occurring in these groups are considered high-risk pregnancies and are important drivers of mortality and morbidity. (See Annex 1.) The FP Integrated project will also reach men and boys, especially with respect to male engagement in FP/RH and gender-based violence. Strong applications will pay particular attention to describing how high impact and other effective FP practices and messages will be used to reach the 70 percent of the population who live in rural areas and do not have easy access to facilities or community health workers. Strong applications will also be creative in proposing the use of underutilized channels, networks, and community organizations and infrastructure to reach women and men, and boys and girls, to help them practice healthy family planning behaviors. These behaviors include using modern contraceptive methods to avoid: pregnancy before age 18; rapid, repeat pregnancy; unwanted pregnancy; and unwanted high parity, post abortion, and HIV-positive pregnancies. To sustain improvements, applicants should describe their approach to working in full partnership with MISAU, especially at the provincial and district levels, to strengthen select systems, such as FP management systems, that increase the effectiveness, efficiency, quality, and coverage of family planning services.

Applicants are requested to submit a proposed Year One Work-plan, along with their application.

I.2. Background and Problem Statement:

Mozambique, a country in Southern Africa, has a population of about 24 million inhabitants. Close to 70% of the population live in rural areas and over half live on less than one US dollar a day.[4] Mozambique ranks 178 out of 185 on the Human Development Index and has one of the lowest life expectancies in the world at 50 years old.[5] Education, especially at the secondary level, has remained low and, in 2011, only 17% of girls and 18% of boys were enrolled in secondary school.[6] Mozambique has made significant progress over the years in reducing infant and child mortality. From 2003 to 2011, infant mortality declined from 101/1000 to 64/1000 and under-5 mortality declined from 152/1000 to 97/1000.[7] Mozambique has also made significant progress in addressing the HIV/AIDS epidemic by investing significant resources to help reduce adult prevalence from 15% in 2005 to 11% in 2009.

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[3] USAID, UNFPA, WHO/IBP, and Partners, High Impact Practices in Family Planning, 2012, available at: http://www.fphighimpactpractices.org/

[4] UN Mozambique Development Indicators. Available at: http://mz.one.un.org/eng/About-Mozambique/Mozambique-Key-Development-Indicators

[5] UNESCO Institute of Statistics Report (2013). Available at: http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=289&IF_Language=eng&BR_Country=5080&BR_Region=40540

[6] UNESCO Institute of Statistics Report (2013). Available at: http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=289&IF_Language=eng&BR_Country=5080&BR_Region=40540

[7] Demographic Health Survey Mozambique 2011. Available at: www.measuredhs.org

Despite these achievements, limited progress has been made in maternal health and family planning (FP). The maternal mortality ratio (MMR) has declined only slightly from 530 maternal deaths/100,000 live births in 2003 to 408/100,000 in 2011. Mozambique's MMR ranks as one of the highest in Southern Africa. The modern contraceptive prevalence rate (mCPR) declined from 16.8% in 1997 to 11.9% in 2003 and has remained unchanged at 11.3% in 2011. Fertility has increased from 5.5 to 5.9 children per woman. Unmet need for family planning remains high with 29% of all women wanting to space or limit pregnancy, but without access to modern contraceptive methods. Target populations, such as HIV-positive women and youth, have even higher levels of unmet need to delay, space, or limit childbearing.

HIV presents a serious public health threat in Mozambique. Adult prevalence is estimated at 11.5% with up to 25% of adults infected in some Provinces.[8] Significant financial and programmatic investments have been made to prevent transmission and provide treatment to those infected; however, additional efforts are needed. According to recent reports only 45% of those eligible are receiving treatment in Mozambique.[9] Studies in Sub-Saharan Africa suggest high unmet need for FP among HIV-positive women with between 51-96% of HIV-positive women expressing a desire to limit or space pregnancy but not using any form of contraception.[10] Still, few programs targeting HIV-positive women provide counseling and services for FP. Special populations at high risk for HIV are also at increased risk for unplanned pregnancy and have high unmet need for FP, yet are often reached only with HIV-related services. In Kenya, 85% of sex workers reported an induced abortion as a result of an unplanned pregnancy and, in both Swaziland (66%) and Madagascar (52%), over half of sex workers reported a prior unwanted pregnancy.[11]

Mozambique's high fertility has led to a significant "youth bulge," meaning a large share of the population are children or young adults. In Mozambique, 45% of the population is below age 15.[12] One quarter of both girls and boys initiate sexual relationships by the age of 15, and the adolescent pregnancy rate is one of the highest in Sub-Saharan Africa.

In Mozambique, 45% of girls ages 15-19 in the lowest income group are either parents or pregnant with their first child. Adolescent pregnancy affects not only the health of the young woman and her child, but also long-term education and employment opportunities for both boys and girls.

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[8] HIV Fact Sheet Mozambique (2009). INSIDA Mozambique. Available at: http://www.measuredhs.com/pubs/pdf/HF33/HF33.pdf

[9] WHO, UNICEF, UNAIDS (2013). Global Update on HIV Treatment 2013: Results, Impact and Opportunities. Available at: http://apps.who.int/iris/bitstream/10665/85326/1/9789241505734_eng.pdf

[10] Halperin DT, Stover J and Reynolds HW, Benefits and costs of expanding access to family planning programs to women living with HIV, AIDS, 2009, 23(Suppl. 1):S123–S130

[11] Khan MR, Turner AN, Pettifor A, Van Damme K, Rabenja NL, Ravelomanana N, Swezey T, Williams D, Jamieson D; Mad STI Prevention Group, Behets F. (2009). Unmet need for contraception among sex workers in Madagascar. Contraception. 79(3):221-7.

[12] Pathfinder Mozambique Factsheet. 2005 Available at: http://www2.pathfinder.org/site/DocServer/Mozambique2.pdf?docID=291

Early marriage among young girls is common and contributes to early sexual initiation and early pregnancy. Nationally, 21% of girls are married by age 15; this rises to 53% in some Provinces like Nampula. Many of these relationships are polygamous with significantly older partners. Estimates indicate that 19% of married girls ages 15-19 are in polygamous marriages where the partner is an average of 10 years older.[13]

The need for sexual and reproductive health services, including contraception and family planning for youth, is evident. Previous multi-sectoral programs in Mozambique such as *Geração Biz* (Busy Generation) made some progress in addressing these issues. The program focused on providing youth-friendly clinical services including STI/HIV and pregnancy prevention, in-school interventions, and community-based outreach. Results showed improvements in knowledge about SRH issues, some changes in perceived gender roles and norms, and improved service uptake. For example, from 2003 to 2005, use of contraceptive methods (including condoms) increased from 36% to 60% and voluntary counseling and testing (VCT) increased from 11% to 38%.[14] While still in existence and led by the GRM, the program has been reduced significantly and it is unknown if results have been sustained.

Family planning is an essential part of primary health care and has been identified as a key intervention to addressing maternal morbidity and mortality, child health, nutrition, and HIV/AIDS. Data show that family planning can prevent up to 32% of maternal deaths and 10% of child deaths globally.[15] Family planning can drastically reduce the spread of HIV/AIDS by preventing HIV-positive births.[16] HIV-positive women have consistently reported high unmet need for FP (up to 90% in Rwanda) and are at increased risk of delivery, postpartum, and newborn complications, and death.[17]

Addressing and understanding the benefits of family planning beyond the health sector are equally important for key populations like youth. For example, addressing the sexual and reproductive needs of young adults can contribute to the achievement of the demographic dividend[18] and spur economic growth. Increased numbers of working-age

[13] Population Council 2004. Child Marriage Briefing: Mozambique. Available at: http://www.popcouncil.org/pdfs/briefingsheets/MOZAMBIQUE.pdf

[14] Pathfinder International (2009). From inception to large scale: The Geracao Biz Programme in Mozambique. Available at: http://www.pathfinder.org/publications-tools/pdfs/From-Inception-to-Large-Scale-The-Geracao-Biz-Programme-in-Mozambique.pdf

[15] Cleland J, Bernstein S, Ezeh A, Faundes A, Glasier A, Innis J. (2006). Family planning: the unfinished agenda. Lancet. 2006 368(9549):1810-27. Available at: http://www.sciencedirect.com/science/article/pii/S0140673606694804#

[16] Johnson K, Varallyay I, Ametepi P. (2012). Integration of HIV and family planning health services in sub-Saharan Africa: A Review of the literature, current recommendations, and evidence from the Service Provision Assessment Health Facility Survey. ICF International.

[17] Kak L. Chitsike I, Luo C, Rollins N. (2008). Opportunities for Africa's Newborns: Chapter 7 Prevention of mother to child transmission. WHO Report. Available at: http://www.who.int/pmnch/media/publications/aonsectionIII_7.pdf

[18] Demographic dividend refers to a period when fertility rates fall due to significant reductions in child and infant mortality rates and increases in contraceptive prevalence. This increases the portion of the

people who are fully employed in productive activities, and reduced numbers of dependents, can increase the average income per capita, leading to increased economic growth and development. However, if large populations of working-age young adults remain unemployed, there will be little growth per capita. This can lead to increased social and/or political instability[19].

In addition to spurring economic growth through the demographic dividend, FP investments can also lead to improved education status, reduced poverty, increased wealth, and environmental sustainability.[20]

Several factors have hindered family planning efforts in Mozambique over the past decade. Health systems challenges, traditional beliefs favoring large families, myths and misconceptions about contraception, poor access to services, challenging policy environments, and low funding commitments by both the government and donors, have all contributed to low contraceptive use, high fertility rates, and high unmet need for family planning throughout the country.

Health Systems Context

Like many countries in sub-Saharan Africa (SSA), Mozambique is moving towards a more decentralized health system. The Ministry of Health (MISAU) is organized into three administrative or management levels—the central agencies, the District/Provincial level (DPS), and the District and City Health Directorate (SDSMAS). Service provision in Mozambique is dominated by the public sector through the National Health System (NHS). Estimates indicate that almost 95% of health care is provided through NHS government services.[21] However, public sector services reach less than 60% of the population. This is because the majority (70%) of the population resides in rural areas where even the most basic primary health care post is weak. WHO estimates that only 36% of people have access to a health facility within 30 minutes of their homes, and 30% have no access to any health care. Additionally, the quality and type of services provided is varied and only 50% of the population has access to the appropriate level of health care needed.[22]

Facility Based Services

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population that is in the working age-group and reduces spending on dependents thereby facilitating economic growth.

[19] World Bank, World Development Report 2011: Conflict, Security, and Development. Washington, DC.

[20] Cates W. (2010). Family planning: the essential link to achieving all eight Millennium Development Goals. Contraception (81): 460-61. Available at: http://www.k4health.org/sites/default/files/sdarticle%5B1%5D.pdf

[21] Visser-Valfrey M. and Umarji M. B. 2010. July 2010. Sector Budget Support in Practice Case Study Health Sector in Mozambique. London, UK: Overseas Development Institute and Oxford, UK: Mokoro.

[22] Connor C, Cumbi A, Borem P, Beith A, Eichler R, Charles J. (2011). Performance-based Incentives in Mozambique: A Situational Analysis. Bethesda, MD: Health Systems 20/20, Abt Associates Inc. Available at: http://www.healthsystems2020.org/files/2799_file_Performance_based_Incentives_in_MozambiqueA_Situational_Analysis.pdf

Public sector facility service provision is organized into four levels of care. Level 1 includes both rural and urban health centers. Services include inpatient and outpatient prevention and curative services such as deliveries, antenatal services, immunizations, and family planning. In addition, mobile teams (mobile brigades) are sometimes deployed to provide services at the community level. However, these services are not standardized or regularly monitored and lack of funds has limited their use. Level 2 facilities provide additional services including emergency care, trauma, and obstetric surgeries. Level 2 facilities often have more laboratory and x-ray capacity as well. Finally, level 3 and 4 facilities include larger health facilities at the provincial level. There are 3 central hospitals in Maputo, Nampula, and Sofala.

Family planning service delivery occurs at the health facilities at all levels through the maternal and child health (MCH) nurses who provide FP counseling and service provision of most modern methods—condoms, oral contraceptives, injectables, IUDs, and, more recently, contraceptive implants.

Community Based Services

At the community level, service provision is provided through the mobile brigades, the APEs (*Agente Polivalente Elementar*) and/or NGO supported community health workers also called *activistas/animadores.* The Ministry of Health (MISAU) is currently revitalizing the APE program nationally and APE training includes IMCI, distribution of bed-nets, and growth monitoring. Currently there is no provision of family planning services as part of the APE curricula although condoms and dual protection messages are promoted as part of HIV/AIDS services[23].

There are over 10,000 NGO-supported *activistas* or *animadores* working in Mozambique often as volunteers or with very minimal pay. They provide educational information and help mobilize communities around various development areas such as education, economic development and agriculture. Health messages and information is a large part of their scope and often includes family planning messages on birth spacing to support maternal and child survival, dispel myths about contraceptive methods, and discuss healthy family size.

Private Sector

The majority of family planning services are accessed through the public sector. In fact, only 16% of users access methods through the private sector and, of those, the majority through private pharmacies (7%) and grocery stores (4%). Another 7% of women access supplies through "other sources," primarily friends and relatives. The for-profit private sector is largely confined to major cities.

Private sector distribution of FP commodities has focused on condoms to combat the spread of HIV/AIDS. In 2011, 41% of all male and 35% of all female condoms were

[23] Curtin L, Kantner A, Alleman P, Thatte, N. (2012). Family Planning assessment in Mozambique.

distributed through the private sector. There has been little progress in supplying other FP methods through private outlets, in part due to policy constraints that have limited the ability to sell a broad range of contraceptive methods through commercial channels. Currently pharmacies are only allowed to sell oral contraceptive (OCs) pills and, OCs can only be obtained with a prescription. Other methods such as injectables, IUDs, and implants are available only in private clinics. There is documentation of impressive uptake of LARCs in private clinics where services are available indicating a high demand for longer term methods.[24]

I.3. Framework and Links to Other USG Supported Initiatives:

The USG strategy for development and foreign assistance in Mozambique through the Country Development Coordination Strategy (CDCS) has prioritized five strategic goals:

1. Strengthen democratic governance in Mozambique
2. Improve competitiveness of key economic sectors
3. Improve the health of Mozambicans
4. Expand opportunities for quality education and training
5. Enhance capabilities of Mozambican security forces

The FP Integrated Project will respond to Goal 3: Improve the Health Status of Mozambicans. The proposed project will align with other USG and USAID/Mozambique and USG supported Initiatives.

Country Development Coordination Strategy (CDCS)

The USAID/Mozambique CDCS outlines an overarching Development Objective Health Goal -- to "Improve the Health Status of Target Populations" through three results: 1.) Increased coverage of high impact health and nutrition services, 2.) increased adoption of positive health and nutrition behaviors, and 3.) strengthened systems to deliver health, nutrition, and social services (CDCS, 2013). Aligning with this goal and results, the FP Integrated Project aims to: Increase use of modern contraceptive methods by target populations" through three Intermediate Results: 1.) Increased access to a wide range of modern contraceptive methods and quality FP/RH services, 2.) Increased demand for modern contraceptive methods and quality FP/RH services, and 3.) Strengthened FP/RH health systems.

USAID *Forward*

The FP Integrated project will contribute to several reforms under USAID Forward. Specifically, the project will include a strong monitoring and evaluation component and will contribute to building the capacity of local institutions.[25]

[24] DKT 2013 Annual Report
[25] USAID Forward Reforms (2011-2015) Available at: http://www.usaid.gov/usaidforward

Global Health Initiative

In 2011, the GHI Mozambique Strategy was finalized with a focus on investments in key regions, Gaza, Sofala, and Zambezia. The strategy offers a five-year vision for a direct and integrated response to the issues facing the health sector in Mozambique, particularly in maternal child health, nutrition, and family planning. GHI reinforces a need to reach more women and girls, focus on joint planning and direct partnerships with local government and civil society, integrate programming in MNCH and FP, and improve monitoring and evaluation (M&E). The current FP Integrated Project will align with the Mozambique GHI Strategy and Ministry of Health Strategies by focusing on integrating FP into packages of MNCH and HIV services at both facility and community levels. The FP Integrated Project will not fund specific MCH activities that may be supported by other donors; however FP activities will be integrated into and coordinated with MCH and HIV program activities as appropriate. In addition, project sites will be in Provinces that coordinate with those specified under the GHI.

FP 2020

In July 2012, FP 2020 was launched with the goal of reaching 120 million women and girls through increased access to voluntary family planning methods by the year 2020.[26] The Deputy Minister of Health from Mozambique was heavily visible during this summit and ensured that country efforts would focus on: providing FP services at the community level, strengthening facilities to ensure universal access to information and FP services, and increasing the contraceptive prevalence rate to 34% by 2020. In addition, the GRM announced their commitment to increase the percentage share in the national budget allocated to family planning, from the current level of 5% of the global cost of contraceptive procurement, to 10% by 2015, and to 15% by 2020.

PEPFAR

USG agencies, including USAID, are working with the GRM and other donors in a coordinated response to the HIV/AIDS epidemic in Mozambique. USAID's focus is on promoting evidence-based programing in HIV prevention, care, and treatment to achieve tangible impact on the epidemic. The USAID PEPFAR portfolio is committed to building and fostering ownership by aligning the PEPFAR portfolio to national policies and plans through building capacity of service delivery and health systems at National, Provincial and District levels and through public diplomacy to engender strong leadership. Activities are aligned with the GRM's National HIV/AIDS Acceleration Plan 2013-2015 which aims to increase: the percentage of eligible adults and children on ARTs to 80%, the percentage of pregnant women receiving ARVs to 90%, and the percentage of adult male circumcision to 75% in target areas, all by 2015.

The COP 2014 guidance clearly indicates a need for strengthened efforts to integrate FP

[26] FP 2020. Available at: http://familyplanning2020.org

and HIV Programming. The focus of integration is not on HIV status but rather on HIV platforms such as Prevention of Mother to Child Transmission (PMTCT), HIV/AIDS Care and Treatment, Key Populations such as MARPs, and Health Systems Strengthening.[27] The FP Integrated Project will work with community partners to ensure that FP/HIV integration is occurring across all PEPFAR platforms.

PMI

Mozambique was identified for the Presidential Malaria Initiative (PMI) in 2007. The primary goal of PMI investment was to support the GRM, along with other donors and partners, to reduce malaria by 50%. The focus is to scale- up four high impact effective interventions: artemisinin-based combination therapy (ACT), intermittent preventive treatment of pregnant women (IPTp), insecticide-treated bed nets (ITNs), and indoor residual spraying (IRS). In FY2013, PMI Mozambique started to decentralize efforts to provincial and district levels in order to achieve greater impact at the community level. PMI is also investing heavily in Behavior Change Communication Strategies to complement treatment and other prevention efforts. BCC activities are largely supported through the Inter-Religious Campaign Against Malaria (PIRCOM), a consortium of religious groups working in Zambezia, Nampula, Sofala, Inhambane and Gaza. Given the scope of the FP Integrated Project to focus at the community level, links will be made with PMI partners on the ground such as PIRCOM to disseminate IEC materials and messaging about FP and birth spacing at the community level.

Ending Preventable Child and Maternal Deaths (EPCMD)

Ending Preventable Child and Maternal Deaths is USAID's response to the global movement, *A Promise Renewed*.[28] The goal is to end preventable child and maternal deaths in a generation. This will be achieved by: geographic focus in the 24 countries in which 80% of preventable deaths occur; increased focus on high burden populations, for example, rural and urban low-income groups; increased use and scale-up of high-impact solutions in child and maternal health, family planning, and nutrition, such as skilled birth attendants and, for family planning, mobile outreach with trained LARC (long-acting reversible contraception) providers; increased focus on educating women and girls; and, increased attention to monitoring and measurement of progress. The FP Integrated Project has the potential to make an important contribution to EPCMD.

USAID Integrated Health Office (IHO) Strategy

In 2009, USAID/Mozambique finalized a Country Assistance Strategy to be implemented from 2009 to 2014. Goal 3 is focused specifically on health--to "Improve the health of Mozambicans." The strategy specifically outlines efforts to reduce "maternal mortality by increasing rural access to health facilities, and expanding reproductive health services and access to family planning counseling and contraceptives at the health facility and community levels" (Country Strategy, p.11). In addition, the strategy highlights the need

[27] COP 14 Guidance
[28] http://5thbday.usaid.gov/pages/responsesub/roadmap.pdf

to leverage existing initiatives such as PEPFAR to "develop integrated systems that improve comprehensive support for health needs" (Country Strategy, p.11).

Relationship to Other Integrated Health Office Programs

The FP Integrated Project will complement efforts of other projects supported by the USAID/Integrated Health Office Mechanisms. Key projects are listed below:

- The **USAID/DELIVER Project** works with partner country governments and non-governmental and private voluntary organizations to develop, strengthen, and operate safe, reliable, and sustainable supply systems to provide essential health supplies through public and private services. The DELIVER project is currently operating in country to provide contraceptive commodities. The FP Integrated project will link closely with DELIVER to ensure products are being delivered to program sites and referral system between facilities and central warehouses are strengthened.
- The **Central Contraceptive Procurement (CCP)** project provides a mechanism for consolidated USAID purchases of contraceptives, including condoms, and the independent testing of these products. The FP Integrated Project will work closely with CCP to ensure adequate commodities are forecasted for anticipated program growth.

- The **Health Care Improvement (HCI)** project uses modern improvement methodologies adapted from the US health care system to identify and test changes in health care that may improve clinical quality, efficiency, and patient-centeredness. HCI provides a range of services related to other quality improvement strategies, most notably in the area of OVCs. While not a major focus of the FP Integrated project, efforts to integrate sexual and reproductive health for OVCs, including providing IEC materials and contraceptives methods in addition to condoms, will be explored. OVCs are at increased risk of transactional sex, coerced sex, early marriage, and unintended pregnancy.[29] [30]

- The **Capable Partner Program (CAP)** supports health systems strengthening by improving the organizational capacities of civil society organizations, to implement quality health programs at the community level, and to participate actively in the health system. Where applicable, efforts will be made through the FP Integrated Project to engage civil society at the community level on issues around sexual reproductive health and family planning.

- **SCIP Nampula and Zambezia** are currently focused on strengthening community-based services across health areas including HIV/AIDS, MCH, and family planning.

[29] Juma M, Alaji J, Bartholomew K, Askew I, Van den Born B. (2012). Understanding orphan and non-orphan adolescents' sexual risks in the context of poverty: a qualitative study in Nyanza Province, Kenya BMC Int Health Hum Rights. (13): 32.

[30] Gregson S, Nyamukapa CA, Garnett GP. et al. HIV infection and reproductive health in teenage women orphaned and made vulnerable by AIDS in Zimbabwe. AIDS Care. 2005;13(7):785–794.

The FP Integrated Project will build on lessons learned from these projects to improve service delivery at the community level and strengthen referral systems from the community to facility.

- The Recipients will work closely with the new **SBCC Project** that will be awarded in-country. The new SBCC project will be mandated to develop and test SBCC tools and approaches with respect to a variety of health and nutrition topic areas. The FP Integrated project will use, and disseminate, relevant IEC and BCC materials and products developed by the SBCC project in all service delivery points at both facilities and at the community level. In addition, the FP Integrated Project will support efforts by the SBCC Project to evaluate the impact of such materials and approaches.

- The **Maternal Child Integrated Program (MCHIP)** has been operating in Mozambique since 2009. The project supports the GRM/MISAU's Model Maternity Initiative (MMI) which is designed to improve the quality of care for maternal and newborn health services, such as postpartum hemorrhage, eclampsia, obstructed labor, sepsis, newborn asphyxia, and hypothermia. The MMI Initiative started in 2009 and includes 34 of the largest maternity hospitals, covering 21% of institutional deliveries (note: 55% of births in Mozambique occur in facilities). To date, MCHIP has expanded the MMI from 34 to 95 health facilities. The FP Integrated Project will work closely with MCHIP and the MMI to ensure that FP services, including post-partum IUD and FP counseling, post-abortion care, and FP integration into cervical cancer screening, are included in the maternal health care package.

In addition to aligning with USG and Government of Mozambique Strategies, successful implementation will require fostering more collaborative partnerships with the private sector (for profit and non-profit civil society) and other development partners and donors such as UNFPA.

I.4. Alignment with Government of Mozambique Priorities:

The government of Mozambique has engaged in various efforts to prioritize health and development. The Action Plan for the Reduction of Absolute Poverty (PARPA II), the Economic and Social Plan (Plano Económico e Social or PES), and the Health Sector Strategic Plan, 2007–2012 (Plano Estratégico do Sector Saúde, or PESS), all highlight the importance of improved facility and community-based services in Mozambique to achieved Millennium Development Goals and other health goals. In 2010, the Ministry of Health in Mozambique launched a more focused National Family Planning and Contraception Strategy (2010-2015) with two primary goals:

1. Increase the Modern Contraceptive Prevalence Rate from 14% in 2003 to 25% in 2015; and
2. Increase new, modern family planning method users from 12.5% in 2008 to 19% in 2014.

To achieve these goals, the strategy outlined the following key objectives, to: 1.) increase the availability and quality of FP and contraception services, 2.) increase the demand for FP and contraception services, 3.) strengthen the management system, logistics, monitoring and evaluation of FP and contraception services, and 4.) increase commitment and mobilization of resources and strengthen coordination mechanisms.[31]

The MOH strategy also emphasizes human rights, evidence-based practices, gender equity and sustainability. In addition, adolescents/youth, men, and people living with HIV/AIDS were identified as key target populations. The proposed activity will align closely with the existing MOH strategy to ensure that evidence-based practices and interventions are implemented to ensure access to quality FP services. In addition, as mentioned above, the Government of Mozambique has been involved with FP 2020 priorities and, as part of their involvement, have committed to increasing contraceptive coverage to 34% by 2020.

I.5. Objectives, Expected Results and Activities:

Objectives:

The goal of the FP Integrated Project is to increase use of modern contraceptive methods by target populations. To achieve this goal, investments will be made to improve service delivery at both the community and facility level. The FP Integrated Project will implement interventions for target populations that align with USG and GRM priorities. Target populations include postpartum women, HIV-positive women, adolescents, including Orphans and Other Vulnerable Children (OVCs), medium and high-parity women, post abortion care women, and men/boys, especially with respect to the need for male engagement in FP/RH and gender-based violence. These groups have a high unmet need for family planning.

Applicants should describe how their proposed program will expand the implementation and scale-up facility and community-based FP services to meet the contraceptive needs of target populations, to achieve maximum service coverage as quickly and effectively as possible. Applications should reflect a strong knowledge of evidence-based, high impact FP practices, and other effective FP practices, and propose areas to implement and test innovative approaches. For each result, strong applications will describe how their proposed program will work in full partnership with MISAU at the central, provincial, district, and community levels.

Key provinces will be suggested based on the epidemiological and political landscape and previous work in the country (Annex 5). However, applicants are encouraged to provide a justification and rational for working in whichever provinces they feel will result in the greatest impact on FP use and other improved health outcomes.

[31] The Republic of Mozambique Ministry of Health, National Directorate of Public Health (2010): Family Planning and Contraception Strategy 2010-2015 (2020).

Similarly, while some illustrative activities and interventions have been presented, applicants are encouraged to be selective and propose activities based on strategic analyses that consider the current evidence base, contraceptive needs and method mix, availability of existing service delivery mechanisms and platforms, and other issues related to target populations.

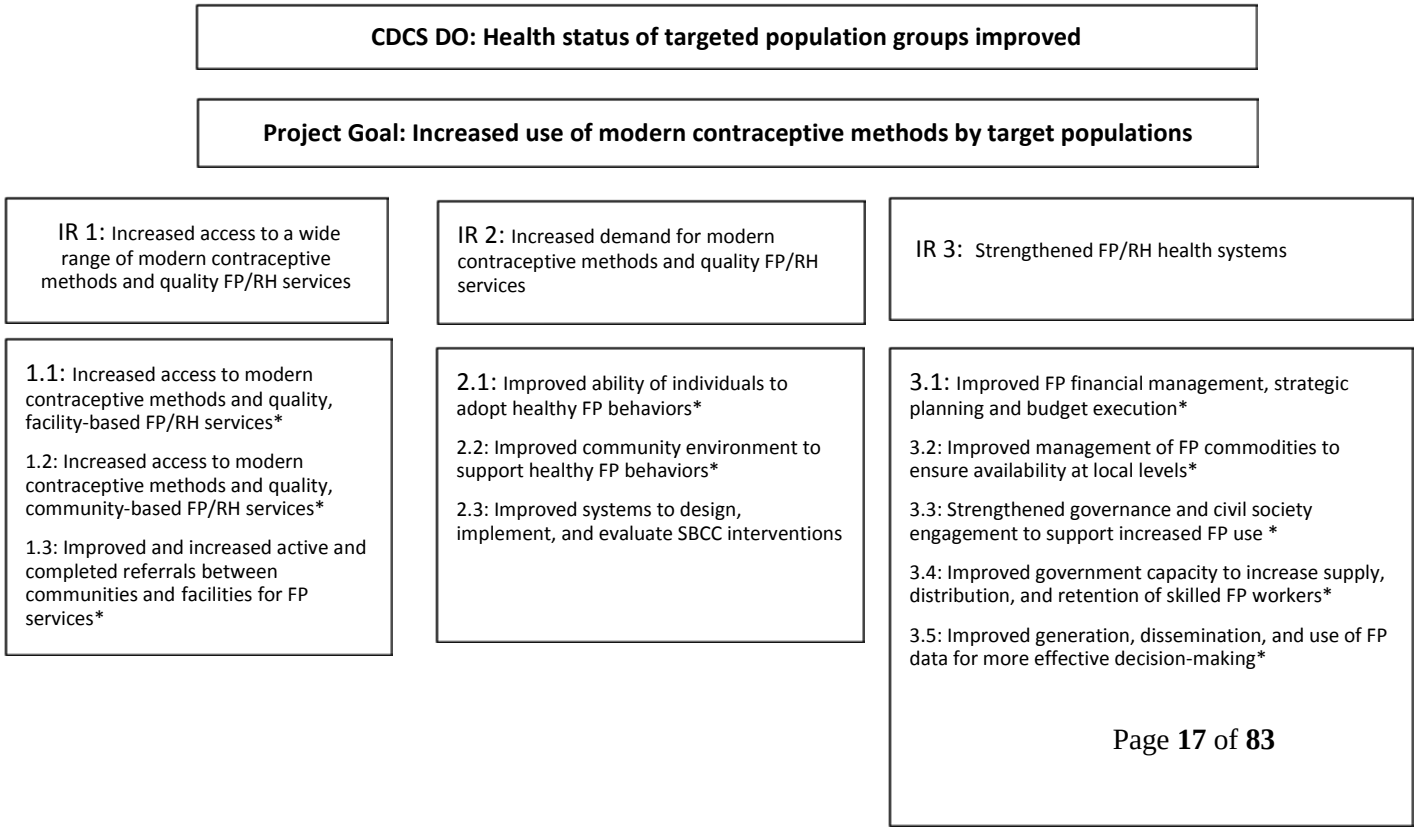
This project will aim to achieve three Intermediate Results:

IR 1: Increased access to a wide range of modern contraceptive methods and quality FP/RH services;
IR 2: Increased demand for modern contraceptive methods and quality FP/RH services; and
IR 3: Strengthened FP/RH health systems.

Expected Result and Activities:

Applicants will describe how their proposed program will increase access to a wide range of modern contraceptive methods and quality FP/RH services. They will describe how their program will integrate FP services and BCC with, or link these services to, MCH and HIV services, including health and non-health community-based organizations. Activities will include those that address key drivers of maternal morbidity and mortality (Annex 1) and have demonstrated clear impact on increasing access to and use of family planning methods (Annex 2). Figure 1 illustrates the results framework proposed for the FP Integrated Project. Each Intermediate Result will be supported by sub-results. A list of illustrative activities is presented below.

Figure 1:



*The FP Integrated project will contribute directly to these Results.

IR 1: Increased access to a wide range of modern contraceptive methods and quality FP/RH services

Sub IR 1.1: Increased access to modern contraceptive methods and quality, facility-based FP/RH services

Applicants should describe how their proposed program will increase access to modern contraceptive methods at facilities, and FP/RH services, provided in compliance with USG regulations. FP clinical services may also be linked to well-baby clinics and high-risk child clinics that provide a standard package of child survival interventions. Applicants should describe how these clinical FP services will be linked to community-based interventions to ensure a continuum of care from the facility to the home.

Illustrative Activities:

- Postpartum FP/RH services, prior to discharge, and at immunization services[32]
- Adolescent contraception/reproductive health services
- Contraceptive method mix expanded to include fertility awareness methods (LAM; SDM), temporary methods, long-acting reversible contraception (LARCs) and permanent methods
- FP integration into select HIV clinical services (i.e. PMTCT; HCT; ART)
- Post-abortion family planning (PAC) services
- Training of LARC and PM providers
- Group education activities, especially for medium and high parity women
- Standards set and implemented for improved quality of facility services
- Position descriptions prepared for all facility-level cadres
- Development of quality, client-centered, counseling protocols for facility and community health workers (protocols respond to clients' needs, include information on side effects, discuss fertility desires, convey HTSP messages appropriate for age, parity, and HIV status, and include screening for GBV)
- Community health committees' role in facility quality improvement defined

Sub IR 1.2: Increased access to modern contraceptive methods and quality, community-based FP/RH services

Applicants should describe how their proposed program will increase access to modern contraceptive methods and quality, community-based FP/RH services. Applicants should consider how they propose to strengthen the APE network to include FP services and expand the mobile brigade network. The *Agente Polivalente Elementar* (APEs) and NGO supported *activistas/animadores* are the primary health workers serving rural

[32] High Impact Practices for Family Planning (2012). USAID, UNFPA, WHO/IBP and Partners. Available at: www.fphighimpactpractices.org See also Healthy Timing and Spacing of Pregnancy Toolkit, available at: http://www.k4health.org/toolkits/HTSP

communities in Mozambique. The Ministry of Health (MISAU) is currently revitalizing the APE program nationally and APE training includes IMCI, distribution of bed-nets, growth monitoring, provision of condoms, and health messaging. USAID will support efforts to include family planning counseling, method distribution (beyond condoms), and referrals as part of standard APE curricula and service provision.

In addition to the APE network, a second cadre of community health workers, the *activistas* or *animadores,* also provide services at the community level. There are over 10,000 NGO-supported *activistas* or *animadores* working in Mozambique, often as volunteers or with very minimal pay. They provide educational information and help mobilize communities around various initiatives related to health and agriculture. They convey family planning messages on birth spacing to support maternal and child survival, dispel myths about contraceptive methods, and discuss healthy family size.

Finally, mobile brigades are used to deliver health services to remote and hard to reach communities. These mobile brigades are linked to a health facility and are part of the existing health infrastructure. Mobile brigades are being used in some regions to provide child health services like immunizations. However, to date their use has not included provision of contraceptive methods (especially long-acting methods) and shortages of funds have limited the ability to expand and maintain the mobile brigades throughout the country. Applicants should describe how they propose to revitalize the mobile brigade platform to provide key family planning services in hard to reach areas. Applicants should describe how they will work with MISAU and local partners to ensure the availability of a wide range of FP methods, including long-acting reversible contraceptive methods, that are in high demand but inaccessible in remote areas.

Engaging the private sector, particularly local pharmacies and drug shops at the community level has potential to increase access to FP methods. To date, only condoms have been distributed through private sector channels. However, there is potential to expand provision to include pills and possibly injectables. The FP Integrated Project will be encouraged to explore opportunities to expand access through other partners working in the private sector.

Illustrative Activities:

- Mobile brigade/outreach service provision for a range of methods including LARCs
- FP integration into select HIV community-level services (i.e., work with HIV-positive pregnant women, OVCs)
- Community-based health worker (APE) provision of family planning services strengthened (i.e., LAM/SDM, pills, condoms, injectables)
- Community-based provision of postpartum family planning services (through pregnancy surveillance, and home visits during antenatal care and postpartum)
- Community-based provision of adolescent contraceptive services linked to youth livelihood, agriculture, micro-finance, or educational groups
- Adolescent contraception/reproductive health services at community levels
- FP integration into non-health community sectors such as environment, agriculture, and microfinance programs

- Linkages with private sector and social marketing outlets to provide FP methods such as condoms, pills, injectables
- Small grants program to community-based organizations to support FP/RH/HTSP education
- Activities to define and strengthen community involvement in mobile outreach
- Activities to support data collection capabilities of community health workers through mhealth
- Quality standards set and implemented for APE FP service provision
- Quality standards set and implemented for LARC service provision in the mobile brigades

Sub IR 1.3: Improved and increased active and completed referrals between community and facility for FP/RH services

In addition to strengthening both facility and community-based services, applicants should describe how their program will strengthen referral systems between community and facility- level services. Applicants should consider how communication technologies between community health workers (i.e. APEs, *activistas, animadores*) may be used to bolster supervision and reporting requirement with facility-based nurses and supervisors.

Illustrative Activities:
- Using Health applications for strengthened referral processes from community to facilities in urban and rural areas
- Building capacity of traditional healers/birth attendants for systematic referrals for FP services
- Increasing the referrals of LAM users to facilities at 6 months to support transition to another modern method of family planning
- Training facility and community health providers in data collection to monitor and track the FP referral process and its relationship to FP use

IR2: Increased demand for modern contraceptive methods and quality FP/RH services

Applicants should describe their proposed approach to increase demand for modern contraceptive methods and quality FP/RH services. Though many women in Mozambique are knowledgeable about family planning methods, demand is still low and unmet need is high (29%).[33][34] Increasing demand includes addressing social and gender norms around contraceptive use, ideal family size, fertility intentions, and other social and cultural factors. Applicants should describe their program's approach to advancing understanding, among target populations, of the role of modern contraceptive methods in improved maternal and child health outcomes. Specifically, they should address the ways that their proposed program will educate target populations on the ways that modern

[33] Demand is defined as the sum of the total unmet need and total current use (Measure DHS)
[34] Unmet need is defined as the percentage of women who are not currently using a method of contraception but want to either delay, space, or limit child-bearing (Measure DHS)

contraceptive methods can be used to practice healthy FP use behaviors including avoiding: pregnancy before age 18; rapid, repeat pregnancy; unwanted pregnancy, and unwanted pregnancy among post abortion care women, medium and high parity women, and HIV-positive women. Applicants should address how they will engage men in FP/RH and address GBV.

Activities to support increased demand for modern contraceptive methods and FP/RH services will coordinate with other USAID-supported SBCC efforts focused specifically on developing tools and materials for strategic behavior change communication.

Sub-IR 2.1: Improved ability of individuals to adopt healthy FP behaviors

Individual empowerment and self-efficacy are central to many behavior change theories. Evidence-based social and behavior change communication at the individual level can help increase knowledge about FP methods. It can also address barriers and myths around use of FP, and help individuals use contraceptives correctly to meet fertility desires and achieve improved health outcomes and quality of life. Applicants should describe how their proposed program will strengthen the ability of individuals to adopt healthy FP behaviors.

Illustrative Activities:

- SBCC activities to increase knowledge about FP's role in achieving healthy timing and spacing of pregnancy behaviors, and their link to improved maternal, newborn, and child health
- Activities to increase knowledge about family planning (i.e., address myths, misconceptions, knowledge about fertility/infertility)
- Activities to enhance individual efficacy and empowerment to use FP, e.g., couples communication
- FP information/referrals linked to literacy, income generation, and life-skills programs

Sub-IR 2.2: Improved community environment to support healthy FP behaviors

In addition to building individual empowerment and efficacy for behavior change, addressing community beliefs, norms, and attitudes can foster a strong community environment for collective behavior change. Applicants should describe their approach to improving the community environment to support healthy FP behaviors.

Illustrative Activities:

- Increasing knowledge of local "influentials" concerning healthy pregnancy behaviors that can be achieved through FP use
- Addressing gender and cultural norms related to healthy family size
- Addressing community norms relating to adolescent pregnancy
- Advancing male engagement in FP/RH

- Integrating FP into non-health sectors/province-wide platforms (i.e. nutrition programs, mothers clubs, youth farmers, women's microfinance/microcredit, Mulheres Primeiros)
- Undertaking advocacy on the role of FP in economic development
- Educating families and communities on immediate and exclusive breastfeeding and LAM at the same time, and their role in maternal and newborn/infant health

Sub-IR.2.3: Improved systems to implement and evaluate SBCC interventions

The FP Integrated Project will build on existing platforms, tools, and materials developed by other USAID- supported behavior change programs. The focus of the FP Integrated Project will be on implementation of SBCC interventions through service delivery networks as outlined in Sub IR 2.1 and 2.3, and support to evaluation of SBCC efforts.

Illustrative Activities:
- Facility-level SBCC plan prepared and implemented, to include program managers, supervisors, and providers in public facilities
- Community-level SBCC plan prepared and implemented, to include community health committees, civil society organizations, adolescent peer educators, youth livelihood groups, faith-based organizations/religious leaders, women's groups, and agricultural groups

IR 3: Strengthened FP/RH health systems

The lack of strong health systems to support service delivery has been recognized as a key barrier to the implementation and sustainability of effective health interventions.[35] Former WHO Director Margaret Chan noted, "Without urgent improvements in the performance of health systems, the world will fail to meet the health-related Goals. As just one example, the number of maternal deaths has stayed stubbornly high despite more than two decades of efforts. This number will not fall significantly until more women have access to skilled attendants at birth and to emergency obstetric care." While the focus of the FP Integrated Project is on service delivery, the Project will address select FP HSS issues to strengthen and sustain the delivery of services. Applicants should describe their approach to strengthening the select FP systems described in the results below.

Sub IR 3.1: Improved FP financial management, strategic planning, and budget execution

Applicants should describe their approach to working in partnership with MISAU to strengthen ministry capacity at the provincial level to prepare and implement an annual, provincial-level plan for effective, quality, family planning service delivery. Strong applications will describe how the proposed program will include high impact practices in family planning, and how the plan will be monitored.

[35] WHO (2007) Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action.

Illustrative Activities:

- Supporting project-funded FP staff to be seconded to the provincial level MISAU (in three provinces) to provide technical assistance – to strengthen public-sector capacity for FP management, annual planning, budget preparation, and implementation of annual provincial FP plans
- Supporting project-funded FP staff seconded to the provincial level MISAU to provide technical assistance to strengthen public sector capacity for monitoring implementation of the annual provincial FP plan
- Supporting project-funded FP staff seconded to the provincial level MISAU to incorporate high impact practices in family planning into the annual provincial FP plan

Sub IR 3.2 Improved management of commodities to ensure availability at local levels

Applicants should describe their approach to improving the availability of contraceptive commodities from the provincial to the community and primary health care levels. Strong applications will describe their program's proposed efforts to coordinate with other projects that are specifically devoted to contraceptive commodity supply chain management.

Illustrative Activities:

- Strengthening facilities' capacity to report on and request commodities
- Improving community health committees' capacity to monitor/report on/obtain contraceptive commodities for local facilities
- Testing and evaluating alternative commodity distribution schemes (e.g., commodities on Coca-Cola trucks to rural areas)

Sub IR 3.3: Strengthened governance, including civil society engagement, for an improved FP enabling environment

Applicants should describe their approach to strengthening the enabling environment for FP, especially at the community level.

Illustrative Activities:

- Strengthening the capacity of civil society groups (women's, adolescent, livelihood groups) for FP/RH advocacy, especially to increase GRM financial commitment to FP/RH
- Improving the capacity of local journalists to report on FP/RH issues
- Strengthening the capacity of local influentials (parliamentarians, district leaders, religious leaders) to speak out on family planning as a maternal and child health and development intervention

Sub IR 3.4: Improved government capacity to increase supply, distribution, and retention of skilled workers

Applicants should describe how they will work in partnership with MISAU to strengthen the FP capacities of health providers, as well as MISAU's capacity to deploy an increased number of FP providers and retain them. Applicants may want to consider focusing on trained LARC providers, FP providers on mobile brigades, and APEs.

Illustrative Activities:

- Expanding mobile brigade capacity for FP service delivery with trained LARC providers between facility and community levels
- Increasing the number of trained LARC providers
- Leveraging community and private sector resources to increase APEs' salaries
- Increasing FP health workers' capacities to provide fertility-awareness methods, e.g., LAM and SDM (SDM and LAM are modern family planning methods.)

Sub IR 3.5: Improved generation, dissemination, and use of FP data for more effective decision-making

Applicants should describe their approach to strengthening FP data collection, at both the community and facility levels, and in the referral process.

Illustrative Activities:

- Strengthening health facility capacity for FP/RH commodities and service data collection
- Improving community health worker capacity for commodities reporting and FP/RH service data collection
- Increasing use of data by district and provincial teams for decision-making

I.6. Core Operating Principles:

Aligning with the GHI, the FP Integrated Project will follow some key operating principles. These principles will help guide the design and implementation of the program.

Country Ownership:

Country ownership encourages USAID-supported projects to support programming and intervention modalities that can eventually be implemented and sustained by local governments and partners. The FP Integrated Project will ensure that activities are well aligned with and supported by GRM initiatives and priorities. In addition, the project will work to build the capacity of local institutions, particularly at the community level, to ensure that FP interventions and services can be sustained beyond the life of the project. The applicant is encouraged to explore opportunities to partner with local government counterparts at the central and/or provincial level, including potentially proposing sub-agreements with the MOH and/or the DPS. In addition, the applicant is

encouraged to identify local civil society organizations that can help implement the activity and to propose how these local partners can help implement this activity and contribute to fostering country ownership.

Health Systems Strengthening:

Weak health systems often limit access to services, particularly at the community level. Though not specifically intended to improve all aspects of the health system, the FP Integrated Project will contribute significantly to strengthening select systems that support FP service delivery. For example, strengthening the reach of mobile brigades from health facilities into communities will not only increase the reach for service delivery, but will inherently strengthen the community-facility linkage in the health system.

Promoting Global Health Partnerships:

Not one donor, organization, or partner country can address all health needs thus highlighting the importance of global partnerships. In addition to working with other USAID-supported and USG-funded projects, the FP Integrated Project will work closely with other donor-supported projects to ensure efforts are aligned and not duplicated. While the focus of the FP Integrated will be on public sector service delivery, the project is encouraged to explore opportunities with the private sector to improve access and service utilization, particularly among key populations such as youth and low-income urban groups. The applicant is also encouraged to propose how they will leverage funds from the private sector and other donors, and how they will complement and coordinate with relevant activities supported by other partners.

Integration:

As stated in the GHI guiding principles, the integration of health sector activities with activities in other sectors – such as water and sanitation, education, food security, agriculture, economic growth, microfinance, and democracy and governance – can achieve high-yield gains for health. The FP Integrated Project will focus integration on health services such as integration of FP into HIV and MCH services at both the facility and community levels, and non-health services. As stipulated by the PEPFAR Country Operational Plan 2014 Guidance, integration of FP into all HIV platforms will be encouraged and monitored. This includes PMTCT, key populations such as OVCs, HIV Counseling and Testing and Care and Treatment Services (COP 14 Guidance). In addition, at the community level, there may be opportunities to further integrate FP with other programmatic interventions such as education, literacy, nutrition, economic growth, youth livelihood, and agriculture.

Focusing on Women, Girls, and Gender Equity: This principle aims to address gender imbalances related to health, promote the empowerment of women and girls, and improve health outcomes for individuals, families, and communities. The FP Integrated Project will address gender by ensuring both women and men of reproductive age are reached

with FP and health services. In addition, a focus on youth will ensure that gender norms and ideals about sexual and reproductive health issues are addressed for both young boys and girls. The FP Integrated Project will work to advance male engagement in FP/RH and address GBV.

Research and Innovation:

According to the GHI, achievement of the GHI goals requires innovative translation of investments in health research into real and measurable population-level health outcomes. It is equally important that programmatic innovation developed at the country level is measured and documented rigorously and shared in scientific communities. The FP Integrated Project will be encouraged to publish results in ways that are informative programmatically and that meet the standards of the scientific community. In addition, research questions that emerge from field based programs will be explored in the FP Integrated Project through a small research component described below.

Improve Metrics, Monitoring and Evaluation:

Monitoring and evaluation will be incorporated throughout the program, beginning with a baseline assessment and including routine implementation monitoring. A comprehensive project monitoring plan (PMP) will be critical to monitor progress in achieving project goals and objectives. A detailed log-frame will be included as part of the PMP along with key indicators. The PMP will be closely monitored on a biannual basis. An illustrative set of indicators is included in Annex 3.

Knowledge Management and Translation:

The FP Integrated Project will be encouraged to disseminate and share information with other projects in Mozambique as well as other partners. Effective strategies for knowledge management will ensure that collaboration between partners is maximized and lessons are learned and shared in the most efficient ways. The project will be encouraged to organize dissemination meetings with local partners on a regular basis to further ensure exchange of information between the field level implementers and other project and donor staff.

I.7. Evaluation Research and Innovation:

Though the FP Integrated Project will focus on implementation of service delivery interventions, this project will provide a platform to test innovative approaches to strengthen service delivery. This will include testing models for integration of FP and HIV Services. Current evidence has indicated the significant potential for improved outcomes by integrating FP and HIV services. Studies have demonstrated a marked increase of contraceptive use and dual method use (i.e., use of a contraceptive plus condoms), increased use of long acting and reversible contraceptive methods, and reduced unwanted pregnancy incidence. And, while integration has been observed in

PMTCT, ART and VCT/HCT settings[36] more needs to be done. A recent review further articulated the need for "stronger programmatic efforts and implementation research to address the obstacles to integrating these two essential services. The following are some illustrative research activities that may be implemented through this award.

- Effect of Integrating FP SBCC Messaging into PMTCT and HCT Programs on FP uptake and quality of HIV services
- Effectiveness of *activistas* and other FP/RH volunteers in increasing demand for and use of modern contraceptive methods and practice of healthy FP behaviors
- Effectiveness of inter-personal FP communication (IPC) by traditional healers including TBAs and Community Leaders, on FP use
- Effectiveness of SBCC education to parity 2 and 3 women on health risks (for mother and child) of high parity and subsequent FP use
- Effect of small-scale grants to non-health organizations on increase in FP knowledge and/or uptake of FP services at the community level
- Effect of mobile outreach (via mobile brigades) on increasing use of and access to long-acting methods for FP at the community level
- Effect on FP use of linking FP to non-health activities for youth (e.g., life-skills activities)
- Effectiveness of SBCC for youth on fertility awareness and relation to avoiding unwanted pregnancy

I.8. Implementation Mechanism:

The IFPP will be a Cooperative Agreement with a five-year term. The project will be managed by the USAID Integrated Health Office MCH's Team. The project will be eligible to receive both USAID PEPFAR and other Health funds from a variety of accounts.

Applicants are encouraged to propose creative, collaborative partnerships with local Mozambican organizations, NGOs, private voluntary organizations, small businesses and firms to implement activities under this program. Proposing at least one new partner in response to this NFO is also strongly encouraged. "New partners" are defined as organizations that have never received USAID funding as either a direct or sub-recipient. Partnerships should be of manageable size with relationships and responsibilities clearly defined.

I.9. Monitoring and Evaluation:

The Integrated Family Planning Project will include a comprehensive Monitoring and Evaluation Plan (M&E Plan). The M&E Plan will include a clearly defined Results Framework with indicators, baselines, and targets for output, outcome, and impact-level monitoring. The M&E Plan will be aligned with PEPFAR and GHI principles for

[36] Wilcher R, Hoke T, Adamchak SE, Cates W. (2013). Integration of family planning into HIV services: A synthesis of recent evidence. AIDS. 27 (Suppl 1): S65-S75.

Mozambique and will include benchmarks for program performance over the course of the five-year implementation period. In addition, metrics to assess country ownership, capacity building efforts, and the sustainability of successful interventions should be included.

The M&E Plan will facilitate monitoring activity progress toward targets and benchmarks in annual work plans that have been developed with the responsible IHO team members and reviewed and approved by the Assistance Officer's Representative (AOR).

Adhering to the USAID Evaluation Policy, the recipient will be responsible for the collection of baseline data that will correspond to the Project's Goal, Intermediate Results, and Sub-Results, as specified in the Performance Monitoring Plan (see USAID Evaluation Policy, p.8). Baseline data (resulting from studies or other sources) should be sex-disaggregated, as appropriate, and used to establish reference points. Baseline data will be critical for future evaluations of the program.

Key evaluation questions to indicate program impact should be proposed and included in the M&E Plan. The Recipient will be responsible for conducting a mid-term program review during the third year of implementation to address both descriptive and normative questions, to include: 1) the extent to which the Integrated Family Planning Project Goal, and Intermediate Results and Sub-Results were met, the reasons for the variance per available baseline data, and how the review's findings can further inform future implementation; 2) project achievements and whether expected results occurred; 3) how the project was implemented in terms of core operating principles; and 4) other questions that are pertinent to project design, management, and operational decision-making.

Given that this program will contribute to all USAID/Mozambique health elements, the program must have the capacity to report results and monitor indicators specific to the IHO performance monitoring plan. The recipient will be called upon to provide these data in the semi-annual and annual report and for USAID portfolio reviews.

{END OF SECTION I}

SECTION II: AWARD INFORMATION

II.1. Number and Type of Awards:

USAID expects to award one Cooperative Agreement under this Funding Opportunity. The Government may issue one or more awards resulting from this funding opportunity to the responsible applicant(s) whose application(s) are the most responsive to the objectives set forth under this NFO. The Government may (a) reject any or all applications, (b) accept other than the lowest cost application, (c) accept more than one application, (d) accept alternate applications, and (e) waive informalities and minor irregularities in applications received.

II.2. Estimate of Funds Available:

Subject to the availability of funds, USAID intends to provide up to US$34,560,000 in total USAID funding for the life of the activity. Funding for accepted application(s) will be provided on an incremental basis subject to the availability of funds and successful performance. USAID reserves the right to change the funding amounts, cycle, and terms of the grant agreements as a result of availability of funding and U.S. Government requirements. Should such changes occur, grantees will be appropriately notified.

II.3. Period of Performance:

The anticipated Start Date for the award is October 1, 2015. The entire period of performance anticipated herein is five (5) years as of the effective date of the award.

II.4. Substantial Involvement:

Consistent with ADS 303.3.11, USAID will remain substantially involved over the life of the Cooperative Agreement to assist the Recipient in achieving the expected outcomes and results of the Activity. On behalf of USAID, the AOR will be substantially involved in the following:

1. **Approval of the Recipient's Implementation Plans**. USAID will approve the Annual Work Plans and the Annual Budget. USAID will also approve the Branding Plan and the Marking Plan, which are to be developed before the signing of the award.

2. **Approval of Specified Key Personnel.** USAID will approve the designation of Key Personnel positions and Key Personnel.

3. **Agency and Applicant Collaboration or Joint Participation.** There are specific elements in the Program Description for which USAID's technical knowledge would benefit the Recipient's successful accomplishment of stated program objectives. The following collaboration or joint participation of USAID and the Recipient on the program are authorized:

- Advisory Committee: USAID will involve in selection of advisory committee member, if the program will establish an advisory committee that provides advice to the Recipient. USAID may participate as a member of this committee as well.
- USAID shall approve the sub-award, transfer or contracting out of any work under the awards.
- USAID shall approve the Recipient's Monitoring and Evaluation Plans.
- USAID shall authorize specified kinds of direction or redirection because of interrelationships with other projects.

II.5. Title to Property:

Property title under the resultant Agreement shall vest with the Recipient upon acquisition unless otherwise specified in the award.

II.6. Authorized Geographic Code:

The authorized geographic code for procurement of goods and services under this Award is 937 as described in 22 CFR 228.

II.7. Authority to Obligate the Government:

The Agreement Officer (AO) is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed agreement may be incurred before receipt of either a fully executed Agreement or a specific written authorization from the AO.

II.8. Order of Precedence:

In the event of any inconsistency between the sections comprising this New Funding Opportunity, it must be resolved by the following order of precedence:

- Section V- Application Review Information;
- Section IV - Application And Submission Information;
- Section I - Funding Opportunity Description;
- Cover Letter.

{END OF SECTION II}

SECTION III: ELIGIBILITY INFORMATION

III.1. New Partners:

In accordance with the Federal Grant and Cooperative Agreement Act, USAID encourages competition in the award of grants and cooperative agreements to identify and fund the programs that best achieve Agency objectives. USAID also encourages applications from potential new partners.

III.2. Eligibility Requirements:

All qualified U.S. and non-U.S. organizations (other than those from foreign policy restricted countries) are eligible to apply. Pursuant to 2 CFR 200.400(g), it is USAID policy not to award profit under assistance instruments such as cooperative agreements, and as such, for-profit organizations must waive profits and/or fees to be eligible to submit an application. For the purposes of this solicitation, NGOs include any incorporated entity, either non-profit or for-profit, other than a governmental organization.

III.3. Ceiling Level

The proposed ceiling level of $34,560,000.00 has been determinated from (1) current activities ahd funding levels from MCH/FP and PEPFAR sources serving maternal health; (2) and Independent government Cost Estimate to determine the amount of funding needed to obtain expected results and targes of this NFO, and (3) strategic planning in conjunction with the USG interagency PEPFAR team of planned FP/RH and MCH funding levels. Accordingly, funding is estimated at the following levels over the life of the project (five years):

- The total USG estimated cost for the Activity for a five year period is $34,560,000.00. The implementing partner will contribute approximately $3.450 million dollars in cost share towards the Activity per the NFO requirement of minimum 10% cost share contribution. The Integrated Health Office (IHO) expects to initiate this activity with approximately $5,050,000.00 in FY16 using prior years funding, with the remaining funding secured in Operation Plan 13 through Operational Plan 15 and Country Operational Plan (COP) 15.

III.4 . Cost Share Requirements:

In keeping with the provision of ADS 303.3.10.1 (Cost-sharing Determination) USAID/Mozambique IHO technical activity management team is responsible for determining the approach to cost sharing based, inter alia, the programmatic and technical context. The USAID/Mozambique IHO technical team has determined that cost sharing on the part of a qualified cooperative agreement partner can be useful to maximize

sustainability and the recipient benefits gained by this Activity. A minimum of 10% cost share is required.

III.5. Responsible Entity:

The successful Applicant will be responsible for ensuring achievement of the program objectives as described in SECTION I: FUNDING OPPORTUNITY DESCRIPTION. Applicants under consideration for an award may be subject to a pre-award audit to determine fiscal responsibility, ensure adequacy of financial controls, and establish an indirect cost rate. The Agreement Officer may determine if a Non-U.S. Organization Pre-Award Survey is required, and if so, would establish a formal survey team to conduct an examination that will determine whether a prospective Recipient has the necessary organization, experience, accounting and operational controls, and technical skills—or the ability to obtain them—in order to achieve the objectives of the NFO.

{END OF SECTION III}

SECTION IV: APPLICATION AND SUBMISSION INFORMATION

IV.1. General Instructions:

1. Issuance of this New Funding Opportunity (NFO) does not constitute an award commitment on the part of USAID, nor does it commit USAID to pay for any costs incurred in the preparation or submission of an application.

2. The Government may make award on the basis of initial applications received, without discussions or negotiations. Therefore, each initial application should contain the applicant's best terms from a cost and technical standpoint. The Government reserves the right (but is not under obligation to do so), however, to enter into discussions with one or more applicants in order to obtain clarifications, additional detail, or to suggest refinements in the program description, budget, or other aspects of an application.

3. Neither financial data submitted with an application nor representations concerning facilities or financing, will form a part of the resulting agreement(s).

4. Please be advised that each applicant (unless the applicant is an individual or Federal awarding agency that is excepted from those requirements under 2 CFR §25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR §25.110(d)) is **required** to:

   i) be registered in SAM before submitting its application;
   ii) provide a valid DUNS number in its application; and
   iii) continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency. The Federal awarding agency may not make a Federal award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time the Federal awarding agency is ready to make a Federal award.

   The registration process may take many weeks to complete. Therefore, Applicants are encouraged to obtain them early to be eligible to apply for this Funding Opportunity.

   DUNS number: http://www.dnb.com/get-a-duns-number.html
   SAM registration: http://www.sam.gov

   Completion of an early registration does not constitute any commitment on the part of the U.S. Government to make an award.

5. Applicants must review, understand, and comply with all aspects of this Notice of Funding Opportunity. Failure to do so may be considered as being non-responsive and may be evaluated accordingly.

6. The complete Notice of Funding Opportunity including all the attachments, can be found and downloaded from http://www.grants.gov. Select "Find Grant Opportunities", then click on "Browse by Agency", and select "U.S. Agency for International Development" and search for this NFO. If there are problems in downloading the NFO, please contact Grants.gov Help Desk at 1-800-518-4726 or support@grants.gov for technical assistance.

   Potential applicants that cannot download the application materials electronically may request paper copies of the NFO by contacting:

   Antonieta Manhica
   Acquisition & Assistance Specialist
   Office of Acquisition & Assistance
   USAID/Mozambique
   JAT Complex
   Bairro Central "C"
   Rua 1231, No. 41
   Maputo, Mozambique
   E-mail: amanhica@usaid.gov

7. Applicants must set forth full, accurate and complete information as required by this NFO. The penalty for making false statements to the U.S. Government is prescribed in 18 U.S.C. 1001.

8. Proprietary Information: Applicants which include data that they do not want disclosed to the public for any purpose or used by the U.S. Government except for evaluation purposes must:

   - Mark the title page with the following legend: "This application includes data that must not be disclosed outside the U.S. Government and must not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this application. If, however, a grant is awarded to this Applicant as a result of - or in connection with – the submission of this data, the U.S. Government must have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in pages ___."; and,

   - Mark each sheet of data it wishes to restrict with the following legend: "Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."

9. The application must include only one prime applicant, which may enter into sub-agreements or sub-contracts with partnering institutions. In this case, the Prime Applicant will be responsible for establishing and maintaining sub-agreement and/or contracting relationships with proposed partners. For the purposes of this Notice of Funding Opportunity, the term "applicant" is used to refer to the prime and any proposed partners.

10. All questions regarding this Notice of Funding Opportunity (NFO) should be submitted in writing (via e-mail) to Antonieta Manhica, Acquisition & Assistance Specialist, at amanhica@usaid.gov and Marianne Pinto-Teixeira, Supervisory Acquisition & Assistance Specialist, at mteixeira@usaid.gov not later than the Deadline for Questions specified at the top of the Cover Letter of this NFO. This will provide USAID with sufficient time to address the questions and incorporate the answers to the questions as an Amendment to this NFO. Any information given to a prospective Applicant concerning this NFO will be furnished promptly to all other prospective Applicants as an amendment to this NFO, if that information is necessary in submitting applications or if the lack of it would be prejudicial to any other prospective Applicant. Amendments (if any) to this NFO will be posted on www.grants.gov.

    USAID anticipates that there will only be one (1) round of questions and answers throughout the Notice of Funding Opportunity process, therefore applicants should submit all questions by the Deadline for Questions specified in the Cover Letter of this NFO.

IV.2. Application Submission Procedures:

1. Applicants are requested to submit separate Technical and Cost Applications. The Technical Application and Cost Application must be kept separate from each other (presented in separate binders or electronic files), and the Technical Application must not make any reference to the cost data in order for the technical review to be made strictly on the basis of technical merit.

2. All information (including both the Technical and Cost Applications) must be submitted in English. If the application is in any other language, it will be treated as nonresponsive and eliminated from further consideration.

3. Each Applicant must furnish the information required by this Notice of Funding Opportunity. The Applicant must sign the application and certifications and print or type its name on the Cover Page of the technical and cost applications. Applications signed by an agent must be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.

4. Applications must be submitted electronically in two separate parts: (a) technical and (b) cost or business application to: ifpp.rfa@usaid.gov not later than the Applications Submission Deadline specified at the top of the Cover Letter of this NFO.

5. The application must be submitted via e-mail to the e-mail addresses specified above with up to three (3) attachments (2MB limit) per e-mail. Telegraphic or faxed application submission is not authorized for this Funding Opportunity and will not be accepted.

6. Preferred software for electronic submissions: Microsoft Word (for narrative text) or Excel (for tables). PDF files are acceptable. The Applicant is required to submit its budget breakdown in Excel Spreadsheet format. The Excel sheets should not be password protected or locked. Formulae must be visible/accessible.

7. After sending applications electronically, applicants must immediately check their own e-mail to confirm that the attachments that they intended to send were indeed sent. If they discover an error in the transmission, they need to send the material again and note in the subject line of the e-mail that it is a "corrected" submission. Applicants should not wait for USAID to advise them that certain documents intended to be sent were not received, or that certain documents contained errors in formatting, missing sections, etc. Each Applicant is responsible for its submission.

8. Please do not send the same e-mail to us more than one time unless there has been a change, and if so, please note that it is a corrected e-mail. If multiple copies of the same e-mail are sent, it will be difficult for USAID to know if there has been any change from one e-mail to the next. Furthermore, the Applicant should appoint one person to send in the e-mail submissions to minimize confusion.

9. If you send your application by multiple e-mails, please indicate in the subject line of the e-mail whether the e-mail relates to the Technical Application or Cost Application, and the desired sequence of multiple e-mails (e.g. “Technical Application/E-mail 1 of 3) and of attachments (e.g. "Cost.Application.Attachment.1.of.4").

10. To ensure receipt by USAID, the Applicant should make sure that e-mail attachments are not greater than 2 MB in size. For cases that exceed this size limit, the Applicant is advised to reduce the document size (MB) and submit its application in multiple e-mails.

11. Applications submitted in hard copy will be accepted if submission in electronic copy is not practicable. Such submissions (whether by hand delivery or international courier/commercial carrier) must be addressed to the Acquisition & Assistance Specialist at the following address:

Antonieta Manhica
Acquisition & Assistance Specialist
Office of Acquisition & Assistance
USAID/Mozambique
JAT Complex

Bairro Central "C"
Rua 1231, No. 41
Maputo, Mozambique
E-mail: amanhica@usaid.gov

The hard copies of the applications (and any modifications thereof) shall be submitted in sealed envelopes or packages. The NFO number (RFA-656-15-000009) must be written on all envelopes or packages. The Applicant should submit one original and two copies of the Technical Application and one original and two copies of the Cost Application. A CD ROM of both the Technical Application and the Cost Application should also be submitted in their respective envelopes/packages. The envelope/package must be labeled "Technical Application" or "Cost Application", and must list the name and address of the sender/Applicant.

Note that such submissions must be received by USAID by the Application Submission Deadline indicated at the top of the Cover Letter of the NFO. Delivery to the post office or air/hand courier representative does not constitute meeting the statutory requirement that applications are received on time at the designated office. For purposes of recording the official receipt of applications, the date/time stamp of USAID/Mozambique will govern.

12. Applicants should take into account the expected delivery time required by the application transmission method they choose.

13. Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this Notice of Funding Opportunity are not desired and may be construed as an indication of the Applicant's lack of cost consciousness. Elaborate artwork, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

14. Applicant must retain for their records copy of the e-mails and application and all enclosures which accompany the application.

15. All applications received by the Application Submission Deadline will receive a receipt confirmation e-mail from USAID, and will be reviewed for responsiveness to the specifications outlined in these guidelines and the application format.

16. Late or Incomplete Submissions: Applications which are submitted late or incomplete may not be considered for award, unless the Agreement Officer determines it is in the Government's interest. If USAID decides to consider such applications, it will be in accordance with ADS 303.3.6.6.

VIII.3. Technical Application Format:

The Technical Application should be specific, complete and concise. The application must demonstrate the Applicant's capabilities and expertise with respect to achieving the goals and objectives of this Activity.

The Technical Application narrative section **must not exceed 30 single-spaced typed pages in English** (12 font size Times New Roman Font, single spaced, typed in standard 8.5 x 11 paper size with one-inch margins both right and left and each page number consecutively).

Information submitted over 30 pages will not be evaluated. To facilitate the competitive review of the applications, USAID will consider only applications conforming to the prescribed format and page limitations. Any other information submitted will not be provided to the Selection Committee and will not be reviewed. Letters of support are not requested and will not be provided to the Selection Committee.

The following will be counted as part of the page limitation:

- Title Page (not counted against page limit);
- Cover Page (not counted against page limit);
- Table of Contents (not counted against page limit);
- Executive Summary;
- Technical Approach;
- Management Approach; and
- Institutional Capacity and Past Performance.

Annexes: Promotional literature and materials regarding the applicant must not be submitted as part of the annexes. The following items are not subject to the page limitation and will not be counted (a page in the technical application, which contains a table, chart, graph, etc., not otherwise excluded below, is subject to the "page" limitation):

- Resumes/Curriculum Vitaes for Key Personnel and long-term professional staff, proposed position descriptions and signed letters of commitment from Key Personnel;
- Partner letters of commitment;
- Branding Strategy and Marking Plan (two pages summary is only required as part of the application package);
- Charts providing information on management structure, matrixes demonstrating staff skills, and organizational chart(s);
- Past Performance Short Forms; and
- Monitoring and Evaluation Plan.

All other items not listed as an annex are included in the above page limitation. Please number pages as "Page of Page" where a page number combined with a letter indicates a page that is exempt from the 30-page limitation.

Annexes can be numbered separately and should be numbered as "Annex 1: 1 of X, Annex 2: 2 of X", et cetera. Pages should be paginated at the bottom.

The Technical Application should confirm or propose modifications to the objectives, activities and indicators described under Section I of this Funding Opportunity. It should also contain a description of key strategies, activities and approaches, as well as the synergies among them that the proposed partner will pursue in order to accomplish the desired results described in this Activity Description, as well as the rationale for selecting them. Gender and youth issues should also be addressed. Interested applicants must provide a detailed technical application and demonstrate how it will achieve the overall goal, program objectives and results as previously described.

The Technical Application will be the most important part of consideration in selection for award of the proposed activity. It shall take into account and be arranged in the order of the technical review criteria found in Section V—for ease of reviewing by the Selection Committee (SC):

> Title Page: The Applicant must include the following basic information in the title page: Proposed project title; NFO number; Name of organization(s) submitting the application; Address of organization(s) submitting the application; Point of contact (POC) at organization; and POC's title, telephone number, fax number and e-mail address.
>
> Cover Page: Describe the names of the organizations/institutions involved in the proposed application. In the case of a group, please indicate the lead or primary applicant clearly; followed by any proposed sub-grantees and/or contractors (hereafter referred to as "subs"), including a brief narrative describing the unique capacities/skills being brought to the program by each institutions. A summary table should be included that lists the Prime Applicant and all partner organizations as well as the percentage of overall program activities that each partner will contribute. The Cover Page must be signed by the organization's official with authority to negotiate/sign on such an application with USAID.
>
> Table of Contents: The Table of Contents should list all parts of the technical application, with page numbers and attachments.
>
> Executive Summary: Brief description of proposed activities, goals, and anticipated results (both quantitative and qualitative). Briefly describe technical and managerial resources of your organization. Describe how the overall program will be managed. State the bottom line funding request from USAID and the bottom line funding secured from other sources (state sources and amounts) for the proposed Activity.

Program Description: The Technical Application Narrative as revised during negotiations, will become the Program Description of any resulting Cooperative Agreement. It must include a clear description of the conceptual approach and the general strategy (i.e. methodology and techniques) being proposed. It must outline specific, focused activities; identify how and where (e.g. geographic locations and level: local, national, etc.) those activities will be implemented; explain how the approach is expected to achieve the proposed objectives; and describe a plan that will enable the activities to continue after the Activity has been completed.

Technical Approach: The technical approach shall address the following five areas as described below. Use clear logic to describe the links between the context analysis, program hypothesis, the objectives, methods and anticipated results.

- The Applicant must describe its understanding of the context for achieving the project goal, objective and indicators. The information and material presented must include relevant background information and analysis of the problem, demand for a solution, and opportunity or challenge relevant to implementing the project and attaining the results.

- The Applicant must detail its proposed approach, interventions and the anticipated results that can be expected from each. While anticipated results are included in the NFO Program Description, Applicants must tailor or add to those results based on their specific approach and interventions proposed. This must include the intended impact on the problem, opportunity, challenge, and demand. The Applicant must clearly demonstrate the relevance of the proposed approach to the Mozambique context and provide a judicious mix of proven and creative local, low-cost, and innovative approaches, interventions or business models to achieve the proposed goal, objective and expected results. The Applicant must include a timeline for its approach and interventions throughout the life of the project, with significant detail in the first year of the effort.

- The Applicant must describe the risks associated with the proposed methods that are likely to affect the project outcomes. The Applicant must include factors that are both within and outside of the Applicant's control, and strategies the Applicant will utilize to mitigate or reduce risk and ensure the proposed results are achieved.

- The Applicant must articulate which key public and private sector stakeholders it intends to coordinate and engage with to advance the project’s goal and objective, to amplify the funding and/or

contributions and to achieve scale that would not be possible only through USAID funds. The Applicant must also explain why those stakeholders are vital to the approach. The Applicant must identify its existing relationship or work history with those organizations. Applicants must describe how they will coordinate and engage with the stakeholders to ensure ownership, maximize synergy and resources, minimize overlap, and achieve the project's goal and objective.

- In light of USAID's guidance in ADS 205 and the USAID Gender Equality and Female Empowerment Policy, the Applicant must describe how the project will address gender inequalities, and promote female empowerment. In carrying out this project and its various interventions, the successful Applicant must also take into consideration social inclusion issues, both in its operations and in its outcomes, to achieve the project goals and to encourage high participation by disadvantaged groups. Specific details must be provided as to how members of disadvantaged groups will be targeted and benefit from and actively participate in project activities.

Management Approach: The project management approach and implementation plan shall address the following:

- The Applicant must include an organizational chart and specify the composition and organizational context of the entire project team (including corporate office support and any sub-recipients/partners). Through the chart and accompanying narrative, the Applicant must specify clear lines of supervision, accountability, decision making and responsibility among staff. The Applicant must explain the management structure presented in the organizational chart with relationships among the individual positions described; logistical support; personnel management of staff; procurement arrangements for goods and services; and lines of authority and communications between organizations and staff.

- If sub-recipients are proposed, Applicants must describe how the partnership will be organized and managed to use the complementary capabilities of proposed partners most effectively, and to minimize duplication of corporate office management structures and maximize resources committed to direct project activities. Efficient and effective technical and managerial project oversight is of particular interest to USAID. The Applicant must specify the responsibilities of all proposed organizations and the rationale for their selection, and proposed reporting relationships between the Applicant and each of these organizations. Letters of commitment must be included in Annex.

- The Applicant must also describe its day-to-day processes and tools it will use to ensure effective management of the project.

- The Applicant must include a complete staffing plan for all activities. It is not necessary to name specific candidates for non-Key Personnel positions in the staffing plan. The Applicant must provide the name of the position, location of the position, the number of personnel per the position, organization of the position (Applicant or sub-recipient), individual staff level of effort per year and their roles and responsibilities.

- Quality of Key Personnel: Applicants are requested to develop a comprehensive staffing plan that will enable achievement of results and that demonstrates an appropriate balance of skills, accountability, and efficiency, including levels of effort and brief position descriptions. The staffing pattern will include a critical number of highly experienced technical and managerial staff sufficient to manage activities under this award. It is critical for applicants to show how the following qualifications are met by the staff proposed, taken as a whole, and how the staffing pattern is conducive to achieving results. The key qualifications for the proposed staff include skills and experience in:

    - Management and administration of assistance instruments such as grants and cooperative agreements;
    - Facility and community based implementation of FP, MCH, and HIV service delivery interventions in resource poor settings;
    - Technical knowledge of FP high impact practices and other effective FP practices;
    - Experience in strengthening public sector FP management capacity and in improving service quality;
    - Partnerships with governments, donors and local organizations;
    - Monitoring and evaluation and research methods for measuring program impact; and
    - Excellent teamwork, interpersonal and cross-cultural skills.

  Applicants will identify five (5) key personnel: Chief of Party/Director; Deputy Director; Deputy for Clinical Services; Deputy for Community Services; and a Monitoring and Evaluation Specialist. Applicants will identify these 5 key personnel by name and position. Each will be one full-time equivalent.

i. Staffing Plan and Key Personnel

The application must include an organizational chart showing placement of proposed personnel (both technical and administrative) with clearly defined position titles, level of effort, and lines of reporting. Applicants shall also discuss proposed technical, managerial and other personnel as deemed appropriate to implement the tasks described in the NFO. Such staff should have played important technical and country-level support roles in the past.

Five key personnel should be proposed with their names, positions, and a brief description of relevant education, skills, and experience to achieve the results of this activity. Applicants shall also include, in an Annex, resumes for all key personnel candidates. Resumes may not exceed two pages in length and shall be in chronological order starting with most recent experience.

Letters of commitment from all key personnel to the effect that they will be available for the period of the cooperative agreement, should the Applicant receive an award, and should also be included in the Annex. The letter of commitment should indicate: (a) availability to serve in the stated position, in terms of days after award; (b) intention to serve for a stated term of service (preferably at least two years); and (c) agreement to the compensation levels which corresponds to the levels set forth in the cost application. Finally, a list of three non-personal professional references should be included in the Annex for each proposed key personnel. The reference information provided in the Annex should consist of the following: full name and relationship, accurate and up to date e-mail address and phone number. The U.S. Government retains the right to contact employment references for all key personnel (including those not provided by the Applicant), and to use this information in the rating of personnel proposed.

The following Key Personnel are illustrative for this project: Chief of Party/Project Director, Deputy Chief of Party/Deputy Project Director, Finance and Operations Director, Monitoring and Evaluation Specialist and Capacity Development Advisor. Below are job descriptions and qualifications for each of the key personnel positions.

Chief of Party /Project Director (PD) (100 percent LOE)
The PD is responsible and has authority and oversight for the entire program. The PD provides managerial and technical support throughout the implementation of the project, including management of sub-partners. The PD is responsible for the development and submission of the Health Operational Plans and PEPFAR Country Operating Plan (COP) technical and budget documents, Annual Program Reports (APR) and Semi-Annual Program Reports (S/APR), in collaboration with the M&E Specialist, and develops requests for supplemental funding. S/he will have main responsibility for representation of the project to the United States Government (USG). The PD bears ultimate responsibility for ensuring that grantees and sub-grantees meet USAID, Health, PEPFAR and program requirements.

Required Qualifications:

- A Master's degree in public health, social sciences, or related degree; and at least 7 years of senior-level management experience in managing large, complex FP/RH and MCH including HIV care and support projects; or a Bachelor's degree in public health, social sciences, or related degree, and at least 10 years of senior-level management experience in managing large, complex care and support projects;
- At least 7 years of supervision experience;
- Demonstrated strong leadership, communications, and interpersonal skills;
- Demonstrated experience working with host country government; and
- Fluency in English and at least one Romance Language—e.g. Portuguese, Spanish, French, etc.

Preferred Qualifications:

- Strong skills and experience in all aspects of program cycle management - design and development, implementation, and monitoring and evaluation;
- Proven coaching, facilitation, and communication skills;
- Outstanding English-language skills, both spoken and written;
- Excellent knowledge of U.S. Government approaches and regulations;
- An excellent team player with good skills in team work and consultative approach to decision making;
- Understanding of U.S. government development assistance mission, values, and principles;
- Minimum of seven years of Chief of Party (COP), or equivalent, experience in Maternal and Child Health, including HIV components;
- Minimum of seven years management experience on large, complex, and multi-faceted donor-funded projects ; and
- Prior experience managing MCH or Family Planning activities, preferably in Africa.

Deputy Chief of Party/Deputy Project Director (DPD) (100 percent LOE)
The DPD is responsible for overseeing all programming, including ensuring the technical quality of services. The DPD works with sub-partners to decide on targets, oversees the development and execution of community action plans, monitors the implementation of the work plans, works with the PD to facilitate operational capacity building initiatives, directly facilitates technical capacity building, and supports coordination with local government and other key partners. The DPD directs and supervises senior program staff and consultants.

Required Qualifications:

- A Bachelor's degree in public health, social sciences, or other related field; Master's degree strongly preferred;
- At least 5 years of senior-level experience managing large, complex FP/RH/MCH and HIV projects;
- At least 3 years of supervision experience;

- Experience working with CSO's in advocacy training and institutional capacity building;
- Demonstrated experience planning, designing, implementing, monitoring, and evaluating projects;
- Demonstrated strong managerial, communications and interpersonal skills; and
- Fluency in English and at least one Romance Language—e.g. Portuguese, Spanish, French, etc.

Preferred Qualifications:

- Strong skills and experience in all aspects of program cycle management - design and development, implementation, and monitoring and evaluation;
- Proven coaching, facilitation, and communication skills;
- Outstanding English-language skills, both spoken and written;
- Excellent knowledge of U.S. Government approaches and regulations;
- An excellent team player with good skills in team work and consultative approach to decision making;
- Understanding of U.S. government development assistance mission, values, and principles;
- Experience managing large, complex, and multi-faceted donor-funded projects; and
- Prior experience managing MCH or Family Planning activities, preferably in Africa.

Finance and Operations Director (FOD) (100 percent LOE)

The FOD is responsible for overseeing project finances and other operational and administrative duties. The FOD will supervise all grant and contract management and reporting on contract and grant performance as well as provide financial and technical management to ensure best use of resources by preparing sound budgets, monitoring project expenses, and ensuring timely preparation of USAID financial reports.

Required Qualifications:

- A Master's degree or higher in Business Administration, Finance, Accounting, or relevant field, and at least 8 years of demonstrated experience in administrative and financial management of large-scale, complex, international development assistance programs; or
- A Bachelor's degree in Business Administration, Finance, Accounting, or related field or a professional qualification in accountancy, with at least 10 years' experience in administrative and financial management of large-scale, complex, international development assistance programs; and
- In-depth knowledge of U.S. Government financial management rules and regulations.

Preferred Qualifications:

- Strong financial and operational management experience with proven management skills;

- Strong interpersonal and team-building skills with significant experience building strong host country national team;
- Extensive experience in developing and managing a donor funded grants program; and
- Proven ability to work with a wide range of local organizations and people.

Monitoring and Evaluation Specialist (M&ES) (100 percent LOE)
The M&ES is responsible for all monitoring, evaluation and reporting activities under the award. The M&ES leads the development of and manages the Monitoring and Evaluation Plan (M&E Plan). The M&ES develops and maintains systems to collect and analyze information on inputs, outputs, outcomes and impact of the program. She/he conducts supportive supervisory visits to sub-grantees to observe, monitor, guide, and provide feedback on the use of data and indicators; analyze monthly data, and support training of M&E personnel in quality assurance methods.

Required Qualifications:
- Master's degree in a public health field, social science, economics, or relevant discipline. Significant study in fields relevant to FP/RH/MCH HIV care and support project, international development and/or program monitoring and evaluation;
- Strong background or formal training in evaluating international development programs such as but not limited to, Maternal and Child Health, Family Planning and Reproductive Health and HIV/AIDS;
- At least 5 years of experience related to monitoring, evaluating and reporting on programs related to FP/RH/MCH HIV or international development in developing countries;
- Demonstrated statistical analysis skills and use of relevant software; and
- Fluency in English and at least one Romance Language—e.g. Portuguese, Spanish, French, etc.

Preferred Qualifications
- Experience in design and implementation of M&E systems in the FP/RH/MCH and HIV/AIDS programs in Africa; and
- Demonstrated knowledge of host country management information systems. Proven leadership to support the strengthening of the M&E systems within a host country's Ministry of Health and other partner organization to improve the availability and use of data for decision-making.

Capacity Development Officer (CDO) (100 percent LOE)
The CDO will lead the project's internal capacity building and quality improvement efforts. The CDO will oversee the technical and organizational capacity development of the prime organization and the sub-partners. The CDO's responsibility is to tailor capacity building plans that may include human resources management, financial management, reporting, resource mobilization, sub-grant management, governance, reporting, monitoring and evaluation.

Required Qualifications:

- A Bachelor's degree in social sciences, business administration, or a related field;
- A minimum of 5 years of experience in capacity building, which includes at least 2 years of experience in capacity development aspects;
- Experience in assessing technical capacity of organizations, developing customized capacity building plans, and providing individualized training, mentoring and on-site support in various technical areas of need; and
- Fluency in English and at least one Romance Language—e.g. Portuguese, Spanish, French, etc.

Preferred Qualifications

- Solid experience in the management of people and systems in high-pressure environments;
- Experience in working with the U.S. Government in the developing country context; and
- Demonstrated experience working with local governments, multi-donor agencies and or developmental partners

Applicants should explain how the key personnel positions, as well as other proposed positions, provide the complete set of skills listed above. The staffing level and pattern may be increased or modified over time if needed to provide effective support to field programs as they evolve, rather than from the onset.

In an annex to the technical application, Applicants must provide resumes and proposed position descriptions for the candidates proposed for all key personnel and long-term professional positions. The resumes should indicate the names of the proposed personnel, and demonstrate that the proposed key personnel and long-term professional staff possess the skills and knowledge to effectively carry out their proposed responsibilities.

Resumes must be no more than three (3) pages in length for each proposed individual and must be presented in chronological order starting with most recent experience. For Key Personnel, each resume must be accompanied by a SIGNED letter of commitment from each candidate indicating his/her: (a) availability to serve in the stated position, in terms of days after award; (b) intention to serve for a stated term of the service; and (c) agreement to the compensation levels which correspond to the levels set forth in the cost application. References may be checked for all proposed long-term personnel. Applicants must provide current contact information, phone and e-mail address for at least three (3) references for each proposed Key Personnel.

Institutional Capacity and Past Performance: Institutional capacity and past performance shall include the following:

- Applicants should demonstrate their clear capacity and experience to accomplish the range of technical interventions described in the technical approach. Applicants

should describe success in implementing and managing outputs and activities similar to those described in the program description, and which achieved significant results. Applicants should also describe their institutional capacity—their ability to gather the resources and expertise necessary to implement their application, and to be able to sustain their efforts for the duration of the Agreement.

- The capabilities of the applicant should be spelled out clearly. Information should include the pertinent work experience and representative accomplishments of the firm/institution in developing and conducting activities of the type required under this award. The proposal shall have supporting verifiable, objective evidence of successful program implementation (e.g. listing of client organizations and previous employers for whom similar or relevant services were provided with names, addresses and contact information). Relevant documents and reports representative of past work related to this award should be submitted as annexes to the technical proposal.

- Applicants should also describe their responsiveness to past clients regarding ability to adapt to the circumstances of different settings and host county priorities.

- The Applicant should submit past performance information which demonstrates its record in conforming to award requirements and to standards of good workmanship; its record of forecasting and controlling costs; applicant's adherence to award schedules, including administrative aspects of performance; the applicant's history of reasonable and cooperative behavior and commitment to customer satisfaction, and its demonstrated professional concern for the interest of the customer; and the competency of the applicant's key personnel who worked on the award.

- Note that past performance information will be used for both risk assessment and greatest value decision by USAID. Also note that USAID may use past performance information obtained from other than the sources identified by the Applicant.

IV.4. Cost Application Format:

The Cost or Business Application must be submitted separately from the Technical Application and must be denominated/presented in U.S. dollars. Certain documents are required to be submitted by a successful Applicant in order for the Agreement Officer to make a determination of responsibility. The following sections describe the documentation that Applicants for Assistance awards must submit to USAID prior to award. While there is no page limit for this portion, Applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

<u>The Cost Application must include:</u>
- Summary Statement of Cost Application;
- Required forms SF-424;
- Pre-award certifications, Assurances and Other Statements of the Recipient;
- Detailed Budget (Excel Format);

- Budget Narrative;
- Cost Share Narrative; and
- Annexes:
    - DUNS Number and SAM;
    - Evidence of Responsibility;
    - Branding Strategy and Marking Plan Summary (2 pages limit).
    - Documents to support History of Performance (as necessary); and
    - Copy of Accounting Manual (as necessary).

Summary Statement of Cost Application: The Summary Statement of Cost application should include the funding requested from USAID and the funding secured from other sources (cost share, see Section III), stating sources and amounts for the proposed program.

Required Forms: The Cost/Business application must be submitted using SF-424 and SF-424A "Application for Federal Assistance" as described below.

- SF-424, Application for Federal Assistance;
- SF-424A, Budget Information – Non-construction Programs; and
- SF-424B, Assurances – Non-construction Programs.

These documents can be found at http://www.grants.gov/web/grants/forms/sf-424-family.html#sortby=1.

Pre-Award Certifications, Assurances and Other Statements of the Recipient: In addition to the certifications that are included in the SF-424 (described above), all applicants must provide the following certifications, assurances and other statements with the application:

These documents can be found at http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf:

- Assurance of Compliance with Laws and Regulations Governing Nondiscrimination in Federally Assisted Programs (This assurance applies to Non-U.S. organizations, if any part of the program will be undertaken in the U.S.);
- Certification on Lobbying (22 CFR 227);
- Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuals (ADS 206, Prohibition of Assistance to Drug Traffickers);
- Certification Regarding Terrorist Financing; and
- Certification of Recipient

Other certifications and statements found in ADS 303, Certifications, Assurances, and Other Statements of the Recipient and Solicitation Standard Provisions: These documents can be found at http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf.

- A signed copy of Key Individual Certification Narcotics Offenses and Drug Trafficking, (ADS 206.3.10) when applicable;
- A signed copy of Participant Certification Narcotics Offenses and Drug Trafficking (ADS 206.3.10) when applicable;
- Other Statements of Recipients; and
- Conscience Clause Implementation (Assistance) (February 2012).

Note that a U.S Recipient providing sub-award to non-U.S. organization must use the Standard Provisions for a Non-U.S. Non-Governmental Organization. A non-U.S. Recipient providing an award to a U.S. organization must use the Standard Provisions for U.S. Non-Governmental Organizations. For sub-awards to Public International Organizations (PIOs), the Recipient must use the Standard Provisions for Cost-Type Awards to PIOs in ADS 308, Awards to Public International Organizations. For sub-awards to partner government entities, the Recipient must adhere to ADS 303.3.21.

Detailed Budget (Excel Format): In addition to the above mentioned documents, the applicant should submit an Excel budget with un-protected spread-sheet (attached to the Cost Application) that includes details line item information using formulae. The cost application should use the budget format shown in the SF-424A. Excel sheets must not be password protected.

Budget Narrative: Include a budget with an accompanying budget narrative which provides in detail the total costs for implementation of the program your organization is proposing. Detailed budget narratives which explain the basis of estimate, such as market surveys, price quotations, current salaries, historical experience, etc. (cost realism and cost reasonableness) and supporting justification of all proposed budget line items must be included.

1. The breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices.

2. The breakdown of all costs according to each partner organization (or sub-Applicant) involved in the program.

3. The costs associated with external, expatriate technical assistance and those associated with local in-country technical assistance.

4. The breakdown of the monetary and in-kind contributions of all organizations involved in implementing the expected Cooperative Agreement.

5. Potential contributions of non-USAID or private commercial donors to this Cooperative Agreement.

6. The procurement plan for commodities.

7. Indicate the name, annual salary, and expected level of effort of each person charged to the Activity. Provide resumes showing work experience and annual salary history for at least the three most recent years for all identified and proposed long/short term key and non-key personnel. If not included in an indirect cost rate agreement negotiated with the U.S. Government, specify the applicable fringe benefit rates for each category of employees, and explain the benefits included in the rate. The same individual information for consultants must be provided as for regular personnel.

8. Travel, per diem and other transportation expenses must be detailed in your application to include number of international trips, expected itineraries, number of per diem days and per diem rates.

9. Specify all equipment to be purchased and the expected geographic source.

10. Financial Plans for all proposed sub-grants and subcontracts must have the same format and level of detail as those of the Applicant. Following the Applicant‘s detailed budget breakdown, detailed budget breakdowns for each sub-Applicants/(sub) contractor must be presented. Sub-Applicant/(sub) contractor budgets must not be intermingled. The first page must be a summary budget, following the same budget format and line items as are set forth above for the full term of the sub-agreement/subcontract. Detailed budget notes which explain how the sub-awards proposed budget was reviewed and how a determination was made that it is fair and reasonable must be provided.

11. Indirect Costs: The applicant should support the proposed indirect cost rate with a letter from a cognizant U.S. Government audit agency or with sufficient information for USAID to determine the reasonableness of the rates. (For example, a breakdown of labor bases and overhead pools, the method of determining the rate, etc.). A copy of the latest Negotiated Indirect Cost Rate Agreement (NICRA), if applicable and if your organization has such an agreement with the US. Government.

    a. Note: Local Institutions usually do not have a Negotiated Indirect Cost Rate Agreement (NICRA) letter with the US Government.

    b. If the applicant has never received a negotiated indirect cost rate, the recipient may choose to charge a de minimus rate of 10% of modified total direct costs [see 2 CFR 200.414(f)]. If the prospective applicant chooses the de minimum rate, the AO must incorporate the 10% indirect cost rate in the award budget and the recipient must follow the requirements in 2 CFR 200.414(f).

    c. Applicants that do not have a NICRA, have the option of submitting the following information to for the AO to make a determination regarding an alternate rate:

i. Copies of the Applicant's financial reports for the previous three-year period, which have been audited by a certified public accountant or other auditor satisfactory to USAID;
ii. Projected budget, cash flow and organizational chart; and
iii. A copy of the organization's accounting manual.

12. If there are any training costs to be charged to this Agreement, they must be clearly identified.

The following information should also be taken into consideration when developing the budget:

Labor - Direct salaries and wages for each year of the Agreement must be in accordance with the organization's established personnel policies, the applicable cost principles and the current salary history of proposed LT/ST employees. To be considered adequate, the policies must be in writing, applicable to all employees of the organization, be subject to review and approval at a high enough organizational level to assure its uniform enforcement, and result in costs which are reasonable and allowable in accordance with applicable cost principles. The narrative should include a level of effort analysis specifying personnel, rate of compensation, and amount of time proposed for key and non-key personnel. Anticipated salary increases during the period of the Agreement should be included.

Additional Requirements for Personnel Compensation:

a. Limitations

Salaries and wages must be reflective of the "market value" for each position. Salaries and wages may not exceed the Applicant's established policy and practice, including the Applicant's established pay scale for equivalent classifications of employees, which must be certified by the Applicant.

Base pay, or base salary, is defined as the employee's basic compensation (salary) for services rendered. Taxes which are a responsibility or liability of the employee are inclusive of, and not additive to, the base pay or salary. The base pay excludes benefit and allowances, bonuses, profit sharing arrangements, commission, consultant fees, extra or overtime payments, overseas differential or quarters, cost of living or dependent education allowances, etc.

This USAID-funded activity implemented under the anticipated Cooperative Agreement will be for an estimated period of performance of five (5) years; also referred to as the Award Period. Unless the Applicant demonstrates otherwise to the USAID Agreement Officer's satisfaction, Cooperating Country Nationals (CCNs) employed by the Applicant solely to work under the USAID-funded project under this Agreement are considered by USAID as employed by the Applicant for a specified period not to exceed the Agreement

Period. This provision must be interpreted in accordance with applicable cost standards as described in the Standard Provisions for Allowable Costs (December 2014).

b. Annual Salary Increases

Annual salary increase and/or promotional increase may be granted in accordance with the Applicant's established policies. Salary increases may be granted after the employee's completion of each twelve months of satisfactory services under the USAID award.

Fringe Benefits - If accounted for as a separate item of cost, fringe benefits should be based on the Applicant's audited fringe benefit rate, supported by a Negotiated Indirect Cost Rate Agreement (NICRA) or historical cost data. If the latter is used, the narrative should include a detailed breakdown comprised of all items of fringe benefits (e.g. health and life insurance, FICA, etc.) and the costs of each, expressed in dollars and as a percentage of salaries. Fringe Benefits for local staff should be accounted in accordance with Mozambique labor law.

Supplies and Equipment - Differentiate between expendable supplies and nonexpendable equipment (NOTE: Equipment is defined as tangible nonexpendable personal property including exempt property charged directly to the award having a useful life of more than one year and an acquisition cost of $5,000 or more per unit, unless the Applicant's established policy establishes nonexpendable equipment anticipated to be required to implement the Activity, specifying quantities and unit cost.)

Allowances, if any, must be broken down by specific type and by person and must be in accordance with the Applicant's established policies and consistent with the DSSR.

Travel and Per Diem - The narrative should indicate the purpose of trip(s), number of trips, domestic and international, and the estimated unit cost of each. Specify the origin and destination for each proposed trip, duration of travel and number of individuals traveling. Proposed per diem rates must be consistent with the DSSR and in accordance with the Applicant's established policies and practices that are uniformly applied to federally financed and other activities of the Applicant.

Other Direct Costs (ODC) - could include costs such as communications, office rental, utilities, report preparation costs, passports, visas, medical exams and inoculations, insurance (other than the Applicant's normal coverage), other filed office operation costs, etc. The narrative, or supporting schedule, should provide a complete breakdown and support for each item of other direct costs.

Proposed (Sub) Contracts/Agreements - Applicants who intend to utilize subcontractors or sub Applicants should indicate the extent intended and a complete cost breakdown, as well as all the information required herein for the Applicant. Extensive (sub) contract/agreement financial plans should follow the same cost format as submitted by the Applicant.

Branding & Marking - USAID anticipates that reasonable budget is estimated in order to cover the branding and marking costs which are in accordance with the applicant's technical approach.

Environmental Compliance - For the purposes of this solicitation, Applicants should reflect illustrative costs for environmental compliance implementation and monitoring in their cost proposal.

Cost Share Narrative: The Applicant should present cost share and discuss it herein in detail. The section of the Cost Application should describe the composition of cost-share (indicating the recommended amount that will be in cash and in-kind). In-kind contributions are allowable as cost share in accordance with the 2 CFR 200.306 for U.S. organizations and the Standard Provision, "Cost Share" for non-U.S. organizations. Cost-share must be included as part of the progress report and financial reporting.

The Applicant is required to include cost share expressed as a dollar figure rather than a percentage to assist in monitoring the amount after award.

Applicants must be aware that all cash contributions and non-Federal third party in-kind contributions must meet all the criteria set forth in 2 CFR 200.306, ADS 303.3.10.1 and the Standard Provision Cost Share (June 2012). Applicant cost share may be in any combination of cash and in-kind support including, staff salaries, volunteer time; valuation of donated supplies, equipment, and other property; and use of unrecovered indirect costs. The Applicant it should ensure that these costs are not included as part of the Indirect Cost Rate to avoid duplication**.**

Cost share is defined by USAID as "contributions, both cash and in-kind, which are necessary and reasonable to achieve program objectives and which are verifiable from the Applicant's records." USAID requires applicants to demonstrate their commitment to the Activity's success by addressing the requirement for cost sharing. Cost sharing, will be evaluated for cost effectiveness and cost realism.

Annexes:

Dun and Bradstreet Universal Numbering System (DUNS) Number and System for Award Management (SAM): Applicants (unless the applicant is an individual or Federal awarding agency that is exempted from those requirements under 2 CFR §25.110(b) or (c), or has an exception approved by the Federal awarding agency under 2 CFR §25.110(d)) are required to:

i) Be registered in SAM before submitting its application (proof of active SAM registration must be provided with the application);
ii) Provide a valid DUNS number in its application; and
iii) Continue to maintain an active SAM registration with current information at all times during which it has an active Federal award or an application or plan under consideration by a Federal awarding agency.

USAID may not make a Federal award to an applicant until the applicant has complied with all applicable DUNS and SAM requirements and, if an applicant has not fully complied with the requirements by the time USAID is ready to make an award, USAID may determine that the applicant.

To begin the registration process, please visit the following websites:

DUNS number: http://fedgov.dnb.com/webform
SAM registration: http://www.sam.gov

The registration process may take many weeks to complete. Therefore, Applicants are encouraged to obtain them early so that, if selected, the award will not be delayed. Completion of an early registration does not constitute any commitment on the part of the U.S. Government to make an award.

For information on how to obtain a DUNS Number see Attachment 2, or use the following link:
https://www.sam.gov/portal/SAM/#1

Evidence of Responsibility: Applicants should submit additional evidence of responsibility which deems necessary for the AO to make a determination of responsibility. The information submitted should substantiate that the Applicant:

i) Has adequate financial resources or the ability to obtain such resources as required during the performance of the award;
ii) Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the Applicant, nongovernmental and governmental;
iii) Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance;
iv) Has a satisfactory record of integrity and business ethics; and,
v) Is otherwise qualified and eligible to receive a cooperative agreement under applicable laws and regulations (e.g., EEO).

Branding Strategy and Marking Plan: It is a Federal statutory and regulatory requirement that all overseas programs, projects, activities, public communications, and commodities that USAID partially or fully funds under an assistance award or sub-award must be appropriately marked with the USAID identity. USAID requires the submission of a Branding Strategy and a Marking Plan by the "Apparently Successful Applicant".

The Apparently Successful Applicant's proposed Branding Strategy and Marking Plan may include a request for approval of one or more exceptions to the marking requirements. The AO reviews and approves the apparently successful applicant's

Branding Strategy and Marking Plan (including any requests for exceptions), consistent with the provisions "Branding Strategy," "Marking Plan," contained in the Certifications, Assurances, Other Statement of the Recipient and Solicitation Standard Provisions, and "Marking and Public Communications Under USAID funded Assistance" contained in ADS 303, Standard Provisions for Non-U.S. Nongovernmental Organizations and ADS 320, Branding and Marking.

Although points will not be assessed for evaluation purposes, **applicants must briefly describe (not to exceed two pages)** how they will promote USAID identity, U.S. Government's support for this Activity and the Activity's achievements in Mozambique. A full Branding Strategy and a Marking Plan will be requested to the "Apparent Successful Applicant" only.

More information on Branding Strategy and Marking Plan are available at http://www.usaid.gov/branding/assistance.html.

{END OF SECTION IV}

SECTION V: APPLICATION REVIEW INFORMATION

V.1. Merit Review Criteria:

The technical applications received will be screened for completeness and a merit review conducted by a Selection Committee (SC) at USAID/Mozambique. Following the merit review of the applications, a letter will be sent to all applicants detailing the outcome of the review.

The SC will review applications based upon the merit review criteria set forth below which have been tailored to the requirements of this Notice of Funding Opportunity.

The Technical Application will be reviewed in accordance with the merit review criteria set forth below. An overall rating for the application will be determined using the adjectival rating and the relative weights of the merit review criteria. The following merit review criteria will be used to assess the applications and make an award decision.

The merit review criteria will be assigned ratings in accordance with the table below. Only the merit review criteria will be assigned ratings. Criteria ratings will be based on the evaluation of sub-criteria, which are of equal importance for each Criteria. Sub-criteria will not be assigned ratings.

Rating	Description
Exceptional	Provides exceptional technical and management approaches for this project beyond the expectation of the Selection Committee. Reflects an innovative approach and/or superior understanding of the requirement in a way beneficial to the Government. Strengths significantly outweigh any weaknesses that may exist. Any weaknesses are easily correctable, and do not represent any performance risk. Must not have any significant weaknesses or deficiencies.
Very Good	Meets and in many areas exceeds the requirements of the merit review criteria. Reflects a high quality of capabilities and/or understanding of the requirement. Strengths outweigh any weaknesses or deficiencies that may exist. Any weaknesses or deficiencies are easily correctable.
Satisfactory	Meets expectations of the criteria. Reflects sound approach and/or satisfactory understanding of the requirement. Strengths outweigh any weaknesses or deficiencies.
Marginal	Does not clearly meet technical expectations. Reflects an uncertain approach and/or incomplete understanding of the requirement. Weaknesses and deficiencies, correctable only with major revisions to the proposal, outweigh any strengths.
Unacceptable	Fails to meet specified minimum performance or capability requirements; the application has multiple weaknesses and one or more deficiencies. Applications with an unacceptable rating are not awardable.

After evaluation of applications, USAID expects to select the applicant which will receive the award to implement the activity. Once this choice is made, USAID may engage in discussions or negotiations with the selected applicant(s) regarding any matter to be covered in the final technical and cost application(s). However, USAID may also award without discussions with the selected applicant(s).

V.2. Technical Review Criteria:

The technical applications will be reviewed in accordance with the three (3) review criteria set forth below, which are listed in descending order of importance:

1. **Technical Approach:**

The Technical Approach Criteria will be assessed based on the following sub-criteria:

- The degree to which the Applicant demonstrates a thorough understanding of the context for achieving the project goal, objective and indicators. The extent to which the information and material presented include relevant background information and analysis of the problem, demand for a solution, and opportunity or challenge relevant to implementing the project and attaining the results.

- The extent to which the Applicant's proposed approach, interventions and anticipated results that can be expected from each are thorough, complete, feasible, and address the intended impact on the problem, opportunity, challenge, and demand. The degree to which the proposed approach is an appropriate mix of proven and creative local, low-cost, and innovative approaches, interventions or business models, and is likely to achieve the anticipated results in the Mozambique context. The extent to which the timeline of the approach and interventions is feasible and realistic.

- The extent to which the Applicant thoroughly identifies and describes the risks associated with the proposed methods that are likely to affect results, and proposes effective strategies to mitigate or reduce risk and ensure the proposed results are achieved.

- The extent to which gender inequalities and social inclusion issues are appropriately addressed both in the Applicant's operations and in its proposed approach and outcomes.

- The extent to which the application demonstrates a realistic and effective approach for coordinating and engaging with key public and private sector stakeholders to ensure ownership, maximize synergy and resources, minimize overlap, and achieve the project's goal and objective.

- The degree to which the application demonstrates a thoughtful approach to sustain specific capacities, practices, behaviors, systems and linkages, and how the Applicant intends to achieve that sustainability. The degree to which benchmarks and indicators are feasible for measuring sustainability.

- The extent to which the M&E plan presents a logical theory of change (TOC) for the proposed technical approach, and details a feasible approach for how the Applicant will measure, evaluate, utilize, and share the data with the Government and other stakeholders.

2. Management Approach:

The Management Approach Criteria will be assessed based on the following sub-criteria:

- The degree to which the Applicant's organizational structure, partnerships, reporting lines, communication channels and management processes and tools present proven solutions that will ensure efficient and effective oversight. Sub-awardees, if proposed, serve specific purposes and bring specialized expertise or resources to the project.

- The extent to which individuals proposed for Key Personnel positions have the requisite management and technical expertise and experience to effectively fulfill the duties required of the positions. The extent that the Key Personnel are committed to the proposed project, and demonstrate a stable and successful employment history.

- The extent the application demonstrates that the number, mix and type of staff are appropriate for the approach and activities proposed by the Applicant—and the proposed staffing plan indicates a significant role for local staff in implementing the project.

3. Institutional Capacity and Past Performance:

The Institutional Capacity and Past Performance Criteria will be assessed based on the following sub-criteria:

- The degree to which the Applicant and any proposed partners demonstrate clear capacity and experience to accomplish the range of technical interventions described in the program description/technical approach.

- The extent to which the Applicant exhibits a past record of customer satisfaction; timeliness of performance; adherence to agreed schedules and other time-sensitive project conditions; cost control and accuracy of financial forecasting; prompt and satisfactory correction of problems; cooperative attitude in resolving clients' problems; and effectiveness of home and field office management to make prompt decisions and ensure efficient operation of tasks.

V.3. Cost Application Evaluation:

Cost will be reviewed for general completeness, reasonableness, allowability and allocability.

Cost realism will be conducted: it is an assessment of the accuracy with which proposed costs represent the most probable cost of performance within the Applicant's technical and management approach. Cost realism review will be performed as part of the review process to (a) verify the Applicant's understanding of the requirements, (b) assess the degree to which the cost application reflects the approaches and/or risk assessments made in the technical application as well as the risk that the Applicant will provide the supplies or services for the offered cost; and (c) assess the degree to which the cost included in the cost application accurately represents the work effort included in the technical application.

V.4. Technical versus Cost Considerations:

All technical review factors—when combined—are significantly more important than cost. While cost may be a determining factor in the final award decision, the technical merit of the application is substantially more important under this solicitation.

V.5. Award Decision:

Award will be made to the responsible Applicant whose application is most advantageous to the Government, with cost and other factors considered. The final award decision is made, while considering the recommendations of the SC, by the AO.

{END OF SECTION V}

SECTION VI: AWARD AND ADMINISTRATION INFORMATION

VI.1. Federal Award Notices:

A notice of award signed by the Agreement Officer is the authorizing document for this NFO. The notice of award will be provided electronically to the applicant's point of contact listed in the application.

Notification will also be made electronically to unsuccessful applicants pursuant to ADS 303.3.7.1.b.

An award will be made only by the USAID Agreement Officer upon his/her signature to incur costs. He/she will only do so after making a positive responsibility determination that the Applicant possesses, or has the ability to obtain, the necessary management competence in planning and carrying out assistance programs and that it will practice mutually agreed upon methods of accountability for funds and other assets provided by USAID.

Prior to issuance of award, some applicants may be required to submit additional information on the organization and key individuals for vetting. For example, for those organizations that have not had previous grants or cooperative agreements with the US Government, Articles of Incorporation or other documentation which substantiates the legal character of the entity will be requested. In such cases, issuance of an award is contingent on the timely receipt of the information requested and the successful completion of the vetting process.

VI.2. Standard Provisions and Deviations:

The award will be administered according to the applicable standard provisions: (i) for U.S. organizations, 2 CFR 200, 2 CFR 700 the Standard Provisions for U.S. Non-Governmental Recipients (http://www.usaid.gov/ads/policy/300/303maa) are applicable; and (ii) for Non-U.S. organizations, the Standard Provisions for Non-U.S. Non-Governmental Recipients (http://www.usaid.gov/ads/policy/300/303mab) are applicable.

VI.3. Reporting requirements:

All required reports must be submitted to the USAID AOR by the due date for the AOR's approval. The Recipient will consult with the AOR on the format and expected content of reports prior to submission. The Recipient should always be ready for revision in program indicators and reporting requirements.

1. Plans:

a. Monitoring and Evaluation (M&E) Plan: The proposed M&E Plan for the entire period of performance must be submitted within 60 days of the award.

b. First Year Work Plan: The First Year Work Plan must be submitted by the Recipient within 60 days of the award. The First Year Work Plan to be submitted will not necessarily be for a full year or may be for more than a full year, depending on the start date of the agreement; this will be defined at the time of award.

c. Environmental Mitigation and Monitoring Plan (EMMP): IFPP should address potential hazards to the environment pertaining to the implementation of the program. The Recipient is expected to submit a five-year EMMP within 60 days of the award and regularly report on the compliance status of the activity as per the approved EMMP.

2. Annual Work Plans:

Starting with the second year of the award and for each subsequent year of performance thereafter, the Recipient must submit Annual Work Plans within 30 calendar days after the end of the previous Fiscal Year according to a format agreed upon by USAID/Mozambique and the Recipient. The Annual Work Plans must be submitted to the AOR for approval. The Annual Work Plans will be developed in collaboration with USAID. Specific details on the format of the Annual Work Plans will be finalized at the time of award. Any updates to the EMPP or M&E Plan should be submitted with subsequent Annual Work Plans and approved by the AOR.

3. Progress Reports

The Recipient must submit an updated report on progress toward agreed performance targets every three (3) months and annually, based on the M&E plan to be developed by the Recipient in collaboration with USAID. Quarterly and annual narrative reports ("Quarterly Reports" and "Annual Reports") are expected to be delivered to USAID/ Mozambique within 30 calendar days after the end of the quarter and 45 calendar days after the end of the Fiscal Year respectively. Each report should include information on activities completed during the preceding period in all regions as well as any support provided at the national level. Each report must also include the following:

- Progress achieved towards benchmarks, tangible results and explanation of quantifiable output of the programs or projects, if appropriate and applicable;
- Reasons why established targets were not met; and

- Analysis and explanation of cost overruns or high unit costs (recipients must immediately notify USAID of developments that have a significant impact on award-supported activities).

Further, notification must be given in the case of problems, delays, or adverse conditions which materially impair the ability to meet the objectives of the award. These notifications must include a statement of the action taken or contemplated and any assistance needed to resolve the situation. The standard and agreed upon indicators should be addressed in all Quarterly Reports and Annual Reports. These progress reports should also include any progress made on the learning agenda as well as any application or scale up of these results; the Recipient is expected to share separate reports of individual studies conducted under this award. A template for the reports will be provided by the AOR.

4. Financial Reports

Financial reporting requirements will be in accordance with 2 CFR 200. Quarterly financial reports are expected to be submitted to USAID/ Mozambique within 30 calendar days after the end of the quarter. The report should include a summary of finances, a pipeline analysis of funds obligated, funds expended, expenses accrued and funds remaining by program areas.

5. Ad Hoc Reports

The Recipient may be requested to submit ad hoc reports on the status of its activities as requested by USAID/ Mozambique.

6. Success Stories

At least two one-page success stories on program activities shall be submitted to USAID/ Mozambique in the Quarterly Report. Please review USAID guidance on "success stories" available at http://www.usaid.gov/stories/.

7. Demobilization Plan

At least 180 calendar days prior to the Completion Date of the Award, the Recipient must submit a Demobilization Plan for the AOR's approval. A Property Disposition Plan, plan for the phase-out of in-country operation and delivery schedule for all required reports or deliverables along with a timetable for completing all required actions should be included in the Demobilization Plan.

8. Final Reports

USAID requires, 90 calendar days after the Completion Date of the Cooperative Agreement, that the Recipient submit a Final Report which includes an executive summary of the Recipient's accomplishments, targets not achieved, lessons

learned, challenges and conclusions about areas in need of future assistance; an overall description of the Recipient's activities and attainment of results and sub-results by region, as appropriate, during the life of the Cooperative Agreement; an assessment of the progress made toward accomplishing the LOP results and expected results and sub-results, and overall project impact; analysis of the significance of these activities; important findings and recommendations; and a fiscal report that describes use of funds expended under this award. The Recipient is expected to submit, with the Final Report, a list of all the studies conducted during the LOP and a compilation of all the publications/materials produced on the learning agenda.

The applicant must submit all deliverables electronically to the Agreement Officer's Representative (AOR).

The deliverables will be considered final once approved by USAID.

Deliverables	**Due Date**
Final work Plan, including gender action plan and local capacity development plan	At Award // 60 days after signing of award
Final M&E Plan	At Award/ 60 days after signing of award
Final Staffing Plan	At Award
Final Communication Plan, including Branding and Marking Plan	At Award
Grants Manual (if applicable)	30 days after award
Gender Analysis	60 days after award
Quarterly Posts, structured as mini-success story highlighting project work and including one photo and brief (a few sentences) accompanying narrative	Quarterly
Quarterly Reports, structured to align with the work plan, gender action plan, and local capacity development plan, including M&E data and financial reports tracking expenditure by funding type (FP, MCH, PEPFAR). Quarterly reports must include at least one success story suitable for USAID's Blog or Newsletter	30 days after the end of each fiscal quarter. Quarterly reports for the final quarter of each fiscal year may be combined with the semi-annual reports
Semi-Annual Reports, structured to align with the work plan, gender action plan, and local capacity development plan, including M&E data and financial reports tracking expenditure by funding type (FP, MCH, PEPFAR)	October 1 and April 1 annually

Final Project Report	90 days after award
Initial Environmental Examination (IEE)	30 days after award
Baseline Data	120 days after award
M&E Data	Expected to be in October annually

VI.4. Program Income:

If program income is anticipated to be generated under the award, the income will be treated consistent with 2 CFR 200.307(e) (1) Deduction for U.S. organizations. For Non-U.S. organizations, see the provision "Program Income"; the Program Income is deducted from the USG share of this award in a cost-share scenario.

{END OF SECTION VI}

SECTION VII: AGENCY CONTACTS

Antonieta Manhica
Acquisition & Assistance Specialist
Office of Acquisition & Assistance
JAT Complex
Bairro Central "C"
Rua 1231, No. 41
Maputo, Mozambique
USAID/Mozambique
E-mail: amanhica@usaid.gov
Telephone: +258-21-352115
+258-21-352000

Marianne Pinto-Teixeira
Supervisory Acquisition & Assistance Specialist
Office of Acquisition & Assistance
USAID/Mozambique
E-mail: mteixeira@usaid.gov
Telephone: +258-21-352189

Adam Cox
Agreement Officer
Office of Acquisition & Assistance
USAID/Mozambique
E-mail: acox@usaid.gov

{END OF SECTION VII}

SECTION VIII: OTHER INFORMATION

VIII.1. USAID Rights:

The Recipient is reminded that USAID reserves the right to fund any or none of the applications submitted in response to this solicitation.

VIII.2. Annexes:

Below is a list of the NFO's annexes:

Annex 1: Acronym List

Annex 2: Key Drivers of Mortality and Morbidity

Annex 3: High Impact Practices in Family Planning (UNFPA, USAID, WHO/IBP, Partners)

Annex 4: Human Resources, Supply, Demand, and Policy Environment

Annex 5: Illustrative Indicators

Annex 6: Key Indicators for FP/MCH by Province

Annex 7: Certifications, Assurances, and Other Statements of the Recipient

Annex 8: Standard Provisions for U.S. Non-Governmental Recipients

Annex 9: Standard Provisions for Non-U.S. Non-Governmental Recipients

Annex 10: Past Performance Information Form

{END OF SECTION VIII}

Annex 1: Acronym List

APE	Agentes Polivalentes Elementares- Community Health Workers
ART	Anti-Retroviral Treatment
AOR	Assistance Officer's Representative
ART	Anti-Retro Viral Treatment
CDCS	Country Development Coordination Strategy
CMAM	Central de Medicamentos e Artigos Medicos- Central Medical Stores
CNCS	Conselho Nacional de Combate ao SIDA (National Council to Combat AIDS)
DAF	Direcção de Administração e Finanças – Directorate of Adminstration and Finance
DPC	Direcção de Planificação e Cooperação- Directorate of Planning and Cooperation
DPS	Direcção Provincial de Saúde – Provincial Health Directorate
FP	Family Planning
GBV	Gender Based Violence
GHI	Global Health Initiative
GRM	Government of the Republic of Mozambique
HIV	Human Immunodeficiency Virus
HCT	HIV Counseling and Testing
HTSP	Healthy Timing and Spacing of Pregnancy
HRH	Human Resources for Health
ICSM	Instituto de Ciências de Saúde de Maputo – Health Sciences Institute of Maputo
IHO	Integrated Health Office
IR	Intermediate Result
LARC	Long-Acting and Reversible Contraceptive
LAM	Lactational Amenorrhea Method
MARPs	Most at Risk Populations
MDG	Millennium Development Goals
MISAU	Ministério de Saude –Ministry of Health
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
NGO	Non-Government Organizations
OVC	Orphan and Vulnerable Children
PAC	Post-abortion Care
PEPFAR	President's Emergency Plan for AIDS Relief
PESS	Plano Estratégico do Sector de Saúde- Health Sector Strategic Plan
PFMRAF	Public Financial Management Rapid Appraisal Framework
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
ProSaude	Basket Fund in Mozambique
RH	Reproductive Health
SDM	Standard Days Method
SRH	Sexual and Reproductive Health
USAID	United States Agency International Development
UNFPA	United Nations Population Fund
USG	United Stated Government
WHO	World Health Organization

Annex 2: Key Drivers of Mortality and Morbidity

This project will increase the use of modern contraceptive methods among women and men, and sexually-active boys and girls, in Mozambique to achieve improved reproductive health behaviors. In this way it will contribute to improved maternal and child health and nutrition outcomes, and improved quality of life.[37]

It will use evidence-based recommendations and messages, high impact practices, and promising effective practices established by USAID, UNFPA, WHO, and other organizations to guide project activities. The project will aim to address key drivers of mortality, morbidity, and malnutrition that can be changed through family planning use. In Mozambique, key drivers of mortality, morbidity, and malnutrition that can be prevented by family planning include the following high-risk pregnancies: adolescent pregnancy; rapid repeat pregnancies, high parity pregnancies, HIV-positive pregnancies, and unwanted pregnancy leading to induced abortion.

Adolescent pregnancy: WHO, UNICEF, and UNFPA have long recommended that pregnancy be delayed until at least age 18. In Mozambique, 38 percent of all adolescent girls ages 15-19, and 45 percent in the lowest income group, are either parents or pregnant with their first child (DHS, 2011). Adolescent pregnancy is associated with increased risk of under-five mortality. In Mozambique, the under-five mortality rate is 146 when births occur to women under age 20, and falls to 86 when births occur to women ages 30-39 (DHS, 2011). Similar patterns are seen for perinatal, newborn, and infant mortality rates.

Adolescents in Mozambique also experience the highest proportion of maternal deaths for their age group, compared to other age groups. One in four deaths (24 percent) among women ages 15-19 years is attributed to maternal causes. This proportion falls to 8 percent for women ages 45-49. Gender issues, poverty, education, and culture, among other factors, all play important roles in contributing to adolescent pregnancy.

A 2013 USAID behavior change evidence review concluded that "strong evidence suggest that family planning programs that empower women and adolescents through skill development and goal-setting are more likely to achieve positive reproductive health behavior change, compared to programs that do not include such elements"(USAID BCC Evidence Summit, 2013). The review recommended that for improved adolescent reproductive health, programs invest in "goal-oriented, multi-disciplinary programs that also increase access to contraception – goals may relate to fertility desires, health, education, skill-building, and or employment."

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[37] See also, Healthy Timing and Spacing of Pregnancy, A Family Planning Investment Strategy for Accelerating the Pace of Improvements in Child Survival, available at: http://www.usaid.gov/sites/default/files/documents/1864/calltoaction.pdf
and Healthy Timing and Spacing of Pregnancy: A Family Planning Investment Strategy for Improving the Health and Well-Being of Women and Girls, available at: http://www.usaid.gov/sites/default/files/documents/1864/fpmp_tech_brief.pdf

The Government of Mozambique has stated that one of their key family planning priorities is to reach "illiterate youth living in rural and peri-urban and remote areas" (Republic of Mozambique, Minister of Health, Summit on Family Planning, 2012).

This project will support activities that link access to contraceptives and reproductive health education for adolescents with skill-building and goal-oriented programs, especially at the community level. SBCC messages will need to be conveyed about the importance of waiting until at least age 18, or preferably later, before becoming pregnant for the first time.

Rapid, repeat pregnancy: In 2005, the World Health Organization's report on birth spacing recommended a live birth-to-pregnancy interval of at least 24 months "to reduce the risk of adverse maternal, perinatal, and infant outcomes." This approximates a birth-to-birth interval of about 33 months or almost three years between births.

In Mozambique, 53 percent of births occur less than three years after a preceding birth. Among the lowest income groups, and adolescents' ages 15-19 years, these proportions rise to 60 and 87 percent, respectively.

These patterns of rapid, repeat pregnancy contribute to Mozambique's high rates of under-five, child, infant, and newborn mortality. In Mozambique, under-five mortality is 201 when births are spaced less than two years apart, and falls to 57, when births are spaced four years apart. Similar patterns are found for newborn and infant mortality categories (DHS, 2011). Since a key Government of Mozambique goal is to reduce the Under-Five Mortality Rate to less than 200 deaths per 1000 live births (DHS, 2011, p.9), improved spacing of births to three and four years apart would help contribute to this goal.

Mozambique's low rate of exclusive breastfeeding and lack of use of the Lactational Amenorrhea Method of family planning also contribute to short birth intervals. The Lactational Amenorrhea Method [LAM] is considered a modern family planning method and is effective in preventing pregnancy for six months postpartum if certain conditions are met. Despite USAID success in other countries in educating women in the use of LAM, women in Mozambique have not yet been educated in its use. Studies have shown that use of LAM increases the duration of exclusive breastfeeding, and improves breastfeeding practices. WHO recommends 6 months exclusive breastfeeding. The median duration of exclusive breastfeeding in Mozambique, in the last three years before the DHS survey, was 1.3 months (DHS, 2011). Thus, improving LAM use may help improve exclusive breastfeeding and newborn nutrition status.

Effective postpartum family planning programs reach women to respond to their pregnancy spacing or limiting preferences and thus help prevent rapid, repeat pregnancy and high parity births (high parity is discussed below). The Government of Mozambique aims to increase postpartum consultations by 50 percent (DHS, 2011, p.9). The GRM has stated that a government priority is to "introduce long-acting methods and permanent

methods of contraception to women at postpartum and post-abortion care for youth and women intending to postpone their pregnancy for a longer period of time, …and for women with grand multi-parity" (Republic of Mozambique, Deputy Minister of Health, Summit on Family Planning, 2012).

A 2013 USAID evidence review found that postpartum programs implemented in developing countries that "clearly specify the healthy timing and spacing behaviors to be practiced, reach women at regular intervals in the year following the birth" and provide contraceptive methods, significantly increase postpartum family planning use, compared to other types of programs (Al- Tawab 2007; Ahmed and Baqui, 2013; FALAH Project, 2011; Sebastian and Khan, 2012).

This project will implement effective postpartum family planning to respond to women's pregnancy spacing and limiting preferences. SBCC messages will need to be developed about the importance of waiting 24 months after a live birth before becoming pregnant again.

High Parity Pregnancy: A recent global study found that the risk of maternal death increases as the number of children born to a woman rises from 2 to 6 or more. For 46 counties over 10 years, the study found that maternal deaths declined by 7-35 percent as the number of children per woman fell (Stover and Ross, 2010). In Mozambique, 89 percent of women with five or more children do not use family planning (DHS, 2011, p.100).

Mozambique has one of the highest fertility rates in sub-Saharan Africa and, in recent years, the total fertility rate (TFR) has increased. In the rural areas, the TFR has risen from 5.8 in 1997, to 6.1 in 2003, to 6.6 in 2011. The urban areas have witnessed a slight increase from 4.4 in 2003 to 4.5 in 2011 (DHS, 2011).

In Mozambique, there is evidence that high parity women have less access to health services, compared to lower parity women. For women giving birth the first time, 34 percent deliver at home, while this proportion rises to 53 percent for women at parity six or higher (DHS, 2011). For women giving birth the first time, 64 percent are assisted by skilled attendants, yet for women parity six or higher, this falls to 45 percent (DHS, 2011). For women with no children, 54 percent report "at least one problem" accessing health services, while this proportion rises to 72 percent for women with six children or more.

As described in the section above, this project will implement effective postpartum programs, as well as community-based programs, to reach high parity women, and women approaching high parity, to address their spacing or limiting needs. SBCC messages will need to be developed to educate families on the risks of high parity pregnancies.

HIV Positive Women and Girls: Studies have shown that HIV-positive women are at increased risk of maternal death. One analysis noted, "HIV impacts on direct

(obstetrical) causes of maternal mortality by an associated increase in pregnancy complications such as anemia, postpartum hemorrhage, and puerperal sepsis. HIV is also a major indirect cause of maternal mortality by an increased susceptibility to opportunistic infections such as pneumonia, tuberculosis, and malaria" (McIntyre, 2003). In a different analysis, the same author commented that in some areas, HIV/AIDS-related maternal deaths have overtaken direct obstetrical causes as the leading cause of maternal mortality (McIntyre, 2005).

It is also important to note the global evidence on the effects of injectable hormonal contraception on HIV acquisition. Current WHO guidelines stipulate all contraceptives to be safe and effective for HIV+ women. In addition, recent modeling studies have shown that the risk of maternal death through unsafe delivery to be greater than any potential risk of HIV acquisition due to hormonal injectable contraceptives (Polis, 2013). Thus, an emphasis on a wide range of contraceptive methods such as pills, injectables, implants, and fertility awareness methods is critical.

In addition, SBCC messages to women and girls who are HIV+ will need to be developed to educated this group and their partners on the risks of maternal death.

Unwanted Pregnancy leading to Induced Abortion: The World Health Organization (WHO) estimates that 13 percent of maternal deaths are attributable to induced abortion. This percentage, however, is most likely an underestimate, given that data used in these analyses do not represent a random sample of the population at risk, but usually include only data that are available at the time. Induced abortion's contribution to Mozambique's maternal mortality ratio of 408 is not known.

Post-abortion care (PAC) aims to prevent repeat abortion. USAID strongly supports post-abortion care which is defined as: (a) emergency treatment of complications of spontaneous or induced abortions; (b) post-abortion contraceptive counseling and method provision to prevent repeat abortion; and (3) referral for other reproductive health services. USAID considers PAC a family planning High Impact Practice (meaning a practice that evidence shows leads to increased family planning use). Key activities found to increase PAC impact include: decentralization (expanding PAC services from the hospital or health facility to the rural health post) and contraceptive method provision on the ward, rather than referral to another facility for family planning services.

A comprehensive PAC assessment in Mozambique conveyed the significant need for improved access to and quality of post-abortion care (Dgege, Jamisse et al, 2005). Among other findings, the study noted that: only 28 percent of the clients who did not want to become pregnant received a contraceptive method; only 37 percent of clients who did not wish to become pregnant reported being asked about their choice of methods; and, in one province, none of the clients reported receiving any contraceptive information.

Priority activities to improve access to and quality of post-abortion care in Mozambique may include: development and provider use of quality, client-centered counseling

approaches; provision of ward-based family planning services; expansion of and access to quality PAC services at lower levels of the health system, including the health post; and expanded method provision in PAC service delivery.

Annex 3: High Impact Practices in Family Planning (UNFPA, USAID, WHO/IBP, Partners)

High Impact Practices in Family Planning

"Promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths" ~Lancet 2006

What are High Impact Practices?
High Impact Practices (HIPs), when scaled up and institutionalized, will maximize investments in a comprehensive family planning strategy. This list is ***not*** intended to constitute or replace a strategy, which should be informed by the *Elements of Success in Family Planning Programming* and driven by country context.

How are practices identified and selected?
In an effort to support the renewed focus on evidence-based programming a Technical Advisory Group (TAG) was formed. The TAG is made up of over 25 international experts in family planning research, programming, and implementation identified from donor agencies, research institutions and service delivery organizations. The TAG meets at least once a year to review evidence and make recommendations on updating and implementing High Impact Practices.

Create an Enabling Environment

Creating an Enabling Environment facilitates implementation of HIPs in service delivery. The following HIPs are identified based on expert opinion and demonstrate correlation with improved health behaviors and/or outcomes. These outcomes include improvements in unintended pregnancy, fertility, or one of the primary proximate determinants of fertility (increased modern contraceptive use, delay of marriage, birth spacing, breast feeding).

- Galvanize **commitment** to family planning through advocacy and policy development.
- Develop, implement, and monitor **supportive government policies**.
- Support **financing** for family planning services and supplies at the national and local levels.
- Develop an effective **supply chain management system** for family planning so that women and men can choose, obtain, and use the contraceptive methods they want throughout their reproductive life.
- Implement a systematic, evidence-based **health communication strategy** that includes communication through multiple channels to enable people to make voluntary and informed health care decisions.
- Develop in-country capacity to **lead and manage** family planning programs.
- Advocate to keep **girls in school**.

HIP FAMILY PLANNING HIGH IMPACT PRACTICES

Annex 4: Human Resources, Supply, Demand, and Policy Environment

Human Resource Challenges

Like many countries, service provision is largely constrained by a lack of health providers. Currently there are only 0.27 physicians per 10,000 population in Mozambique compared with 0.83 per 10,000 in the rest of sub-Saharan Africa (SSA) (WHO, 2010). There is a similar shortage of nurses with only 3.10/10,000 compared with 4.54/10,000 in SSA. Recent Ministry of Health estimates further indicate that there are only 6.5 doctors and 28 nurses and a total of 66 health care workers per 100,000 people (MOH, 2012). WHO recommends a minimum of 143 health workers per 100,000 people making the proportion in Mozambique one of the lowest in the world. In addition to low numbers of health workers, the technical capacity of the existing workforce is mixed. Clinical training standards are not enforced, there is little management training, and poor working conditions and minimal compensation contribute further to high turnover and poor recruitment particularly in low resourced settings. Systems for tracking, motivating, and retaining staff are weak. In addition to health worker shortages, logistics and commodity systems are weak resulting in severe stock outs of medicines including contraceptives especially at provincial, district and facility levels. Reporting requirements to monitor both stock and quality of service provision is limited and weak. Separate registers are maintained for vertical services (i.e. FP, HIV, Immunizations) and indicators being measured are inadequate especially for family planning, which document number of visits, and CYP but offer no information on numbers of actual users or types of contraceptive methods used.

Supply side challenges

Health Facility Workforce: There is an acute shortage of OB/GYN Physicians and MCH nurses in Mozambique's health system, particularly at the district and sub-district levels. At these levels, family planning services are provided mainly by MCH nurses and by a medical technician when one is assigned. However, the MCH nurses are responsible for a wide range of preventive and curative integrated MCH services, in addition to client record keeping and preparing commodity requisitions. The MOH does not have a professionally trained midwifery cadre however they have developed a strategy for engaging Traditional Birth Attendants (TBAs) to provide FP and refer for institutional deliveries.

Community-Based Workforce: There is no large-scale community-based family planning service delivery program. The APE (Agente Polivalente Elementar – Portuguese for Community Health Worker) is the only type of community health worker that is officially part of the MOH system. About 1,200 have already been trained and plans call for fielding about 2,300 nationwide by 2013. However, one factor that may limit expansion is the literacy requirement. In rural areas, only about 26 percent of women are literate, and for the country as a whole, 40 percent. For this reason, many APEs are male. At the Family Planning Summit, the GRM stated their interest in donor support to add family planning service delivery to the APEs' responsibilities. If and

when donors decide to support the APEs, an important first task will need to be the design of a system to supply them with contraceptive commodities.

Contraceptive Commodities Supply System: The public health supply chain consists of two central warehouses, in Maputo and Beira, eight large hospitals, 10 provincial warehouses, 150 district warehouses, and 1,400 service delivery points. Stock outs of contraceptives continue to be a challenge particularly as programs grow though some progress has been made. A June 2013 report on 12 service delivery points reported no stock outs in Microgynon, 25 percent stock outs of Depo Provera, 77 percent stock outs of IUDs, and 50 percent stakeouts of condoms (DELIVER, End Use Verification Report, June 2013). There is no effective system for service delivery points to record commodity consumption data or to request commodities from district warehouses on a monthly basis, and the system faces continuing problems with the supply chain from the district warehouses to the facilities.

Private Sector: According to the 2011 DHS, 16.1% of all users accessed contraceptive supplies through the private sector, primarily private pharmacies (7.3%) and grocery stores (4.1%). Another 6.8% of women accessed supplies through "other sources," primarily friends and relatives. The for-profit private sector is largely confined to major cities.
Condoms are the main family planning method currently supplied through the private sector, which in 2011 provided 41.3% of all male and 35.1% of all female condoms. Some pills and IUDs were distributed through pharmacies and private clinics, but nearly 90% of all women still obtained these methods from public facilities.

Much private sector distribution of FP commodities has focused on condoms to combat the spread of HIV. Until now, there has been little progress in supplying other family FP through private outlets. This may be due in part to policy constraints that have limited the ability to sell a broad range of contraceptive methods through commercial channels. Only pharmacies are currently allowed to sell OCs; injectables and IUDs are only available in private clinics. In Mozambique the provision of medicines and health supplies and equipment is dominated by four major pharmaceutical companies, and commercial FP supplies can only be imported through one of them, which recently has not been giving much priority to importing contraceptives, which tend to have low profit-margins.

Method Mix: The 11 percent modern method contraceptive prevalence rate is dominated by use of pills (4.5 percent) and injections (5.1 percent). IUD use is at 0.1 percent and implant use is effectively zero however anecdotal data consistently highlight that implants are widely acceptable and a preferred contraceptive method, when made available. USAID is currently supporting IUD services postpartum at five model maternity services. High demand for implants has been reported and USAID has budgeted for their purchase in 2013. However, appropriate provider capacity and quality assurance systems are not widely in place for their use. Permanent methods are not actively supported. Emergency contraception is available in pharmacies but not in the public sector. Fertility awareness methods (Lactational Amenorrhea Method and Standards Days Method) are not taught and their use, as well as use of traditional

methods, is nil. Given the lack of human resources for family planning, and the supply issues, provision of these methods would seem highly appropriate.

Youth Friendly Services: For –years, UNFPA and other organizations had implemented a national youth program, *Geracao Biz*, which included the establishment of Youth Friendly Services at health facilities, and links with schools and other youth-oriented programs. The program has since been taken over by the GRM and key elements are being mainstreamed into public sector service delivery. Data are unavailable on the extent to which youth actually used the Youth Friendly Services established at public sector facilities.

Mobile Brigades: Mobile Brigades are used to reach remote rural areas. They have usually been organized to provide immunization services, but often include a range of services such as ANC, and IMCI. More recently family planning has been added. This includes distribution of condoms, pills, and injectable contraceptives like DMPA but to date has not included provision of long-acting reversible contraception (LARCs) such as implants or IUDs. Scale-up of the mobile brigades for family planning has been hindered by health system constraints – shortages of MCH nurses, lack of vehicles, lack of funding for fuel, and lack of commodities.

Demand side challenges

Social Behavioral Change Communication Program**:** Mozambique currently does not have a strong program of social behavior change communication, information, education for educating the population about family planning and reproductive health. Only 45 percent of women have heard a family planning message on the radio, 18 percent on television and 9 percent from newspapers. For women and men, a much stronger effort is needed to help them understand the benefits of delaying the first birth, the need for spacing subsequent births, and using family planning for an improved quality of life. USAID studies undertaken in the most challenging regions of Bangladesh, Egypt, India, and Pakistan show that when families understand that family planning protects the health of the mother and child, program areas achieve a significant increase in family planning use.

Knowledge of Contraception and the Role of Family Planning in Preventing High Risk Pregnancies: In Mozambique, 70 percent of the population lives in rural areas and 78 percent of women have never spoken with a facility or community-based health worker about family planning (DHS, 2011). Despite this, 96 percent of women know at least one modern method of contraception. Knowledge of contraceptive methods, however, does not necessarily translate into healthy behaviors – for example using family planning to avoid high risk pregnancies. Unfortunately, data from Mozambique about what women and men know about the use of family planning to avoid high risk pregnancies are unavailable, but will be needed to guide SBCC activities.

Gender and Cultural Norms: The SBCC effort will need to address gender and cultural norms that inhibit family planning use. For many women in Mozambique, their

autonomy in health decisions is limited – 32 percent report that their husband is the principal decision-maker with respect to their own health care (DHS, 2011, p.236). Lack of women's autonomy is seen in other areas. For example in Zambezia Province, 37 percent of women report that their husbands are the main decision-maker with respect to the income the woman earns (DHS, 2011, p.231). Relatively high rates of physical violence will also need to be addressed in any SBCC program. Thirty-three percent of women and 25 percent of men have been victims of physical violence.

Low Literacy Rates: Low literacy rates – 40 percent for women nationally and 26 percent in rural areas – will require the SBCC program to find provincial level platforms – networks of "influentials" such as traditional healers and religious leaders – as well as health and non-health community organizations such as microenterprise, literacy, income generation, and women's groups, for community education rather than relying on the use of printed IEC materials, or even radio and television.

Ideal Number of Children: For married women ages 15-49, the ideal number of children is 5.3, while for married men of the same age the ideal is 6.1. It will be important for SBCC activities to educate women and men about the risks women face when the number of children per woman increases from 2-3 to six or more.

Global and National FP Policy Environment

The GRM has developed an excellent *Family Planning and Contraception Strategy, 2010-2015*, and the government's commitments at the July 2012 London Family Planning Summit offer a clear and well-thought out statement of strategic priorities. However, family planning visibility within the MOH is limited to the Maternal and Child Health Department. An action plan, budget review, and data collection and monitoring system at national, provincial and district levels is needed to begin to carry out the GRM strategy, as well as increased staffing.

At the 2012 London Family Planning Summit, the GRM pledged its commitment to "increase cost sharing… from the current 5 per cent of the global cost of procurement of commodities to 10 percent in 2015 and to 15 percent by 2020." Since 2013, the GRM has allocated more than $2 million for the purchase of contraceptive commodities, but these funds have not been spent. For 2013, USAID has allocated $US2.2 million and UNFPA almost $US3 million for the purchase of commodities. The World Bank has also committed to supporting contraceptive commodities.

Annex 5: Illustrative Indicators

Illustrative Impact Indicators in USAID Supported Project Areas

- # facility-based users of modern contraceptive methods, disaggregated by method/age, including fertility awareness methods
- # pre-discharge postpartum users of modern contraceptive methods, disaggregated by method/age
- # modern contraceptive method users referred from immunization services
- # HIV + women using modern contraceptive methods
- # PAC clients accepting modern contraceptive method pre-discharge
- # community-based users of modern contraceptive methods, disaggregated by method/age, including fertility awareness methods
- # Post-partum clients accepting modern contraceptive method at discharge

Illustrative Outcome Indicators in USAID Supported Project Areas

Access to Facility Services

- # of health providers trained on clinical methods (LARCs, PMs)
- # of health providers trained on LAM/transition and SDM
- # health facilities reporting no stock-outs of contraceptive methods

Quality of Facility Services

- # facility client exit interviews reflect client-centered counseling on project priority topics (e.g., side effects, fertility desires, HTSP)
- # facilities adhering to agreed project standards (e.g., clean bathroom, no stock-outs, etc.)
- # facilities reporting active involvement of community health committee

Access to Community Services

- # APEs providing family planning services (methods and counseling)/disaggregated by age/method
- # Mobile Brigades per quarter; number FP users reached through Mobile Brigades, disaggregated by type of method
- # women in communities reporting LAM /SDM use

Quality of Community Services

- # client community interviews reflecting client-centered counseling on priority project topics (e.g., side effects, fertility desires, HTSP)
- # Mobile Brigade client exit interviews reflect client-centered counseling on priority project topics (e.g., side effects, fertility desires, HTSP)
- # confirmed referrals from communities to facilities for family planning services

Ability of Individuals to Adopt Healthy Behaviors

- # of community postpartum women who can correctly state the three LAM conditions
- # of men who can correctly state how long to wait after a live birth before attempting the next pregnancy
- # men who can identify one health risk for the mother if she experiences more than 4 pregnancies

Improved Community Environment to Support Healthy Behaviors

- # of adolescents who can access family planning information and services through community non-health organizations such as livelihood groups
- # of community leaders who speak out per quarter at community meetings about use of family planning for improved maternal and child health and quality of life
- # traditional healers who are trained to counsel women and families about family planning at the community level, and provide services

Annex 6: Key Indicators for FP/MCH by Province

Key Indicators for FP MCH by Province following the lifecycle approach

Data from Population Reference Bureau, 2012, Mozambique DHS, 2011

Province	Total Population	Women with Secondary Education (%)	Woman Literate (%)	Median age 1st marriage (years)	Median Age 1st sex (years)	Unmet Need for FP (%)	mCPR (%)	TFR	Births in Health Facility* (%)	IMR (per 1000)	Under 5 mortality (per 1000)	Full vaccine coverage (%)	Median Duration of EBF (years)	Children Stunted (%)	Children Under-weight (%)	Children Wasted (%)	HIV Prev (%)
Total	*23,702,000*	*18.5*	*40.2*	*18.8*	*16.1*	*28.5*	*11.3*	*5.9*	*55*	*64*	*97*	*64.1*	*1.4*	*42.6*	*5.9*	*14.9*	*11.5*
Niassa	1,182,393	14.2	31.8	18.3	14.6	27.1	11.4	7.1	61.7	31.8	100	77.2	0.5	46.8	3.7	18.2	3.7
Cabo Delgado	1,632,065	8	24.5	17.6	15.3	12.1	2.9	6.6	36.1	24.5	116	58.5	2.7	52.8	5.6	20.6	9.4
Nampula	4,049,082	10.9	28.2	18.9	16.1	25	5	6.1	53.2	28.2	66	66.3	0.6	55.3	6.5	15.5	4.6
Zambézia	3,897,064	7.6	24.6	19	15.5	35	4.6	6.8	28.6	24.6	141	47.3	1.4	45.2	9.4	21.3	12.6
Tete	1,801,528	12.2	23.8	18.4	17.1	26.4	15.1	6.8	50.9	23.8	128	58	2.2	44.2	5.6	17	7
Manica	1,438,476	25.9	49.4	17.5	16.8	29.7	12.5	5.8	76.3	49.4	114	64.6	0.7	41.9	6.7	10.8	15.3
Sofala	1,671,864	18.8	39.6	18.6	16.6	27.8	8	6.1	73.1	39.6	105	78.4	0.7	35.7	7.4	11.3	15.5
Inhambane	1,301,967	19.4	51.7	18.8	15.7	34.4	12	4.9	55.5	51.7	58	64.7	0.6	36	2.2	6.9	8.6
Gaza	1,344,095	20.8	55.8	19.3	16.8	35.9	18.2	5.3	67.6	55.8	110	76.3	3.6	26.8	1	6.3	25.1

Annex 7: Certifications, Assurances, and Other Statements of the Recipient

See the following link:

http://www.usaid.gov/sites/default/files/documents/1868/303mav.pdf

Annex H: Standard Provisions for U.S. Non-Governmental Recipients

See the following link:

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

Annex I: Standard Provisions for Non-U.S. Non-Governmental Recipients

See the following link:

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

Annex 8: Past Performance Information Form

CONTRACTOR PAST PERFORMANCE REPORT - SHORT FORM
PART I: Contract Information (to be completed by offeror)
1. Name of Contracting Entity:
2. Contract Number:
3. Contract Type:
4. Contract Value (TEC): (if subcontract, subcontract value)
5. Description of Work/Services:
6. Problem: (if problems encountered on this contract, explain corrective action taken)
7. Contacts: (Name, Telephone Number and E-mail address)
7a. Contracting Officer: **Phone Number:** **E-mail Address:**
7b.COR: **Phone Number:** **E-mail Address:**
7c. Other:
8. Offeror:
9. Information Provided in Response to RFP No.: