REQUEST FOR APPLICATION
No.: RFA-680-11-000001
Accelerating the Reduction of Malaria Morbidity and Mortality Program (ARM3)

AMENDMENT NO. 01

QUESTIONS AND ANSWERS

Question 1:

a) Who is in charge of the 2011 and 2013 national bed net distribution campaign (see p. 10)?

Answer: The 2011 and 2013 national bed net distribution campaigns are being managed by the National Malaria Control Program. The main source of financing is the Global Fund Round 3 grant which is being led by Africare and NMCP.

b) What will be the role of the ARM3 recipient?

Answer: As the 2011 national campaign is planned for the period before the award of ARM3, the recipient will not provide direct assistance in the campaign. ARM3 will support IEC/BCC activities promoting the utilization of the LLINs, which could include household visits and follow-up activities after the campaign. ARM3 involvement in the 2013 campaign is also currently anticipated to be limited to IEC/BCC activities.

c) Would the recipient be responsible for meeting the coverage targets for pregnant women and children under 5 (as outlined under "Indicators and Targets on p. 16 of the RFA)?

Answer: ARM3 will contribute to the targets for these indicators through IEC/BCC and strategies in the private sector, such as social marketing. These are national targets and achievement of the indicator targets will not be attributable to one partner or PMI alone.

Question 2: Once ARM3 is underway, will DELIVER maintain its responsibility of distributing PMI-purchased malaria commodities within Benin through sub-contracts with local transporters?

Answer: Yes, DELIVER will continue to be responsible for distributing PMI-purchased commodities through local transporters.

a) If yes, will this include distribution of LLINs? If LLINs are not included in DELIVER's distribution mechanism, should ARM3 applicants formulate a strategy for LLINs distribution? Will ARM3 have a specific geographic responsibility for LLINs distribution specifically? Will ARM3 be responsible for distributing any other PMI-supplied commodities related to malaria control?

Answer: This will include LLINs distribution to the health zone and facility level. Other commodities will be delivered to CAME. ARM3 will not be responsible for distributing any commodities procured by PMI through DELIVER.

b) Will DELIVER purchase and be responsible for distributing ACTs, SP, quinine, iron folate, RDTs, microscope and microscopic supplies for case management, diagnosis, and IPTp? To what level of the health system will DELIVER handle distribution, and will ARM3 be responsible for distribution below that?

Answer: Yes, DELIVER will purchase and be responsible for distributing ACTs, SP, severe malaria kits, RDTs, microscopes and microscopic supplies for case management, diagnosis, and IPTp. DELIVER will deliver all items except microscopes and microscopic supplies to CAME. Microscopes will be delivered to the NMCP for distribution. ARM3 will not be responsible for distribution of DELIVER procured products.

c) Will ARM3 support IPTi if this is an MOH policy?

Answer: If PMI and the NMCP decide to support IPTi it will become part of ARM3's mandate under prevention and treatment of malaria in children under five. As mentioned on page 16 of the RFA: "As new malaria control interventions, such as intermittent prevention treatment in infants, are developed and approved, this program will support the NMCP to integrate these new approaches into the national strategy."

Question 3: What is the Regional Institute of Public Health in Ouidah's (IRSP) routine malaria information system's (RMIS) current annual budget, and what is their present Scope of Work? Does PMI want the recipient of ARM3 to continue to support their current SOW, or is it expected that under ARM3, IRSP will expand its present mandate? Is there a plug-in figure that the IRSP will be expected to receive under ARM3? What is the current percentage of public and private health facilities currently covered by the RMIS?

Answer: IRSP is conducting sentinel site surveillance not the RMIS. IRSP currently covers 5 sites and will not be expanding to additional sites as previously planned due to decisions made at the central level of PMI. The figure indicated in the FY 2010 Table 2 from the Malaria Operational Plan (MOP) for Benin is $200,000, while $250,000 is budgeted in the FY 2011 MOP.

Question 4: Can ARM3 funding be used to support community level incentives and/or can ARM3 funding be used to train community-based personnel?

Answer: Community-based treatment activities are not currently included in ARM3. Case management at the community level as indicated in the FY 2010 Table 2 from the Malaria Operational Plan (MOP) for Benin is implemented by BASICS. If there is a gap in community case management (CCM) activities after the end of the Task Order, ARM3's implication in CCM will be indicated in the MOP. Community-based personnel may be included in IEC/BCC activities, which may necessitate training.

Question 5: What percentage of zonal level facilities were beneficiaries of PISAF IMCI training? What percentage of the facilities in the 34 health zones is implementing the IMCI strategy with an enhanced ARI/diarrheal malaria module?

Answer: IMCI training has been coordinated by the MoH with a variety of partners, including PISAF. Training is organized by health zone, with 24 clinicians trained by eight trainers (doctors and 2 pediatricians from the department and zone as well as one regional/national IMCI trainer) per health zone. The training is based on the 11 day WHO curriculum and includes a 6-8 weeks post-training follow-up supervision. The health worker is not counted as having been trained until they have had the post-training assessment.

Of the 34 health zones, there is 1 that has not yet been targeted with clinical IMCI training (Toucountouna-Natitingou-Boukombe), 7 that will require one or more additional training sessions to reach the minimum level of at least 60% of providers trained (Kerou-Kouande-Pehunco, Nikki-Kalale-Perere, Ndali-Parakou, Tchaourou, Abomey Calavi-So Ava, Ouidah-Kpomasse-Tori Bossito, Kandi-Gogounou-Segbana), and 3 where training has been held but not the post-training follow up visits because of the non-availability of the regional/national IMCI trainers and funding (Allada-Toffo-Ze, Dassa-Glazoue, and Save-Ouesse). IMCI training is coordinated by the Direction of Mother and Child Health.

Question 6: In section *A.4.2.3 Indicators and Targets*, the RFA mentions two indicators which are currently under review by RBM and WHO, and are likely to change soon. These are the second bullet "Proportion of children under-five with fever in the past two weeks who received treatment with ACTs…" and the fourth bullet "90% of mothers/caretakers will have sought treatment with the use of ACTs…". Given that each of these will likely need to change to include diagnosis as part of the treatment protocol, how does USAID wish applicants to anticipate program indicators which will include diagnosis (i.e. Proportion of malaria registered cases that are confirmed) as an important precursor to treatment?

Answer: The current policy for diagnosis is in the process of being changed. This will impact on the first indicator "children under-five with fever in the past two weeks who received treatment with ACTs..." Applicants should anticipate this change and include relevant indicators such as "Proportion of children under five with fever in the last two weeks tested for malaria" and "Proportion of children under five with a positive test result treated with ACTs." The second indicator cited above will not be affected by testing policies as mothers/caretakers should continue to bring suspected cases to the health center within 24 houses of the onset of symptoms to be diagnosed and treated according to the policy in place. As is currently the case, the health facility will determine if the suspected case is indeed malaria.

Question 7: Given recent changes in the WHO recommendations for treatment of severe malaria, does USAID anticipate advocacy for the GOB to adopt the new guidelines as part of this RFA? Should ARM3 applicants anticipate the new guidelines being adopted by the MOH in planning our activities?

Answer: The NMCP has already revised the guidelines for severe malaria to take into account recent changes in WHO recommendations. Support for severe malaria, including training and supervision, under ARM3 should follow the new guidelines.

Question 8: We know that the PISAF project has developed the following systems/training programs for malaria control:

-Training program for community health workers on diagnosis and treatment of malaria
-Training facility based personnel on IPTp
-National supervisory system for malaria case management
-Logistic management software

Are these PISAF systems expected to be scaled up under ARM3? If yes, would applicants have access to these systems/programs through the MOH or USAID?

Answer: Normally these systems will be handled over to the MOH and therefore will be available to applicants. The Medistock software has already been accepted by the MOH and scaled-up to all 34 health zones. The formative supervision approach and IPTs training materials supported by PISAF are also already being scaled-up and should be available through the MOH for applicants. ARM3 will not be training community health workers on diagnosis and treatment.

Question 9: With the regards to the geographic areas:

a) Could USAID please clarify the geographic scope of ARM3? Will it be nationwide or will it be limited to select health regions, health zones, or other geographic areas?

Answer: The geographic scope of ARM3 is national. That is to say that activities are not confined to a region or geographical area but can be scaled-up and/or targeted to areas in the most need. ARM3 will work closely with other donors to avoid duplication.

b) Under BASICS and PISAF, USAID is currently supporting selected health zones in Benin. Will ARM3 continue to focus on these zones initially, or is it expected that new health zones will be immediately included, and would these be prioritized?

Answer: ARM3 will not focus on the BASICS and PISAF intervention zones (see response to question 9a.)

c) Another question related to geographic focus pertains to IRS focus areas-- Is ARM3 expected to focus on these areas?

Answer: ARM3 should include the Atacora in program activities. As in the response to parts a) and b), it is not a prescribed focus area for ARM3.

Question 10: Please indicate when applicants should assume the implementation of the ARM3 project will start?

Answer: As soon as the award has been made to the successful applicant.

In the RFA it states, "This activity will be implemented over the course of the next five years. Section I, Page 5. Implementation should be scheduled to begin in fiscal year 2011".

Question 11: Could USAID clarify if the ARM3 project will be solely funded by PMI monies, or if there is another source of USAID funding available? Assuming that the ARM3 project will be solely funded by PMI monies, is it correct to assume that any support to IMCI training could only relate to malaria activities?

Answer: ARM3 will be funded solely by Malaria funds under PMI. Activities for ARM3 should adhere to those planned in the Malaria Operational Plans for Benin. ARM3 will only work on clinical IMCI. Under PMI, clinical IMCI is considered to be the appropriate method for diagnosing and treating malaria in children under five. As such PMI funds can cover IMCI training in its entirety (the 11 day training program).

Question 12: How frequently will the End User Verification Survey be implemented under ARM3?

Answer: The End User Verification survey is currently being conducted once a quarter. There is discussion between Washington and PMI countries as to whether that frequency should be maintained or a less frequent timetable adopted (every 6 months for example). If a decision is made before the award of this cooperative agreement prospective applicants will be informed.

Question 13: Does ARM3 expect logistics management of malaria commodity elements to be integrated into the RMIS?

Answer: The RMIS is part of the national health information management system or SNIGS. Logistics elements should be integrated into the RMIS to the extent that such data is or should be included in the SNIGS.

Question 14: Please clarify how many of the 35 points allocated to Management Plan and Institutional Capacity is for personnel.

Answer: The bullet points listed under the category are equally weighted.

Question 15: Is it correct to understand that both the primary applicants and any partners substantially involved in implementation must each submit 5 projects to describe their organizational past performance?

Answer: Yes, only those partners relative to the project.

Question 16: The RFA prescribes key positions-would there be receptivity to a proposed reformulation of those key positions. Could an applicant, for example, pose another staffing scenario for the key positions (with appropriate justification), while maintain the number at 5?

Answer: A proposed reformulation of the key positions can be submitted for consideration as long as it is supported with appropriate justification.

Question 17: On page 30 of the RFA, there is a missing Roman numeral iii. Is it correct to assume that this is a mis-numbering or is there missing information?

Answer: This is a case of mis-numbering.

Question 18: Can USAID funding under the ARM3 project be used on the following:

a) Reasonable goods and services procured by MOH staff during its implementation of ARM3 activities?

Answer: No. The MOH will not be procuring good and services under ARM3.
In accordance with ADS 304.3.3, you may not use assistance instruments (grants and cooperative agreements) to obtain goods/services for the Government or carry out program activities which the U.S. Government has obligated itself to provide under an international agreement.

b) Per diem and travel costs incurred by MOH staff during its implementation of ARM3 activities? If yes, which will be the standard per diem rate to be used in developing the budget (the applicant's, USAID's or the MOH's).

Answer: Per diem and travel costs incurred by MOH staff for its participation in the implementation of ARM3can be covered as appropriate. Participation of MOH staff in trainings and workshops will be covered as for any other participant. As for the rate to be used in developing the budget, refer to Page 37 of the RFA – Budget Narrative (iii) Travel and Transportation … "Per diem should be based on the applicant's normal travel policies (applicants may choose to refer to the Federal Standardized Travel Regulations for costs incurred)".

Please note that the NMCP will have its own budget for supervision activities (already revised in Table 2 for FY 2010 and to be revised for FY 2011 and future years). Therefore costs for supervision activities by the national level will not be part of ARM3 costs.

c) MOH staff for their services as trainers in its implementation of ARM3 activities? If yes, which will be the standard per diem rate to be used in developing the budget (the applicant's, USAID's or the MOH's)?

Answer: MOH staff designated as a trainer is not normally paid for their services. MOH staff cannot be paid for activities that fall under the scope of work of their position.

Question 19: Page 28 of the RFA states that "the technical application should not exceed 25 pages in length, exclusive of annexes and shall consist of the following sections:"

- Cover page (1 page)
- Application Executive Summary (3 pages)
- Program Narrative (25 pages)
- Annexes

Later in the paragraph it states that "Cover pages, dividers, …. do not count within the 25 page limitation". Could USAID please clarify if the Application Executive Summary count in the 25 pages or not? If it does, the application would be 28 pages.

Answer: The cover page and executive summary do not contribute to the 25 page limit of the technical application.

Question 20: In the table on page 9 the RFA indicates that the DELIVER program Task Order 3 for Malaria will continue to procure and distribute LLINs. On the same page it also indicates this activity is currently implemented through the IMPACT program and will be competed under ARM3 and implemented through the private sector. In the following description of increasing supply and use if LLIN, the activities listed include social marketing and strategies to include the private sector; however there is no direct mention of project funds to be used for procurement of LLINs.

Can USAID please clarify if the ARM3 will also fund the procurement of LLINs in the context of social marketing activities?

Answer: DELIVER will procure and deliver LLINs for use in health facilities (public and authorized private) during routine services and/or by the NMCP for mass distribution campaigns. ARM3 will cover LLIN procurement and distribution in the private sector (commercial and community settings). ARM3 funds will be used to procure LLINs for social marketing (see Table 2 FY 2010 MOP where is it indicated that ARM3 will procure and distribute 40,000 LLINs through the private sector).

Question 21: On page 21 of the RFA the text indicates that "funds are made available in the MOP for this program to support third year Peace Corps Volunteers to coordinate activities between PMI and Peace Corps". The FY10 Benin MOP indicates that the partner for these funds is Peace Corps.

Can USAID please clarify if the funds referred to in the RFA are already directly provided to the US Peace Corps or are expected be programmed through the ARM3 mechanism to support Peace Corps Volunteer community projects, or if this is mentioned for the purposes of ensuring coordination and linkages?

Answer: Peace Corps is indicated as the mechanism in the MOP to highlight the collaboration between the two agencies. The funds however for the third year Peace Corps Volunteer listed in table 2 under in-county management and administration costs will go to ARM3 to provide housing and work related expenses (including in-country work related travel to project or volunteer sites). Under the prevailing procedures for hosting a third year volunteer, Peace Corps provides a volunteer in response to a scope of work submitted by a USAID implementing partner.

NOTE: These funds are not designated to support volunteer community projects. Funds for community projects are listed under the community-based interventions section and will be provided directly to Peace Corps to be managed by Peace Corps.

Question 22: In addition to key staff, the RFA indicates on page 33 that applicants must provide resumes and letters of commitment for individuals who will work at least 75% of his/her time) on the program, for both the applicant and proposed key sub-grantees.

Can USAID confirm that the applicant is only required to submit resumes and letters of commitment for the five staff designated as Key Personnel and subject to USAID approval?

Answer: Yes, resumes and letters of commitment for the five Key Personnel are required and subject to USAID approval.

Question 23: Is there a minimum number or a limit to the number of Past Performance references that should be included as an Annex to the Technical Application?

Answer: Refer to Page 31 of the RFA entitled "Organizational Past Performance".

Question 24: Can figures that are put on separate pages be included but not be counted towards the page limit?

Answer: Pages included in the Annex will not be counted towards the page limit. All other pages included in the "Program Narrative" will count towards the 25 page limit.

Question 25: Can the program implementation plan and first year implementation plan be included in the annex, as opposed to the program narrative?

Answer: Yes, program implementation plan and first year implementation plan can be included in the annex.

Question 26: On page 31 of the RFA, the applicant is asked to describe at least five past performance references. Are five past performance references required for each major partner, or should only five *total* past performance references be included?

Answer: The past performance references are required for each major partner.

Question 27: There appears to be a discrepancy in what is required under section "management and institutional capacity" as listed on pages 30-31 of Section IV and what is listed under Section V on pages 40-41. Could USAID clarify whether the management and institutional capacity section is to include both management and capability or whether the capability is expected to be described under section 4, past performance.

Answer: There is no discrepancy as the management and capability section is referring to the proposed structure and staff for ARM3 and the applicants' demonstration of their capability to manage the program in a sound, efficient and collaborative manner that maximizes the ability of the program to build national capacity and achieve stated objectives. Section 4 is for past performance of the applicant on similar activities and will be provided by the organizations referenced.

Question 28: Under Section E, page 28 of the RFA, the sections of the technical application are outlined. Past Performance is listed as a requirement under the program narrative, while past performance references are listed under the annex. Please clarify that a narrative only should be included in the main text while past performance references are to be included in the annex?

Answer: Yes, narrative only should be included in the main text while past performance references are to be included in the annex.

Question 29: The RFA states that USAID expects the commodities for the public sector to be purchased through the DELIVER Mechanism. Does this include LLINs, ACTs, RDTs, other commodities including those for the private sector and community case management? Does this include any commodities for severe malaria management?

Answer: DELIVER will procure commodities (LLINS, RDTs, ACTS, SP, severe malaria kits, microscopes, etc.) for use in health facilities (public and private), including those to be used for community case management where indicated. Yes, commodities for severe malaria will also be procured by DELIVER.

Question 30: The RFA states that USAID plans to maintain until 2012 the "Strengthening Community Case Management of Child Illness" Task Order, and integrate it into ARM3 after 2012, if needed. Please clarify whether ARM3 is expected to complement the work of this task order in other regions of the country from the beginning or only begin involvement after the end of the task order.

Answer: ARM3 will not be conducting community case management activities to complement the work under the Task Order in other regions. Global Fund support is already supporting malaria case management at the community level in the areas not covered by the Task Order. ARM3 case management activities will focus on facility-based treatment.

At the end of the Task Order, PMI and the NMCP will decide if continued PMI support for community case management is needed. If such a decision is made it will be reflected in the future MOPs and approved Table 2s. ARM3 will only begin involvement in community case management after the end of the Task Order and then only <u>if</u> selected as the implementing mechanism in the MOP.

Question 31: Benin's national Malaria M&E Plan includes the following indicator: "Proportion of ***children*** under five with fever in the last 2 weeks brought to health providers within 24 hours of onset of symptoms" while the RFA suggest to monitor the "Proportion of ***mothers*** and caretakers of under five with fever in the last 2 weeks brought to health providers within 24 hours of onset of symptoms". Please clarify whether ARM3 is expected to measure both indicators or does USAID have a suggestion on how to harmonize these indicators? (Do you have a preference for the definition of this indicator?)

Answer: ARM3 should use the indicator in the national Malaria M&E plan.

Question 32: The RFA clearly states that USAID would like the ARM3 implementers to support LLIN distribution based on changing needs and the dynamic funding environment. What role does USAID's envision for ARM3 participation in the Global Fund mass distribution campaigns to be held in 2011 and 2013? In between mass campaigns, should ARM3 be involved in free or subsidized routine distribution through Health Facilities? Are there other LLIN distribution strategies besides private sector distribution through social marketing is USAID considering?

Answer: ARM3 is to support LLIN distribution through the private and commercial sector, using methods such as social marketing for example. Due to new initiatives such as mass distribution campaigns, ARM3 should be flexible in its strategies and programming to respond to changing needs (whether coverage levels, demand or other funding partners). The role of ARM3 in the Global Fund mass distribution campaigns id support for communication and behavior change (utilization of the LLINs distributed during the campaign). ARM3 will not be involved in free or subsidized routine distribution through health facilities beyond the extent that ARM3 will be providing training in IPTp and IMCI and supervision for malaria case management. USAID is not currently considering any other strategies for private sector distribution beyond social marketing.

Question 33: Can USAID confirm that submission of applications through grants.gov is not required?

Answer: Yes, applications through grants.gov are not required. Submissions must be sent via courier to the address indicated in the Request for Application (RFA).

Question 34: Of the cost application documents listed on RFA pp. 35-40, can USAID clarify which ones are required from proposed sub-recipients?

Answer: All the documents are required. Sub-recipients should provide sufficient detail information on their budget. A breakdown of all cost associated with the program and NICRA if any.

Question 35: In the table on RFA page 9, item 14, "procurement and distribution of LLINs through the private sector" is listed as one of the anticipated activities for ARM3. In the interests of ensuring comparability among cost applications, would USAID care to provide a plug figure for commodity procurement?

Answer: This activity is listed with the budgeted amount in Table 2 of the FY 2010 (revised) and FY 2011 MOPs. The estimated numbers of LLIN to be procured and amount budgeted for the activity (procurement of the LLIN and all supporting activities for social marketing) is indicated in the table.

Question 36: Is it intended that LLINs be distributed free of cost? If not, and the nets are expected to generate program income, which of the alternatives in 22 CFR 226.24(b) will the recipient be instructed to apply in managing this income?

Answer: It is not intended that the LLINs procured and distributed by ARM3 through the private sector be distributed for free to beneficiaries.

Program income generated from the distribution of LLINs shall apply to standards set forth in 22 CFR 226(b)(1) …. "Added to funds committed by USAID and the recipient to the project or program, and used to further eligible project or program objectives."