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Regional Acquisition and Assistance Office

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Subject: Request for Applications (RFA) Number 674-10-0051 Support for Integrated Service Delivery

Ladies and Gentlemen:

The United States Government, as represented by the United States Agency for International Development (USAID) Mission in Malawi is seeking applications from qualified organization(s) /consortium(s) to implement the delivery of services linked to improved access to and utilization of high quality health care for all Malawians supported and sustained by vibrant communities, strong national leadership and engaged civil society. This program is expected to receive HIV/AIDS; Malaria; Nutrition; MCH and Family Planning funding. Activities funded under this program fall under the U.S. Foreign Assistance Framework objective of Investing in People.

The objective of the three Cooperative Agreements is to ensure achievement of the program objectives contributing to progress in three critical areas: 1) Reducing fertility and population growth, which are essential for attaining broad based economic growth; 2) Lowering the risk of HIV/AIDS to mitigate the enormous impact on human resources and productivity; and 3) Lowering maternal and infant and under-five mortality rates.

Please refer to Section I, Funding Opportunity Description for a complete statement of goals and expected results.

Pursuant to 22 CFR 226.81, it is USAID policy not to award profit under assistance instruments. However, all reasonable, allocable, and allowable expenses, both direct and indirect, which are related to the grant program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organizations, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for-profit organizations), may be paid under the agreement.

This RFA is being issued and consists of this cover letter and the following:

Section I.	Funding Opportunity Description;
Section II.	Award Information;
Section III.	Application and Submission Information;
Section IV.	Application Review Information;
Section V.	Award and Administration Information;
Section VI.	Other Information; and
Section VII.	References and Acronyms

For the purposes of this RFA, the term "Grant" is synonymous with "CA"; "Grantee" is synonymous with "Applicant"; and "Grant Officer" is synonymous with "Agreement Officer (AO)".

Subject to the availability of funds, USAID intends to award three Cooperative Agreements and provide approximately US$100,173,911 in total USAID funding to be allocated over a period of 5 years for each of the following:

SECTOR I: Support for Service Delivery (SSD) - $65,289,911;

SECTOR II: Social and Behavior Change Communication (SBCC) - $24,200,000: and

SECTOR III: Health Policy and Systems Strengthening (HPSS) - $10,684,000.

One award is anticipated for each Sector discussed in this RFA. USAID reserves the right to fund any or none of the applications submitted.

If your organization decides to submit an application for any of the above sectors, it must be received by the closing date and time indicated at the top of this cover letter and Section III of the RFA in accordance with the instructions contained in the RFA. Any questions concerning this RFA must be submitted in writing to me via email at cfrost@usaid.gov and to Ms. Beatrice M. Lumande at blumande@usaid.gov.

If it is determined that the answer to any question(s) is of sufficient importance to warrant notification to all prospective recipients, a Questions and Answer document, and/or if needed, an amendment to the RFA, will be issued. Therefore, questions should be submitted no later than the date indicated on the cover page.

Applicants are requested to submit both technical and cost portions of their applications in separate volumes, and in separate electronic attachments. Award will be made to the responsible applicant whose application offers the greatest value to the U.S. Government.

Issuance of this RFA does not constitute an award commitment on the part of the Government, nor does it commit the Government to pay for costs incurred in the preparation and submission of an application. In addition, final award of any resultant agreement cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, potential applicants are hereby notified of these requirements and conditions for award. Applications are submitted at the risk of the applicant; should circumstances prevent award of a cooperative agreement, all preparation and submission costs are at the applicant's expense.

Sincerely,

Christopher Frost
Agreement Officer

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ACRONYMS

ACSD	Accelerated Child Survival Development
ACT	Artemesinen Combination Therapy
ADB	African Development Bank
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
AO	Agreement Officer
AOTR	Agreement Officer's Technical Representative
ART	Antiretroviral Therapy
ARV	Antiretroviral drugs
BCC	Behavior Change Communication
BEmOC	Basics Emergency Obstetric Care
BEmONC	Basics Emergency Obstetric and Newborn Care
BLM	Banja La Mtsogolo

CBDA	Community Based Distribution Agent
CDC	Centers for Disease Control and Prevention
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CIMCI	Community-based Integrated Management of Childhood Illnesses
CPT	Cotrimoxazole Prophylaxis Therapy
CPR	Contraceptive Prevalence Rate
CTC	Community Therapeutic Care
DFID	Department for International Development (British Government)
DIP	District Implementation Plan
DHMT	District Health Management Team
DHO	District Health Officer
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment-Short Course
DMPA	Depo-provera
DP	Development Partner
DQA	Data Quality Assessment
EHP	Essential Health Package
ENA	Essential Nutrition Actions
FP	Family Planning
GOM	Government of Malawi
GTZ	German Cooperation Agency
HBC	Home based care
HFAC	Health Facility Advisory Committee
HEU	Health Education Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPN	Health, Population and Nutrition
HPNO	Health, Population and Nutrition Office
HRH	Human Resources for Health
HSA	Health Surveillance Assistant
HTC	HIV Testing and Counseling
HTSP	Healthy Timing and Spacing of Pregnancies
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IP	Infection Prevention
IPTp	Intermittent presumptive treatment in pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Nets
JICA	Japanese International Cooperation Agency
LAPM	Long Acting and Permanent Method (of FP)
LLIN	Long Lasting Insecticide-treated Nets
LMSS	Leadership, Management and Systems Strengthening
MAG	Management Advisory Group
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDHS	Malawi Demographic Health Survey
M&E	Monitoring and Evaluation
ME&R	Monitoring Evaluation and Research
MGDS	Malawi Growth and Development Strategy

MICS	Multiple Indicator Cluster Survey
MIP	Malaria in Pregnancy
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MOWCD	Ministry of Women and Child Development
NAC	National AIDS Commission
NAF	National HIV/AIDS Action Framework
NGO	Non-Governmental Organization
NHP	National Health Policy
ORS	Oral Rehydration Salts
OVC	Orphans and Vulnerable Children
PBF	Performance Based Financing
PC	Peace Corps
PCRV	Peace Corps Returned Volunteer
PEPFAR	President's Emergency Plan for AIDS Relief
PMI	President's Malaria Initiative
PMP	Performance Management Plan
PMTCT	Prevention of Mother to Child Transmission
POW	Program of Work
PQI	Performance Quality Improvement
PS/SM	Private Sector/Social Marketing
PTA	Parent Teacher Association
RBF	Results Based Financing
RH	Reproductive Health
RUTF	Ready to Use Therapeutic Food
SCM	Supply Chain Management
SCMS	Supply Chain Management Systems
Sd-NVP	Single-dose neveripine
SNL	Saving Newborn Lives
SEG	Sustainable Economic Growth
SI	Strategic Information
SLA	Service Level Agreement
SOAG	Strategic Objective Agreement
SP	Sulfadoxine-Pyramethmine
SSD	Support for Service Delivery
STG	Standard Treatment Guideline
SWAp	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
U5MR	Under Five Mortality Rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

SECTION I - FUNDING OPPORTUNITY DESCRIPTION

1. BACKGROUND

I. Summary

This program consists of three interrelated solicitations being issued by USAID/Malawi to support the Government of Malawi's (GOM) health sector strategy. The purpose of these three solicitations is to engage three or more partners to implement integrated programs that will assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the community and referral (health centers and District hospitals) levels with the aim of improving the health and well-being of the population of Malawi. The three projects will work in targeted districts in all the five health zones of Malawi as well as at the national level. The three solicitations are the following and are discussed in detail in later sections by each sector.

- **SECTOR I**: **Support for Service Delivery (SSD)**- a five-year, $65,289,911 award to implement an integrated service delivery program that will assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the community and referral (health centers and District hospitals) levels with the aim of improving the health and well-being of the population of Malawi. **Support for Service Delivery** will focus on: expansion of community and facility level service delivery, including the delivery of information and BCC, products and services for priority EHP services, and strengthening referrals (health center and District Hospitals). This project will also focus on the renovation and/or creation of appropriate infrastructure and the implementation of performance-based financing. The Prime/Lead Recipient for this award will be responsible for the Project as a whole and take the lead in supporting project implementation in the targeted districts in one zone. To support implementation in the targeted districts of the other four Zones, the Prime Recipient will propose 2-4 Sub-Recipients, each of which will be responsible for Project implementation in the targeted districts of 1-2 Zones. The Prime Recipient and the Sub-Recipients, if they are not indigenous organizations, may also engage other, indigenous partners (Sub-Sub-Recipients) in the targeted districts and Zones to assure adequate coverage of community-based and facility (referral) services.

- **SECTOR II**: **Social and Behavior Change Communication (SBCC)**-a five year, $24,200,000 award to support social and behavior change communication by delivering a comprehensive package of technical assistance to the GOM and to the local partners mentioned in the SSD activity above. **Social & Behavior Change Communication** will support, at the national level, improved strategic planning and strengthened coordination for effective SBCC, development and production of SBCC packages under a national multi-level communication initiative to be implemented through mass media, within community and facility settings and through capacity building of counterpart institutions. At the district level, the SBCC Program recipient, will directly assist Support for Service Delivery Partner (SSD) and other funded USAID partners, and identify SBCC needs, and develop and test new, innovative approaches and materials. The recipient will further support capacity-building of SSD recipient and sub recipients through training, mentoring and on-going technical support for all aspects of SBCC, including use of the SBCC packages and effective approaches to community mobilization. The Project will also improve district level coordination of strategic SBCC activities with all relevant partners to ensure integration of different health messages, prioritization and timing of key SBCC interventions in an integrated manner.

SECTOR III: **Health Policy and Systems Strengthening (HPSS)**- a five-year, $10,684,000 award to improve functioning of the health system and improve sustainable service delivery impact of the EHP in Malawi through strengthened policies, management, leadership and fiscal responsibility of the Ministry of Health (MOH). **Health Policy and System Strengthening** will support capacity building of health personnel and promote health system performance in order to improve comprehensive delivery and sustainability of integrated quality health services. HPSS will support national level activities that aim at improving coordination of policy development, implementation and review across key focus technical areas of Maternal and Child Health, Family Planning, HIV/AIDS, Nutrition, Human Resources for Health, and Systems Strengthening. The HPSS program, in collaboration with other partners on the ground, will also provide financial and technical assistance to strengthen leadership and management capacity for MOH head quarters, zones and district levels to effectively lead and manage health sector priority programs.

Malawi will also support implementation and monitoring of key health financing processes such as the National Health Accounts (NHAs) and the health SWAp as well as promote the use of Performance Based Financing for implementation of selected interventions.

Although each Recipient will have its distinct scope of work and roles and responsibilities, they must closely and effectively collaborate throughout the life of these projects. (See coordination as above and also in each sector program description for more detail on these relationships.) USAID/Malawi STRONGLY suggests that interested applicants in any sector, read all sector description as the program as a whole is tightly linked one to another and any response must reflect that understanding and programming.

II. Overview of Health Status in Malawi

Although health status in Malawi has improved in recent decades, particularly for children, many health challenges remain. In 2008, Malawi's population was just over 13 million, 32 per cent higher than in 1998. Life expectancy is low at 46 years and about 42 per cent of the population is of reproductive age (15-49 years). If the high fertility remains, Malawi's population will grow from about 13 million in 2008 to 40.5 million in 2040, challenging Malawi's attempts to improve health, education and other services and improve the well-being of its people and its environment. Malawi is experiencing a youth bulge with 52 per cent of the population less than 18 years of age.

- **Infant and Under Five Mortality**

While Malawi is on track to achieving MDG 4, infant and under-five mortality rates remain unacceptably high at 72 per 1000 and 122 per 1000 births respectively. Neonatal mortality accounts for one-third of infant deaths and one-fifth of deaths among children under five years. The majority of newborns die within the first seven days of life, usually at home and they primarily die from infections, prematurity/low birth weight, and asphyxia. After seven days, the major causes of infant and child deaths are pneumonia, malaria, diarrhea, HIV/AIDS and malnutrition.

- **Maternal Mortality**

The maternal mortality ratio (deaths per 100,000 live births) is very high (984 in MDHS 2004; 807 MICS 2006). Facility-based studies in Malawi identified postpartum infection, obstructed labor/ruptured uterus, and post-partum hemorrhage as the three biggest killers, accounting for two-thirds of maternal deaths. Although a very high percentage of women receive at least one

antenatal visit (93 per cent in the DHS 2004; 97 per cent in MICS 2006), only 56 per cent of deliveries are attended by a skilled attendant and only 57 per cent of deliveries take place in a health facility.

- **Family Planning**

Between the early 1990s and 2004, Contraceptive Prevalence Rates (CPR) for modern contraceptive methods rose from less than 8 per cent to about 28 per cent. The MICS 2006 recorded CPR at 38 per cent. Despite this fairly dramatic surge, total fertility in Malawi has plateaued at about six children per woman. Several factors, such as late adoption of family planning (i.e., after having four or more children) may contribute to the continuing high fertility. Finally, 28 per cent of married women want to space or limit the number of children but are not using a family planning method. Although contraceptive use is well established in Malawian culture, access to services particularly for the rural communities and the youth remains a challenge.

- **Malaria**

Malaria is endemic in 95 per cent of the country with over 85 per cent of malaria infections due to *Plasmodium falciparum*. The MOH estimates that there are approximately six million episodes of malaria per year, with the disease accounting for 40 per cent of all outpatient visits. Malaria is the number one cause of hospital admissions among children under five. While important progress has been made in malaria control and prevention, gaps remain in use of Insecticide Treated Nets (ITNs), use of Artmesinin Combination Therapy (ACTs), and complete coverage of Intermittent Presumptive Treatment of malaria in pregnancy (IPTp).

- **Nutrition**

Malnutrition remains a serious health and development problem. Stunting and underweight statistics have not changed in decades: nearly half (46 per cent) of Malawi's children (male and female rates are similar) are stunted and 21 per cent are underweight (MICS, 2006). In recent years high coverage of some nutrition interventions has been achieved, e.g. bi-annual vitamin A supplementation coverage for children aged 0-59 months is high, at 80 per cent (MOH, 2009), the rate of exclusive breast feeding is 56%, and 55 per cent of households use adequately iodised salt (Ministry of Education, 2006).

- **HIV/AIDS**

National prevalence is estimated at 12 per cent and women are more likely to be infected than men. Nearly one million people are HIV-infected and it is estimated that 100,000 Malawians become infected each year. Like other Southern African countries, Malawi's generalized epidemic is spread primarily through heterosexual intercourse, followed by mother-to-child transmission. Condom use at last high-risk sex among the 15-24 year age group is at 40 per cent among women and 60 per cent among men. As of December 2009, with support from the Global Fund and PEPFAR, more than 190,000 Malawians are on Anti Retroviral Treatment (ART). An estimated 500,000 Malawian children have lost a parent to HIV/AIDS.

- **Water and Sanitation**

Although 75 per cent of the population has access to potable water, according to the 2006 MICS, transport and storage often result in contamination. Regarding sanitation, the MICS found that 88 per cent of the population was using sanitary means of excreta disposal including pit latrines (98 urban and 86 rural); however, many of the latrines are of rudimentary construction and affect the quality of nearby water supplies.

- **Tuberculosis (TB)**

TB is a serious public health problem in Malawi, with the country being ranked the 14th highest incident rate in the world. Malawi's TB epidemic is worsening in both severity and magnitude. The co-infection rate of HIV/AIDS and TB is estimated at 70 per cent.

- **Overview of Health Sector in Malawi**

Malawi's Ministry of Health provides oversight on a sector wide health response as well as delivers approximately 60% of all health services for the country. At the national level, its various health departments and related technical working groups, develop national policies, protocols and guidelines, and define strategic priorities for delivering health services, including health specific communication priorities to be implemented.

In line with GOM policy on decentralization, Ministry of Health devolved responsibility for the delivery of health services to the districts in a phased manner. This strategy was adopted based on two considerations - the current capacity of the district and city assemblies to handle health related issues and the need for sensitizing the Councilors on MOH strategies to enable them make informed positive contributions during assembly or at various committee levels. There is therefore direct budgetary allocation to the districts, which makes District Health Management Teams (DHMT) accountable directly to the district assemblies for decisions on financial management, planning and expenditures. Planning of district health activities is based on the district implementation plans. The planning uses a bottom up approach with communities, health centre, district staff and other significant stakeholder's involvement.

Budgeting at district level is activity based. However, the Ministry will roll out budgeting allocation of financial resources to health centers in the near future. It is envisaged that health centers will learn shortly how to develop their own implementation plans. The plans will be consolidated at the district and will form part of district assembly development plan for the particular financial year. Money meant to fund health activities at the assembly level will be ring fencing to protect it from being abused or allocated for activities not related to health. It is expected that the Councilors and Community at large will be conversant with the operating budget and plans for Community activities, Health Centers and District Hospital activities.

Between the District and Central Ministry of Health is the Zonal health structure. Five (North; Central East and West; Southern East and West) Zonal Health offices were established to provide technical, management and administrative support and to coordinate the activities of a cluster of up to seven districts in a zone in the most effective and efficient manner possible and to facilitate the transition to devolution. Zone Offices provide front-line technical support in health services management and delivery to the districts and facilitate a more integrated approach to disease prevention and control, health care delivery and the implementation of the EHP Program of Work (POW). Zone Offices also support districts in terms of administrative and financial management in line with the policies of the government.

Health care delivery is provided at three levels, primary secondary and tertiary. Services at community (primary) level are provided through: volunteers; Village Health Committees (VHCs); Community Based Distribution Agents (CBDAs) and health surveillance assistants (HSAs). Services at this level are conducted through door-to-door, village clinics, mobile clinics, or at manned or unmanned health posts. Health centres are categorized as primary health although most health centres offer curative and maternal services and are manned by nurses and clinicians. District hospitals (secondary level) are referral centres for health centres and they also service the local town population offering both inpatient and outpatient services. Central

hospitals (tertiary) act as district hospitals for their districts. They are different from district hospitals in that they provide specialist referral care for their respective regions. Specialist hospitals offer very specific services such as mental health services and inpatient care for Tuberculosis. The Christian Health Association of Malawi (CHAM) is responsible for the provision of about 37% of all services. Other providers include private-for-profit and private, not-for-profit entities, local government, the military and police health services and small clinics offering care for company employees and their families. CHAM facilities are not private sector institutions in the conventional sense, as the MOH governs policy at these facilities and is their major source of funds. Three percent of health care is provided through the private sector including Banja LaMtsogolo.

At the national level, the Ministry of Health's Health Education Unit's mandate is to plan, coordinate, and monitor national health communication activities through use of advocacy events, development of mass media, print, and community mobilization events. It is unique in that its role within the MOH requires them to support all MOH departments as its implementation arm for communications development, as well as engage with a range of multi-sectoral partners within the public and private sector. At the district level, they manage district health education officers in their role as SBCC coordinators, strategic planners, implementers of communication interventions, and communications advisors of Health Surveillance Agents (HSAs), Community Based Organizations (CBOs), and CBDAs.

Other key national partners playing a role in a multi-sectoral response to SBCC include the Ministry of Gender, the Ministry of Information, and Ministry of Local Government. Within sexual reproductive health and HIV and AIDS, the Ministry of Health works closely with the National AIDS Commission to ensure that the national HIV response across all sectors has a harmonized, strategic focus for SBCC at all levels, and priorities are established annually. The coordination bodies within the MOH bring together local partners, such as CHAM, BLM, other NGOs, and in some cases the private sector – all of which play a critical role in service delivery and SBCC.

Table: Roles of GOM governance structures and their key partners

Level	**Entity**	**Major Role**	**Key Partners**
National	Ministry of Health	Develops national, policies, protocols, guidelines	National AIDS Commission, Line ministries, Donors, Private sector partners, Civil Society, TWGs and sub-committees,
Zones	Zonal Offices	Provides supervision, training and M&E support to districts	Development partners
District	District Health Office, Health facilities,	Implements health services conforming to national standards	Private sector providers, (CHAM, BLM), Social marketing partners
Community	HSAs, Village Health Committees, CBDAs	Mobilize communities to identify health needs and use health services; .Provide community based services.	Traditional leaders, FBOs, CBOs NGOs, Support groups

III. Health Priorities in Malawi

In the Malawi Growth and Development Strategy (MGDS) of 2006-2011, the GOM identifies "Health and Population" as an important sub-theme, and notes that a healthy population is "not only essential but also a prerequisite for economic growth and development." Consistent with this perspective, the GOM, with significant support from its development partners, has embarked on key reforms of the health sector with the adoption in 2004 of the Sector-Wide Approach (SWAp). The SWAp serves as an overarching strategy to improve efficiency in the utilization of available resources to achieve health sector goals of reducing mortality, morbidity, and fertility and improving the health of all Malawians. The SWAp I is implemented through a joint Program of Work, which guides the investments and activities of all partners. The priorities of the joint POW revolve around the provision of the Essential Health package (EHP) as part of the Malawi Poverty Reduction Strategy. The broad objective of the POW is to raise the level of health status of all Malawians by reducing the incidence of illness and occurrence of premature deaths in the population. The EHP in Malawi is based on the country's implementation of the Primary Health Care strategy whose fundamental principle has been to improve the health status of the population by focusing on a cost effective package of essential health services through the involvement of the beneficiaries themselves in service delivery.

The EHP addresses the major causes of morbidity and mortality that mainly affect the poor and the most vulnerable groups in society. To ensure maximum benefit by the poor, it is government's policy that the EHP be provided "free" of charge at the point of delivery at all public health facilities. The policy implications are that every Malawian is entitled to EHP services at any government facility free of charge irrespective of their social status. Where government facilities have introduced private wards and user fees are enforced, only those patients choosing to access such privileged services will pay the required user fees. Conditions included in the EHP are: vaccine preventable diseases; malaria; adverse maternal and neonatal outcomes (including family planning/reproductive health and safe motherhood initiatives); TB; acute respiratory infections; acute diarrheal diseases; STIs; eye, ear and skin infections and common injuries. Because the EHP cannot be delivered in a vacuum, the service package includes the strengthening and development of Laboratory services; drugs procurement, distribution and management; information, education and communication (IEC); support and supervision; pre and in-service training; planning, budgeting and management systems and monitoring and evaluation including epidemiological surveillance.

IV. Development Partners (DPs) in Malawi

Donor Partners participating in the SWAp I arrangement are: DFID, Norway, Germany (KfW), Belgium (Flemish), UNICEF, and the Global Fund. USAID is a signatory to the Memorandum of Understanding (MOU) from SWAp I as a discrete donor. Some DPs are considered both pooled and discrete donors; these include the African Development Bank, the European Union, GTZ, JICA, Iceland, UNICEF, UNDP, UNFPA, and WHO. Other DPs are Canada (CIDA) and the World Bank, notably, is providing funding only for HIV and AIDS under a pooled funding arrangement to support the National HIV/AIDS Action Framework (NAF). Malawi is also managing grants from the Global Fund for AIDS, TB, and Malaria and receives support from several private foundations, namely the Gates Foundation and the Clinton Foundation. As directed by the Ministry of Health, many of these development partners implement their programs in districts according to their significant health needs and other criteria. USAID is the main United States Government (USG) supporter of health programming in Malawi. In general,

USAID's activities have been directed to districts not funded by other DPs but their activities fall under the POW.

In addition to USAID, two other US Government agencies, Peace Corps and the Centers for Disease Control and Prevention (CDC), are also involved in health activities. Peace Corps trains all its volunteers to support community level prevention efforts for EHP; some volunteers also work with youth, kitchen gardens and village health committees. Some Peace Corps Returned Volunteers (PCRVs) are assigned to District Assemblies where they may support DHMTs in planning and management. Under PEPFAR, CDC and USAID partner to improve laboratory services, expand HTC, support biomedical preventive services like PMTCT and male circumcision, roll out and expand treatment services, including pre-ART, and strengthen the national surveillance program to track HIV and malaria incidence.

V. Overview of USAID's Health Program in Malawi

In considering the many health challenges and issues affecting the Malawi health sector, the **Health, Population and Nutrition (**HPN) Team recognized that USAID/Malawi must set priorities consistent with the Agency's and the GoM's principles: using USAID/Malawi's strengths, applying lessons learned from recent experiences in Malawi, and ensuring greatest impact consistent with USAID/Malawi's funding streams and levels. USAID/Malawi's priorities for support in the health sector respond to pressing needs at the national, zonal, district, and community levels and, through its partners, will generate results from the top down through the system as well as from the bottom up. USAID/Malawi has and will have significant levels of funding to ensure impact in Malaria, Family Planning, Maternal and Neonatal Child Health (MNCH), including Nutrition, to some extent Water and Sanitation (WATSAN), and HIV/AIDS and Tuberculosis. USAID/Malawi HPN recently developed a working strategic document that bridges existing programs into the Global Health Initiative and prepares for the advent of SWAp II; future programs will be guided by the new strategic framework as found below. The framework is representative of the parameters of the GHI including: a particular focus on improving the health of women, newborns and children through programs including infectious disease, nutrition, maternal and child health, and safe water. USAID is already aligned with GHI principles leading to significant health improvements and creating an effective, efficient and country-led platform for sustainable delivery of essential health care and public health programs; in fact, this approach is an essential part of the foundation for these new awards.

VI. USAID/Malawi's Strategic Framework

This strategic framework for 2009-2015 does not represent a dramatic change in USAID/Malawi's goals and objectives for the sector. The Goal is closely aligned with that of the SWAp I POW, which is: To raise the level of health status of all Malawians. USAID/Malawi will track the same indicators as the SWAP I Monitoring Evaluation and Research (ME&R) framework: Infant Mortality Rate (IMR), Under 5 Mortality Rate (U5MR), Maternal Mortality Ratio (MMR), HIV prevalence among 15-24 year old pregnant women, and Total Fertility Rate (TFR). The health portfolio for USAID has been integrated across disease specific areas and functioning holistically since before 2006. This approach has proved successful and has helped lead to dramatic results in reductions in maternal and child morbidity and mortality as well as recent increases in family planning coverage and HIV prevention, care and treatment. This approach has also helped foster national systems, sustainability and decentralization of critical health care services.

Vision Statement: Equitable access to high quality health care for all Malawians supported and sustained by vibrant communities, strong national leadership and engaged civil society.

Mission Statement: To promote, improve, and protect the health and well being of Malawians through investing in sustainable, strategic, high quality health initiatives and partnerships that support Malawi's development goals and U.S. foreign assistance priorities.

Goal Statement: Healthier Malawian Families.

At lower levels of the SWAp I POW ME&R framework, USAID/Malawi and its implementing partners will align their monitoring with key SWAp indicators, as follows:

i. Program Objective/Outcomes: USAID/Malawi's Health Sector Program supports: Increased availability of quality **EHP services**; and increased utilization of EHP services.
a) OPD utilization rate
b) Proportion of 1 year old children immunized against measles
c) % of births attended by skilled health personnel
d) Routine Vitamin A supplementation coverage in children 6-59 months

ii. Program Outputs: USAID/Malawi's Health Sector Program will support access to and knowledge of and use of priority EHP services in targeted districts including hard-to-reach, underserved, and very poor women and children.
a) % of facilities able to deliver OPD, Immunization, FP and Maternity services
b) % of health centers offering Basic Emergency Obstetric and Neonatal Care (BEmONC)
c) # of people alive and on ART at the end of the reporting period
d) # of ITNs distributed in the country during the reporting period

iii. Program Processes: USAID/Malawi's Health Sector Program will support selected Pillars of EHP with emphasis on: pharmaceuticals; human resources; and, routine operations.
a) # of service level agreements on MNH signed with CHAM and other providers
b) # of students graduating from health training institutions
c) # (%) of supervision visits to health facilities by the DHMT

iv. Program Inputs: USAID/Malawi's Health Sector Program will support key policies and strategies, coordination, and health financing (as a discrete donor).
a) % of GOM budget allocated to health
b) % of recurrent budget funded and utilized annually
c) Per capita allocation to health sector
d) % of health centers with minimum staffing norms
e) % of health facilities with functioning water, electricity, and communication
f) % of health facilities with adequate equipment

USAID anticipates SWAp II will use similar indicators to those for SWAp I; however, as SWAp II is designed, USAID and its partners may need to adjust its indicators to be aligned with a new ME&R framework. At the health facility level, USAID/Malawi health sector resources will continue to support capacity to manage referrals for MNCH, FP, nutrition, malaria, and HIV/AIDS treatment management, as well as capacity in long acting and permanent methods of family planning and Basic Emergency Obstetric and Neonatal Care (BEmONC).

Through all USAID funded health programs, SBCC is an integral part of demand creation for priority health services, adoption of healthy behaviors through community change, and increased access to health commodities such as ITN bednets, waterguard, ORS, and contraceptives through social marketing.

VII. USAID/Malawi's Components and Strategy

Program Components
The major components of USAID/Malawi's health program from 2009 to 2015 are divided according to service delivery levels and type of interventions that the health team will focus on. The components are outlined below:

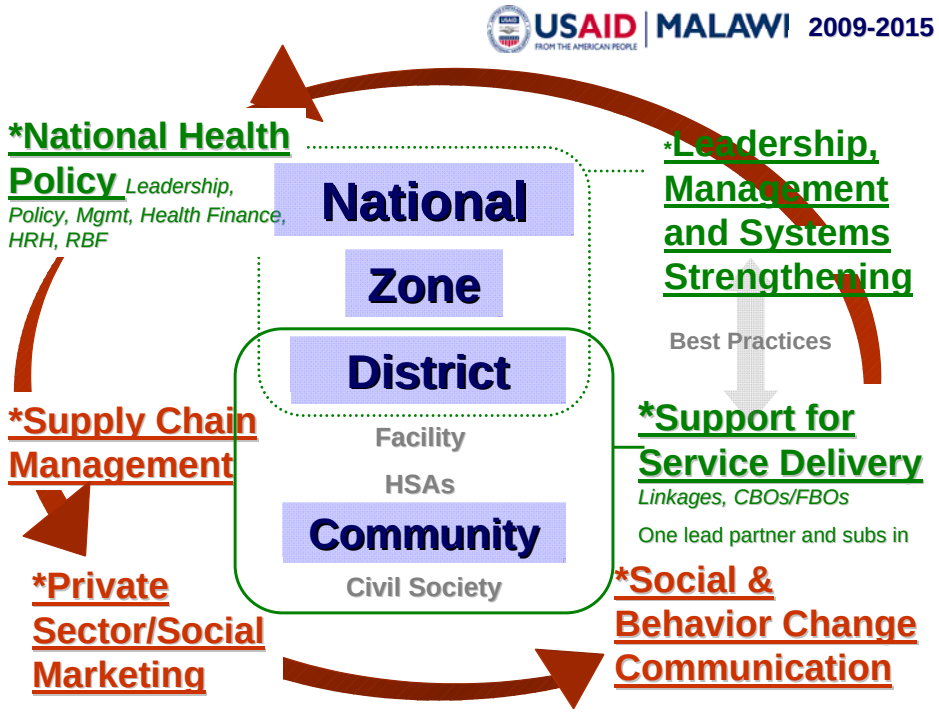
a) Point of service and community level
- Providing support for service delivery of identified priority areas
- Strengthening Social and Behavior Change Communication
- Strengthening the Private Sector and health commodity social marketing
- Strengthening Supply Chain Systems

b) Policy/ national and district level
- Health Policy advocacy and district level systems strengthening
- Strengthening Social and Behavior Change Communication
- Strengthening the Private Sector and health commodity social marketing
- Strengthening Supply Chain Systems

The three program components, Health Policy and Systems Strengthening, Support for Service Delivery, and Social and Behavior Change Communication will focus on expanding access and use of key, high priority health information, products and services at the community level and referral (health centers and district hospitals) level. Similarly, the Private Sector/Social Marketing and Supply Chain components, which will focus on both policy influence and service delivery at facility and community levels. These will be implemented through separate but interrelated awards. Although each award and partner will have its distinct scope of work and roles and responsibilities, these programs must closely and effectively collaborate throughout their implementation life to achieve holistic impact. Given its role in strengthening leadership, management and systems through the central, zonal and district levels and considered as a "vital link" between the central MOH and the districts, the HPSS Project will need to coordinate very closely not only with the other programs that overlap with it at central level to maintain strong coordination and leadership in advocacy efforts that address interests of each program but also with those projects that are implementing at district and community level.

The diagram below illustrates the major components of USAID/Malawi's HPN Program 2009/15. The three components on the left side represent specially targeted projects/activities that focus on addressing high priority needs that require specialized and focused attention and are implemented through the three interrelated solicitations herein.. Note that Policy elements and leadership and management have been combined into one Sector (Sector III). As indicated by its location in the center, the core of the program is a focus on the district and community levels. At this level, involving HSAs, their related facilities, and civil society, the USAID program through the Support for Service Delivery component will assure the delivery and quality of a comprehensive package of health service interventions, for which an illustrative list is provided under "Priorities" in the Sector I description. Without the delivery of these interventions to those in need at the primary health care facilities and community level no change in health status can

be achieved. However, the on-going delivery of these interventions relies on leadership, management and systems that support HSAs and other health service providers at facilities and in communities. Therefore, closely linked with Support for Service Delivery (SSD) component is the Health Policy and Systems Strengthening (HPSS). As the diagram shows, this component overlaps with the SSD component at the district level; the HPSS will focus on policy, leadership, management and systems issues, for example, improved supervision and quality assurance that most impact on service delivery at district and community levels. However, issues of leadership, management and systems are directly affected by zonal and national level policies and actions. To make a difference at the district level, the HPSS component will work at all levels - national, zonal, and district - to assure effective implementation of change.



These two components, SSD and HPSS (National Health Policy and Leadership Management and Systems Strengthening) will be supported by three other components: Social and Behavior Change Communication (SBCC), Private Sector/Social Marketing (PS/SM), and Supply Chain Management (SCM). SBCC will support community mobilization and social and behavior change efforts of the SSD component, by ensuring effective behavior change messages, support materials, strategies, capacity building, and follow up, as well as local and mass media support for these efforts. In close collaboration with the SBCC component, the Private Sector/Social Marketing component will support marketing of high priority products and services in the target districts where the SSD and HPSS will focus. In addition, the PS/SM component will complement public sector service delivery by seeking to extend the reach of its private sector approaches to those able to pay and, where feasible, to underserved areas. The Supply Chain Management component also links with HPSS and the SSD components with a separate, in depth emphasis on resolving supply chain management bottlenecks. SCM will collaborate in particular with HPSS as a complementary support for systems strengthening. Although certain components, as indicated below and in the schematic, will focus on selected levels of the health system, all five components will have implications for national level policy making and programming and, therefore, will link with national level decision makers.

- The three components in green, SBCC and HPSS are integrally linked to SSD, which will focus on all five zones and targeted districts. While the impacts of these components are likely to be primarily at the district level and below, they will also have important benefits for the zones, other districts within the zones and the national level.

- SBCC, SCM, PS/SM have specific roles within the target districts as described above. They are also intended to have national level impact and will affect all districts. SBCC will have a role in coordination at the national level and with all stakeholder organizations in developing formative research, harmonized and cohesive strategies and packaged interventions to support effective implementation so as to assure reinforcing SBCC efforts and greater impact. Similarly, PS/SM will support private sector approaches, including social marketing, in all districts to complement and support GOM service delivery efforts. Given that supply chain bottlenecks plague all districts, the SCM component will take a nation-wide approach to finding and implementing solutions.

Strategic Outcomes and Results

In expanding access and use of the priority EHP services at the community level, USAID/Malawi's strategies for implementing the program components reflect lessons learnt from its experiences in health programming in Malawi and internationally. With this strategy USAID/Malawi intends to achieve:

Comprehensive delivery of key selected, high impact interventions. At both community level and health facility levels, USAID/Malawi's programs will ensure integration of and access to priority health interventions for women and children that can make a difference in their health and increase involvement of men in care. Lessons will be drawn from interventions that have already been successfully tested/piloted in Malawi through programs such as Accelerated Child Survival and Development (ACSD), Essential Nutrition Actions (ENA), Saving Newborn Lives (SNL) and Family Planning, but have not been offered in a comprehensive, integrated manner or scaled up.

Saturation. To ensure impact at the district level, USAID/Malawi will provide technical and implementation assistance for full coverage ("saturation," or at least 80 per cent of traditional authorities) of targeted districts, rather than spread activities thinly over many districts. If other development partners are supporting activities in the same districts, Projects must ensure close collaboration and complementary support.

Approach for scale out. It is expected that USAID/Malawi implementing partners will initiate their work in service delivery in several traditional authorities within a targeted district, then, scale out over the next few years so as to extend coverage of the high impact interventions throughout the district. Innovation in scale out will be important to reach a critical mass of coverage.

- **Scale up.** Given that USAID/Malawi will support systems strengthening and service delivery at both district and zonal level and activities may also be implemented across zones, lessons learned and experiences from target districts will be made readily accessible to all other districts within the zones even if they are not target districts. Thus, the impact of these interventions should extend well beyond the target districts.
- **Multi-level.** In all intervention areas, whether technical support for health services or for systems, effective change must occur at all levels: central, zonal, district, and community, with particular emphasis on implementation from the zonal level to the districts and communities. Planned interventions must address the identified constraints of the health system.

- **New/renewed areas of emphasis.** These areas include: behavior change communication; community level service delivery; performance-based financing; selected systems strengthening, with emphasis on those most pertinent to effective community level services; private sector/social marketing; supply chain management; and a woman and child centered approach as promoted under the new Global Health Initiative.

Human resources for health will steadily improve. Human Resources for Health are critical in the delivery of health services and management at policy level. The situation in Malawi is still critical despite some improvements in recruitment of HSAs through the Global Fund to strengthen primary health care delivery, nurses and clinicians through the just ended Emergency Human Resources Plan (EHRP). With the phasing out of the EHRP, it is likely that staff shortages will again increase with training institutions producing very few health workers. HRH is therefore an area that needs close monitoring at policy level to ensure programming is not affected. Where task shifting will be implemented, policy development and monitoring will be crucial for program success. Other innovative responses will be needed.

2. OBJECTIVE

The objective of this program is to implement the delivery of services linked to improved access to and utilization of high quality health care for all Malawians supported and sustained by vibrant communities, strong national leadership and engaged civil society and ensuring achievement of the program objectives contributing to progress in three critical areas: 1) Reducing fertility and population growth, which are essential for attaining broad based economic growth; 2) Lowering the risk of HIV/AIDS to mitigate the enormous impact on human resources and productivity; and 3) Lowering maternal and infant and under-five mortality and morbidity. The program will be implemented in three sectors as follows: **SECTOR I**: Support for Service Delivery (SSD)- for an integrated service delivery program that will assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the community and referral (health centers and District hospitals) levels with the aim of improving the health and well-being of the population of Malawi; **SECTOR II**: Social and Behavior Change Communication (SBCC) to support social and behavior change communication comprehensive package of technical assistance to the GOM and to the local partners mentioned in the SSD activity above; and **SECTOR III**: Health Policy and Systems Strengthening (HPSS) to improve functioning of the health system and improve sustainable service delivery impact of the EHP in Malawi through strengthened policies, management, leadership and fiscal responsibility of the MOH. In addition to these three projects, USAID/Malawi has two other project components, which are not part of this RFA that will be implemented during this USAID Health, Population and Nutrition (HPN) Strategy period 2009/15. These are: **Private Sector/Social Marketing** project that will focus on expanding distribution channels and the range of products for social marketing; it will also explore options for expanding access, quality and capacity of the private sector to deliver priority EHP services and participate in SBCC, service delivery and other aspects of health programming (e.g., SBCC mass media and materials production) and **Supply Chain Management** project that will work at the national level to assure access to priority EHP commodities at all levels of the supply chain and resolve key supply chain problems and bottlenecks.

3. PROGRAM DESCRIPTION

This section provides the program description for each of the three sectors:

SECTION I: SUPPORT FOR SERVICE DELIVERY (SSD)–PROGRAM DESCRIPTION

1. Overview of the SSD Program

The Support for Service Delivery (SSD) project is a five-year project with an estimated budget of $65,289,911**.** The SSD Project is one of three interrelated solicitations being issued by USAID/Malawi to support the Government of Malawi's health sector strategy. The recipient of this award is expected to implement an integrated service delivery program that will assure significant expansion and improved quality of priority Essential Health Package services at the community and referral (health centers and District hospitals) levels with the aim of improving the health and well-being of the population of Malawi. The SSD Program will focus on achieving the following results:

- Increased access and utilization of services for women and children that can make a difference in their health and engage men in care.
- Enhanced quality of health services at community and facility level.
- Improved health seeking behavior by individuals, families and communities (in partnership with the SBCC Recipient)
- Strengthened systems for improved service delivery in collaboration with the HPSS recipient.

2. SSD Background/Context of the SSD Response in Malawi

a) Health Sector Critical Issues and Programming Opportunities by Technical Area

o ***Illustrative Problems/Critical Issues***

A number of analyses have identified challenges in the delivery of health services that constrain Malawi's ability to meet its own health goals, objectives, and the MDGs, which include:

i) Limited access to quality health services and information for people with the most need, particularly those residing in rural areas.

- Poor roads and limited transport options increase costs for accessing distant facilities.
- Shortages of appropriate staff, for example, Health Surveillance Assistants (HSAs), a cadre originally intended to work at community level, are often dispatched to health facilities to cover vacant positions, there are simply too few HSAs to meet community needs. Gender issues also affect selection and deployment of HSAs who are predominantly men. This may limit their effectiveness in health prevention and promotion for services, such as family planning.
- Poor retention of paid staff and unpaid volunteers**,** especially among Non Governmental Organizations (NGOs). Little is known about the motivations of paid staff and unpaid volunteers; and
- Shortages of drugs and frequent drug stock outs**,** largely attributed to a weak supply chain system for commodity distribution, affect all health facilities.
- Limited youth and male involvement

*ii) Limited numbers of skilled staff***.** Although there has been some progress in increasing access to higher quality health provider training, serious gaps remain.

- Training gaps**,** which include a lack of focus on skill development, quality curriculum, and use of innovative teaching methods.

- Over-reliance on group training events that increase costs, leave SDPs shuttered while staff are off-site, and lack opportunities for realistic problem-solving.
- Poor supervision and limited support do not reinforce skills among staff or support a culture of quality and customer service.
- Poor working conditions including inadequate infrastructure and equipment, and limited supplies of medications, medical consumables, and medical supplies; and
- Little respect and poor communication from supervisors and clients for the challenges and obstacles health workers in Malawi overcome on a daily basis.

*iii) Leadership and policy***.** Limited leadership at the national level affects all levels of performance; key positions may remain vacant for long periods; others may not have the skills needed for their assigned positions. Effective oversight and accountability are often missing. There is:

- Limited priority-setting on interventions for the greatest public health impact particularly pertaining to the EHP.
- Uneven application of best practices in policymaking and implementation.
- Poor policy support for private sector participation; and
- No policy that allows contributions from those with an ability to pay for services.

*iv) Need for Improved Systems***.** Although some progress was noted, recent reports indicate significant shortfalls in the following:

Commodity procurement and distribution. The problems are chronic and pervasive (too numerous to catalogue here) and all levels of the health system are affected. The mantra, "no product, no program," is especially relevant in Malawi.

- Human Resources for Health (HRH). Although the MOH has taken steps to address obstacles, it remains one of the major challenges of the health sector in Malawi and needs to be addressed as a systemic issue. Specific issues include; shortages of staff across all professional cadres, inadequate incentives to staff, the lack of professional development opportunities, and the low capacity of training institutions in the country.
- Financial management**.** Skills and capacity are very limited at all levels. With funding now allocated to districts, the system has even less capacity to budget and utilize funds effectively. Effective use of funding is affected by poor prioritization and lack of focus on public health outcomes; and
- Decentralized management**.** Districts, i.e., District Assemblies and District Health Management Teams (DHMT), are now expected to manage funding and plan for and oversee health service delivery for their districts. The MOH intends for the zonal level to have a stronger role in oversight of, technical support to, and coordination among the districts in each zone. Yet the staff has neither the skills nor the financial or technical authorities required to fulfill these roles.
- Limited and/or inadequate infrastructure negatively affects the implementation of the EHP.

*v) Weaknesses in health programming***.** MOH tends to prioritize clinical care over preventive services. The result is:

- Weak Social and Behavior Change Communication (SBCC). Stakeholders raised concerns regarding the quantity and quality of formative research, development of messages and approaches, and targeting of information and campaigns; and
- Limited engagement with the private sector, including private medical practitioners, pharmacies, and other private enterprises**,** as a potential resource for services, information and

systems support. Capacity in the private sector is limited and there are few incentives to draw potential private providers into the system. Social marketing as an approach for getting key health products to people has not been fully explored.

*vi) Culture and environment***.** Health programs often struggle with harmful traditional practices and with gender and or social norms that affect women's ability to make health care decisions for themselves and their children. Specific needs in Malawi include:

- Greater engagement of Traditional Authorities and community leaders**.** They are critical to acceptance by local communities and are essential to dissemination and on-going support of key messages and services; and
- More consideration of and action to address gender relationships and norms**.** MNCH, family planning and other health programs often focus on women and their children as target groups, but men/husbands and other family members, such as grandmothers, sisters-in-law and uncles, often play critical roles in decision-making about seeking health care, utilizing family resources for health services or purchase of food, and practices such as infant and child feeding. For example, harmful cultural norms perpetuate imbalances in gender dynamics between men and women and facilitate high HIV infection rates and low uptake of health services such FP, MNH, Child health, HTC, PMTCT and ART services.

3. SSD Programming Opportunities

In keeping with USAID/Malawi's status as a priority country for funding in malaria; maternal, neonatal and child health (MNCH); nutrition; family planning; and HIV/AIDS (Tier II), and its health funding sources, below is an illustrative list of health intervention priorities, which may evolve and need to be revisited as needs, policy, and priorities change. These areas are all a part of the Global Health Initiative and reflect its priorities. The SSD project aims to include the following technical areas:

- **Maternal Health**, with emphasis on early antenatal care and health seeking behavior for delivery; infrastructure improvements; iron folate supplementation, de-worming; use of LLINs and IPT/pregnancy; focus on primary and secondary HIV/AIDS prevention interventions (behavior change, HTC and PMTCT) and pre and post ART care; birth preparedness; and AMSTL for hemorrhage, and magnesium sulphate and calcium and improved quality of care for prevention and management of eclampsia;
- **Newborn Health**, including newborn drying and wrapping, clean cord care, hand washing, immediate and exclusive breastfeeding, tactile stimulation of asphyxiated newborns, and kangaroo care for low birth weight newborns;
- **Child Health**, including expansion of IMCI and ACSD, promotion of point of use water treatment, ITNs, and hand washing, use of ORS for diarrheal disease, immunization, treatment of malaria, and early treatment of childhood pneumonia;
- **Nutrition**, to include support for essential nutrition actions, such as exclusive breastfeeding, continued breastfeeding to 2 years, timely and appropriate complementary feeding, Vitamin A supplementation, continued feeding during illnesses, and early detection and management of malnutrition at the community level;
- **Family Planning**, to include innovative approaches to improving access; including counseling of all women and couples on methods of FP, provision of or referral for the preferred method (or an interim method if delay in access to the referral), counseling on use of the method chosen, and follow up; reaching out to the youth and males with FP services.
- **Malaria Control**, including national scale programming for correct and consistent use of ITNs, IPTp and other malaria services for pregnant women, and prompt and effective case management for malaria at all levels of the health system; and,

- **HIV/AIDS** prevention; addressing systemic human resources for health issues throughout the clinical spectrum; promotion of an efficient referral system; provision of integrated ante-natal care; integrated infrastructure improvements; and possible promotion of and access to male circumcision.

With more limited resources selected interventions in:

- **Water and sanitation,** with an emphasis on hygiene promotion and promotion of Point Of Use water treatment
- **TB**, including improved case finding, use of DOTS, tracking of TB management and rates.

At the health facility level, USAID/Malawi health sector resources will continue to support capacity to manage referrals for MNCH, FP, nutrition, malaria, and HIV/AIDS treatment management, as well as capacity in long acting and permanent methods of family planning and BEmONC.

4. SSD Program Description

The Support for Service Delivery (SSD) is a five year $65,289,911 program. It is the primary mechanism of USAID/Malawi to assist the Government of Malawi and the Malawi Health Sector to effectively implement high priority health services to improve the health of Malawian families and expand access to priority Essential Health Package (EHP) services. The Recipient of this award is expected to support effective integration of priority EHP services at the community and referral levels (health centers and district hospitals), ensure high technical and programmatic quality at these levels, and reduce gender and other barriers to access and use by individuals and households.

The overall purpose of the SSD Project is to implement the delivery of services linked to improved access to and utilization of high quality health care in targeted districts ensuring achievement of the program objectives contributing to progress in three critical areas: 1) Reducing fertility and population growth, which are essential for attaining broad based economic growth; 2) Lowering the risk of HIV/AIDS to mitigate the enormous impact on human resources and productivity; and 3) Lowering maternal and infant and under-five mortality rates.

In achieving the objective of the award, the recipient will undertake various activities necessary to accomplish the results outlined above. The approaches and activities provided in this program description are presented only as an indication of the types of approaches and activities likely to achieve the results listed above. In preparing an Application for and then implementing this project, the Recipient and Sub-Recipients will need to present how their strategies and approaches are adapted to the needs, challenges, and contexts of the service delivery environment in each district and zone.

Applicants must propose strategies, approaches and activities to achieve the overall outcomes and results, with an emphasis on improved health indicators in targeted districts as identified above. The Recipient and Sub-Recipients should consider how they will phase implementation so as to achieve coverage and impact in the targeted districts, integrate services and SBCC activities, keep appropriate focus on priority services, and build the capacity of Malawi MOH staff and local, indigenous partners to assure medium- to long-term sustainability of community level impact. Applicants should review experience to date, identify priority areas for integration, such as MNCH with HIV/AIDS and nutrition (PMTCT) and HIV/AIDS with FP and MNCH,

and develop approaches for scale out and scale up. As noted in the results for integrated services above, Applicants should aim for service delivery points and community service providers that can not only deliver multiple services but also assess client needs at every visit so as to assure "no missed opportunities."

All illustrative approaches/activities described below are only relevant if they are directly linked to improved indicators. Therefore the Recipient must determine and implement priority actions within this illustrative list that are most apt to result in improved health outcomes, in the near and middle term. Given the distinct issues in each district and zone, and even among different districts in the same zone, it is likely that some activities that are priorities in certain zones or districts are not as important in others.

5. SSD Geographic Coverage/Award Structure.

The SSD Project will be responsible for scaled up and integrated priority EHP service delivery within primary health care clinics as well as referral levels in **two to three targeted districts in each of the five zones of Malawi** so as to cover a total population of approximately 8,000,000. The prime/lead recipient of the SSD project will be responsible for the project as a whole and take the lead in implementation in the districts in at least one zone. To support implementation in the districts of the other zones, the prime recipient will propose between 2-4 sub-recipients**,** each of whom will be responsible for project implementation in the districts of one to two zones. The sub-recipients, as well as the prime recipient may also engage other, indigenous partners (sub-sub-recipients) in the districts and zones to assure adequate coverage of community-based services and build capacity in local organizations for longer-term sustainability. The prime/lead recipient will also assure effective coordination and the quality and effectiveness of the programming by the sub-recipients, as well as ensuring the sharing of lessons learned, materials, and approaches among the implementation partners.

To achieve results, the SSD Recipient will need to coordinate its activities with a variety of partners and organizations. Of particular importance will be its own Sub-Recipients and Sub-Sub-Recipients in the Zones and Districts on which the Prime Recipient will rely for effective implementation. The SSD prime recipient should expect to spend a substantial amount of time and resources in the clinical mentoring of staff and addressing systemic issues, which negatively affect the delivery of primary health care services, such as: human resources, clinical capacity, referral systems, and infrastructure challenges. The aforementioned areas are of particular importance in an integrated package of maternal health, which include HIV, ANC, labor and delivery, and family planning. The prime recipient will also work with clinical staff in leadership positions to strengthen their management capacity, building their capacity to more effectively and efficiently engage with district health teams, clinical staff, and clients. In addition, the Recipient will spend a substantial amount of time coordinating the integration of the other two Sector Projects mentioned herein. The COP will serve as chair of the management advisory group (MAG) and will be responsible for producing join work planning. There will need to be efforts made up front in particular with the SBCC Project as that Project will serve as the technical SBCC arm for the SDD recipients and sub recipients. Note also that local activity costs for SBCC activities at the district and below will be budgeted by the SSD partner.

In addition to these requirements, the SSD Recipient and Sub-Recipients will need to coordinate with:

a) The MOH and District Health Management Teams, with emphasis on district level and below;

b) Other health service delivery partners and agencies and, in particular those active in priority EHP programming in Malawi;

c) At the community and district levels, engage a range of non-governmental organizations, community groups, faith-based organizations, and religious, traditional, community, and elected leaders in a joint effort to support improved health programs and outcomes; and

d) The other Sector USAID Projects, including PEPFAR funded HIV prevention, care and treatment partners.

Strategies. The SSD Recipient and Sub-Recipients will be responsible for implementing key elements of the major strategies presented in USAID/Malawi's health sector strategy 2009/15:

- **Comprehensive delivery of selected, high impact interventions.** At both community and referral facility (health centers and District hospitals) levels, the Recipient and Sub-Recipients will ensure access to and promote use of the priority EHP interventions for women and children that can make a difference in their health and engage men in care.

- **Saturation.** To ensure impact at the district level, the SSD Recipient and Sub-Recipients will provide technical and implementation assistance for full coverage ("saturation"—estimated at least 80 per cent) of targeted districts. The Recipient will develop approaches for scale out and scale up of the priority EHP services.

- **Multi-level.** The SSD Recipient and Sub-Recipients will focus on change in priority EHP health service delivery at all levels, with particular emphasis on implementation at the community and referral (health centers and district hospitals) levels with linkages, as needed and appropriate (and in collaboration with HPSS) to the district and zonal levels.

- **New/renewed areas of emphasis.** The SSD Recipients and Sub-Recipients will invigorate support for community and referral level service delivery by applying best practices, strong technical inputs, and innovative approaches, such as performance-based financing, to addressing the challenges in Malawi. The Recipient and Sub-Recipients will also be responsible for the implementation of behavior change communication programming (to be developed and supported by the SBCC partner), selected systems strengthening, with emphasis on those most pertinent to effective community and referral level services (to be supported by the HPSS partner), and collaborate in private sector/social marketing and supply chain management.

6. SSD Program Objectives:

- Increase access and utilization of EHP services for women and children that can make a difference in their health and engage men in care.
- Improve quality of health services at community and facility level in target districts
- Improve health-seeking behavior by individuals, families and communities.
- Strengthen health care delivery system through development, testing, and scale up of innovative and sustainable community-based service delivery approaches building on experience in Malawi to date and considering GOM medium- and long-term budgetary constraints**.**

➢ Facilitate coordinated, coherent, harmonized and mutually supportive activities with Government of Malawi (GOM), SBCC; HPSS ; SBCC and Private Sector and Social Marketing (PSSM) partners, and other national stakeholders to ensure integration and leveraging of program inputs to scale up service delivery.

7. SSD Expected Results and Illustrative Activities

Result I – Increased access and utilization of services for women and children that can make a difference in their health and engage men in care.

Illustrative Activities

- Develop, test, and scale up innovative and sustainable community-based delivery approaches building on experience in Malawi to date and considering GOM medium- and long-term budgetary constraints**.**
- Exploit primary health care opportunities in the delivery of an integrated MNCH platform.
- Analyze health service coverage and identify gaps and implement sustainable approaches to service delivery to fill the gaps**.**
- Where needed, develop plans for phasing in additional priority information, products, and services at SDPs and through community-based providers.
- Develop, test, and expand successful approaches to reaching youth with priority EHP information and services (in close collaboration with SBCC Recipient)**.**
- Increase the number of trained providers in MNH, FP/RH, HIV, malaria, child health and nutrition (GOM, CHAM, other local groups)**.**
- Collaborate with GOM, NGOs, including PEPFAR funded HIV prevention, treatment, care and support partners and other development partners' implementing partners to coordinate SBCC and service delivery and complement efforts wherever possible**.**
- Address the unmet need for short, long-term and permanent methods for family planning methods in the target districts.
- Develop formal relationships to extend and scale out integrated service coverage through NGO and other partners as needed**.**
- Engage civil society, community organizations and groups, religious, community, traditional and elected leaders, clients, and health officials in monitoring the availability of and access to priority EHP services, at the community and facility levels.
- Facility renovation and new construction for improved ANC/FP service provision where necessary.

Result II – Enhanced quality of health services at community and facility level.

Illustrative Activities

- Address the issues of inconsistent use of FP methods due to misconceptions or side effects in the focus districts.
- Ensure that all policies and guidelines governing priority EHP care reflect international standards and best practices and are available and used at SDPs and by community-based providers**.**
- Balance off-site training for providers with on-site training and follow up to assure application of skills**.**

- Support use of quality assurance approaches that assure application of best practices and up-to-date, high quality, clinical practice, particularly in MNCH.
- Explore use of performance-based financing in at least MNCH, FP, PMTCT, especially on the supply side.
- Collaborate closely with SBCC Recipient to ensure strengthening of interpersonal communication and counseling skills and other skills needed to effectively integrate SBCC into service provision**.**
- Update, with HPSS Recipient, supervision tools and procedures and assure application at all levels so as to reinforce technical skills as well as interpersonal skills and motivation**.**
- Employ performance improvement approaches to sustain motivation through a variety of approaches including clinical mentoring.
- Engage community leaders and members, clients and health providers in monitoring quality and providing feedback to improve performance.
- Strengthen linkages between community- and facility-based health care workers, particularly through reform of the referral system.
- Strengthen the quality of service for community-based care for key accelerated child survival and reproductive health interventions.

Result III - Improved health-seeking behavior by individuals, families and communities.

Illustrative Activities

- Provide sites and support for research on appropriate messages, dissemination through mass and other media, and other SBCC tools**.**
- Mobilize community, political, and religious leaders, community level providers, and other local groups to support service delivery and adoption of appropriate health behaviors**.**
- Undertake SBCC activities, using SBCC packages and technical assistance, as defined in the Sector II SBCC Program Description to inform community members and households about priority EHP services and their importance to health, e.g., regarding danger signs in pregnancy and newborns, growth monitoring, infant and young child feeding**.**
- Strengthen the role of community-based care for key accelerated child survival and reproductive health interventions.
- Improve quality of services offered so as to improve health-seeking behavior.
- Strengthen, through training and other means, the role of local NGOs and community groups in SBCC activities, campaigns, and programs**.**
- Promote engagement with local government bodies as sources of in-kind and financial support as well as assistance in dissemination of key messages and support for change in community norms related to health.

Result IV - Health sector capacity strengthened

Illustrative Activities

In close collaboration with the HPSS Recipient will involve the following:

At the **Central level:**

- Liaise with MOH regarding experiences and issues in health service delivery and support in the zones.

- In consultation with USAID/Malawi and District Health Management Team and Zonal Health officers, identify priority concerns to raise with Central level officials.
- Provide relevant assistance in developing and implementing solutions to priority performance issues and concerns.
- Inform MOH regarding lessons learned and success stories at the zonal level and below.
- Take responsibility for assuring effective implementation of management and health systems required for effective delivery of priority EHP services.

At the **Zonal level:**

- Test performance- or results-based financing approach (es) as a way to improve health outputs and outcomes. GTZ and Norway are also involved in this type of financing and so needs to be complementary and coordinated.
- Develop leadership, management and teamwork with the DHMT.
- Identify and resolve bottlenecks in drug and supply management.
- Expand and strengthen quality assurance mechanisms.
- Strengthen referral sites.
- Participate in testing of new, innovative tools and approaches for systems strengthening
- Support the identification of local best practices and facilitate sharing at the national/central level.
- Support health information analysis and use for monitoring and health services strengthening.
- Participation in development of training and other capacity building approaches in systems management for managers and providers
- Identification of issues and needs in leadership, management and systems at referral facilities (health centers and District hospitals) and community-level service providers

At the **District level**

- Develop leadership, management and teamwork with the District Health Teams.
- Assess, monitor and support execution of national policies and best practices within the districts
- Identify and resolve bottlenecks in drug and supply management.
- Expand and strengthen quality assurance approaches, e.g. improvement collaborative and supportive supervision.
- Strengthen referral sites.
- Support the identification of local best practices and facilitate sharing at the national/central level.
- Support health information analysis and use for monitoring and health services strengthening.
- Input into systems and tools for improving key administrative areas, such as supply chain management and quality assurance
- Enhancing provider skills in the priority technical areas

At the **Community/service delivery points (SDPs)**:

- Develop leadership, management and teamwork with the SDP team and community leaders, as appropriate.
- Ensure access to training and job aids that reinforce and support quality services.

- Ensure mechanisms for providing feedback on service and pharmaceutical access and quality to district and zonal levels.
- Empower facility- and community-level health care workers to access and deliver quality essential drugs in a timely manner
- Support outreach to NGOs, private sector entities, community workers, elected officials and other community leaders and collaboration with other sectors.

The SSD Recipient will be charged with ensuring achievement of the program objectives contributing to progress in reducing fertility and population growth, lowering the risk of HIV/AIDS and lowering maternal and infant and under-five mortality rates. In the last decade, indicators for infant, child, and maternal health and family planning in Malawi have not improved as much as expected, and use of family planning has actually declined. Family planning and neonatal and maternal health are of particular concern. The SSD Recipient will support innovative initiatives to address key problems and constraints on access, quality, and use affecting priority FP/MNCH services. These include: family planning counseling and provision of contraceptives, including clinical provision of long-acting and permanent methods (LAPM); maternal health, including antenatal care (ANC), delivery, and postnatal care; essential newborn care; child survival, including immunization, case management of diarrheal disease, pneumonia, and malaria; and nutrition, including breastfeeding, complementary feeding, and effective responses to moderate and severe/acute malnutrition.

In implementing these initiatives and activities, the SSD Recipient will work in close collaboration with USAID/Malawi's bilateral partners responsible for community mobilization and behavior change communication campaigns and activities as well as the Mission's bilateral partner in health systems strengthening, leadership, and management. The Recipient will also need to establish and maintain linkages with other priority health programs including malaria prevention and control efforts, HIV/AIDS activities, and water and sanitation improvement efforts. In some cases, and depending on availability of funds, the Recipient will be asked to directly support activities in these areas.

8. SSD Expected Outcomes from the Program

The primary results expected in this area are the increases in access, quality and use of FP, MNCH, HIV, Malaria and Nutrition services. Even though the results are presented separately from the management and systems results, USAID and the GOM understand that achievement of these results is strongly interdependent. A set of preferred indicators to measure progress in these areas is provided below. The Recipient is expected to develop a complete results monitoring approach to facilitate tracking of progress in these areas.

Required Indicators

Family Planning

- Modern method Contraceptive Prevalence Rate
- Couple Years of Protection
- Number of service sites, including community providers, that offer at least three modern methods of (and/or referral for) FP
- Number of service sites per targeted district that offer LAPM.
- Per cent of FP services provided through CBD services
- Number of counseling visits for FP/RH as a result of USG assistance

- Number of people that have seen or heard a specific FP/RH message
- Number of interventions providing services, counseling, and /or community based awareness activities intended to reduce rates of gender-based violence
- Number of service delivery points providing FP counseling or services

Maternal Care

- Per cent of ANC visits initiated during the first trimester
- Per cent of ANC visits that meet standards for high quality ANC or FANC
- Per cent of pregnant women tested for HIV
- Per cent of pregnant women who sleep under an LLIN
- Per cent of pregnant women who receive IPTp
- Percent of women taking iron supplementation in the last 7 days
- Per cent of births attended by trained personnel in districts
- Per cent of attended births that meet basic standards of care (such as use of partograph, administration of oxytocin, post partum care within 48 hours, etc.)
- Number of maternal care sites, ANC and labor delivery, renovated and/or rehabilitated
- Number of sites per district that provide BEmONC
- Per cent of communities with adequate transportation arrangements for emergencies in delivery
- Per cent of HIV-positive women initiated on ART
- Per cent of HIV-positive women receiving medication to prevent mother-to-child transmission according to national guidelines.
- Maternal Mortality Rate

Post-partum and Newborn Care

- Per cent of newborns started with breastfeeding within the first hour
- Per cent of facilities with trained personnel in neonatal aspiration.
- Per cent of newborns who receive essential newborn care at birth in targeted districts
- Percent of mothers and newborns receiving post partum care within three days of delivery

Child Health

- Per cent of children under 5 years with prompt access to appropriate Community Case Management (CCM) of malaria, diarrhea, and pneumonia
- Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers
- Number of people reached through community outreach that promotes the treatment of malaria according to national guidelines

Nutrition

- Percentage of underweight (WAZ<2) children aged 0-59 months
- Percentage of wasted children (WHZ<2) aged 0-59 months
- Percentage of infants 0 to 5 months of age who are fed exclusively with breast milk
- Percent of children 6-23 months with appropriate infant and young child feeding practices (continued breastfeeding, age-appropriate dietary diversity, age-appropriate frequency of feeding)
- Percentage of children who receive Vitamin A supplementation every 6 months
- Number of children reached by USG-supported nutrition programs

- Number of people trained in child health and nutrition through USG-supported health area programs

Malaria

- Per cent of pregnant women and children who slept under an ITN the previous night
- Number of ITNs/LLINs distributed in the country
- Percent of pregnant women receiving an ITN at their first antenatal visit
- Percent of children under 5 receiving an ITN through contact with a health facility
- Percent of pregnant women accessing at least 2 does of IPTp
- Percent of febrile children under five accessing prompt and effective treatment
- Percent of community members in target catchment area exposed to malaria behavior change messaging in the areas of correct and consistent use of ITNs, malaria in pregnancy, and case management of fever.

HIV/AIDS

- Rate of mother to child transmission of HIV
- Number of HIV+ pregnant women initiated on ART
- Number of couples counseled and tested for HIV
- Number of HIV positive persons receiving cotrimoxazole prophylaxis
- Percent of HIV positive patients who were screened for TB in HIV care or treatment settings

Other Priority, Selected Indicators (to support integrated programming)

Integrated Priority Service Delivery

- Number/per cent of service delivery sites (facility and community-based providers) offering clients at least three types of services (FP, MNCH, nutrition, HIV/AIDS, malaria) at each visit
- Per cent of population in targeted districts within five km of service delivery point providing and/or referring for priority EHP services
- Number/per cent of service delivery sites (facility and community) that assess service needs of clients at each visit.
- Number of renovated, rehabilitated, or new service delivery sites.
- Level of missed opportunities to meet needs for family planning, nutrition, immunizations, malaria, and HIV/AIDS at single visit to SDPs and community-based providers.

Integration of SBCC and Services

- Effective use of SBCC packages in community level service delivery to promote use of services and behavior change
- Voluntary Family planning established as a community norm
- Increased knowledge and awareness of the benefits of appropriate health practices, e.g., hand washing, complementary feeding.
- Increased demand for and use of priority EHP services
- Effective use of opportunities for community mobilization for promoting use of priority EHP services and behavior change.

Integration and strengthened systems at SDPs and community-based providers

- Improved quality of health services at SDPs and from community-based providers in targeted districts
- Improved supervision of health services at SDPs and community-based providers in targeted districts
- Data used to improve health services management and for performance improvement
- Distribution of priority EHP commodities improved; stock outs reduced of priority EHP commodities
- Appropriate referrals increased to higher level facilities and patients effectively managed.

9. SSD Cross Cutting Capacities

The SSD Recipient will also need to address other important cross-cutting areas of support that are important to achieving better health outcomes.

A. Participation of Civil Society and Local NGOs*:*

Civil society organizations and local NGOs and FBOs have close ties to communities and are an important complement to government-delivered health services. All USAID/Malawi Health Program partners will help develop and improve the participation and sustainability of these groups. The SSD Recipient will need to consider the role for these groups in the focus districts and collaborate with other projects in this area.

B. Local and Traditional Government engagement:

At the District and community level, health services rely on the cooperation and support of local government bodies. They can also be sources of additional in kind and financial support for key health activities. The SSD Recipient will need to help reinforce these linkages between the health officials and other local authorities.

C. Quality Assurance and other Systems*:*

USAID's partners will collaborate and assure compatibility in their approaches as they endeavor to improve access to and quality of care. The SSD Recipient will take the lead in this area but will need to collaborate with other partners in their respective program areas. USAID supported models of district and zonal support has proven effective and lessons learnt should be applied here under QA and systems support.

D. Gender:

All USAID/Malawi Health Program partners will encourage responsiveness to issues of gender. Outreach to men and women will focus on education about health, encourage their active roles in supporting their own well-being, and monitoring the quality of health services in their communities.

E. Infrastructure refurbishment.

The physical state of many community level and referral facilities (health centers and District Hospitals) and the condition of the equipment needed for priority EHP services in Malawi is often less than ideal for high quality service delivery; with modest investments in refurbishment and essential equipment, the facilities can be upgraded and made more functional. Where and when needed, and preferably with contributions from local or district authorities, the Recipient and Sub-Recipients will provide this assistance in the targeted districts.

F. Performance-Based Financing.

Incentivizing quality service delivery provision has the ability to drastically improve health outcomes for Malawian women and children. As such, approaches that addresses incentives of service delivery points and/or their personnel (supply side) are encouraged across the technical sectors to improve the quality and quantity of services offered at the site; performance-based financing that incentivize the demand side for services will also be considered.

10. SSD Related Activities

The SSD Recipient will need to coordinate activities with other technical programs and assistance to be provided by USAID/Malawi and other development partners. The primary areas for this collaboration are described below.

- **Social & Behavior Change Communication** will support, at the national level, improved strategic planning and strengthened coordination for effective SBCC, development and production of SBCC packages under a national multi-level communication initiative to be implemented through mass media, within community and facility settings and through capacity building of counterpart institutions. At the district level, the SBCC Program recipient, will directly assist the Support for Service Delivery Partner (SSD) and other funded USAID partners, and identify SBCC needs, and develop and test new, innovative approaches and materials. The recipient will further support capacity-building of SSD recipient and sub recipients through training, mentoring and on-going technical support for all aspects of SBCC, including use of the SBCC packages and effective approaches to community mobilization. The Project will also improve district level coordination of strategic SBCC activities with all relevant partners to ensure integration of different health messages, prioritization and timing of key SBCC interventions in an integrated manner (refer to SBCC RFA for details).

- **Health Policy and Systems Strengthening** will work in all five zones, in close collaboration with Zone Supervisors, and focus on strengthening the roles and supervisory capacity of zone supervisors and offices. Through its support for the Zones, the Recipient will be responsible for improving leadership, management and health systems at the district level and below that are needed for effective health program implementation and sustainability in the long term. The HPSS project will also work with the Malawi Ministry of Health on key policy issues affecting the health sector. Among these are: issues associated with human resources for health, such as policies on Health Surveillance Assistants (HSAs) and community health volunteers (CBDAs), an appropriate cadre to address nutrition problems; effectiveness and appropriate models for Results-Based Financing (RBF); policies and guidelines for expanded partnerships with the NGO and for-profit private sector; and, policies and guidelines for the delivery of priority EHP services, as needed.

- **Private Sector/Social Marketing** project that will focus on expanding distribution channels and the range of products for social marketing; it will also explore options for expanding access, quality and capacity of the private sector to deliver priority EHP services and participate in BCC, service delivery and other aspects of health programming (e.g., BCC mass media and materials production).

- **Supply Chain Management** project that will work at the national level to assure access to priority EHP commodities at all levels of the supply chain and resolve key supply chain problems and bottlenecks.

Although each Recipient will have its distinct scope of work and roles and responsibilities, they must closely and effectively collaborate throughout the life of these projects.

11. SSD Expected Results

The SSD Recipient must be results-focused. The primary results expected are presented below; however, the Recipient is expected to develop a more complete results monitoring approach to facilitate tracking of progress.

a) SSD Health Program Results

Malaria:

- At least 90% of children under 5 accessing prompt and effective fever treatment
- At least 90% of children under 5 sleeping under an ITN the previous night
- At least 90% of pregnant women sleeping under and ITN the previous night
- At least 90% of pregnant women receiving 2 or more doses of IPTp

Family Planning:

- Contraceptive prevalence of MWRA increased by 2.0% per year
- Couple Years of Protection increased annually
- All service sites offer at least 3 modern methods of FP
- X number of service sites per District offer LAPM
- At least 15% of services provided through CBD services

Maternal Care:

- Reduce the Maternal Mortality Ratio (LOP indicator)
- Per cent of ANC visits initiated during first trimester
- Per cent of ANC visits that meet standards for high quality ANC or FANC
- Per cent of pregnant women completing at least 4 ANC visits
- Per cent of pregnant women who sleep under an LLIN
- Per cent of pregnant women who receive IPTp
- Per cent of births attended by trained personnel
- X number of sites per District that provide BEmONC
- Per cent of communities with adequate transportation arrangements for emergencies in delivery

Post-Partum and Newborn Care:

- Per cent of newborns started with breastfeeding within first hour
- Per cent of newborns who receive essential newborn care at birth
- Per cent of mothers and newborns receiving post partum care within three days of delivery

Child Health:

- Reduced infant and child mortality and mortality
- Proportion of under 1 year old children fully immunized

- Per cent of children under five years of age with fever in preceding two weeks who received anti-malarial drugs the same/next day
- Per cent of children with measles immunizations

Nutrition

- Percentage of underweight (WAZ<2) children aged 0-59 months
- Percentage of stunted (WAZ<2) children aged 6-59 months
- Percentage of wasted children (WHZ<2) aged 0-59 months
- Percentage of infants 0 to 5 months of age who are fed exclusively with breast milk

HIV/AIDS

- Reduce mother-to-child transmission
- Increase number of HIV+ pregnant women initiated on ART
- Number of couples counseled and tested for HIV
- Percent of adults disaggregated by sex, aged 15-49 reporting more than one sexual partner within the last twelve months.

b) SSD Management Systems Results:

- Training of health managers in data analysis and use at decentralized levels
- Supporting systematic reviews of key program elements all levels of the health system
- Facility and community performance-based financing systems are fully established and efficiently functioning to improve quality of health services.
- Established incentive structure (potentially PBF) for OVC volunteers.
- Increased facility and community health worker performance.
- Supporting periodic data analysis at the all levels of the health system.
- Supported review of health facility and district level data for decision-making and performance improvement
- Functional referral systems in place.
- Improved timeliness and accuracy of HMIS and LMIS reports
- Improved linkages between community- and facility-level health care workers

12. SSD personnel desired qualifications

The following are anticipated qualifications for personnel and the illustrative team composition.

The Applicant must identify positions that will be considered key positions under the resulting award.

Chief of Party:
The Chief of Party must have at least a Master's degree in a relevant discipline and demonstrated long term experience in designing and managing complex primary health care programs in developing countries. The Chief of Party is expected to have the strategic vision, leadership qualities, depth and breadth of technical expertise and experience, professional reputation, management experience, interpersonal skills and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the program description. S/he will also have experience interacting with other projects, host country governments and international agencies. Experience managing complex consortiums or programs is also desired. The interpersonal skills and negotiation skills of this position are critical as they will also serve as the MAG chair and lead the joint planning for the Sectors.

Senior Management Team (1-3):
Among these management and program leaders, they should have substantial (8 or more years) experience and the requisite educational and technical background and experience to provide state-of-the-art leadership, management and oversight on: administrative and financial management and accountability; designing and overseeing complex monitoring and evaluation frameworks, and data quality. Interpersonal skills are critical to the leadership of these awards as they are so closely integrated and USAID/Malawi recognizes the importance of program leadership. This will be reflected all sector's evaluation criteria. Candidates shall also have excellent writing skills in English. The Applicant may structure these positions as appropriate and feasible given that the proposed Management Team will have varying combinations of the requisite skills that best meet the management needs of the program. The Applicant may choose to draw the advisors from staff of the Sub-Recipient organizations.

Senior Technical Advisors (3-4):
Among these advisors, they should have substantial (8 or more years) experience and the requisite educational and technical background and experience to provide state-of-the-art technical advice on: family planning and reproductive health; maternal health, newborn health, child health, malaria, HIV/AIDS, and nutrition. (Some experience in community programming for WATSAN would also be advantageous.) The Applicant may structure these positions as appropriate and feasible given that the proposed advisors will have varying combinations of the requisite skills. The Applicant may choose to draw the advisors from staff of the Sub-Recipient organizations. It is anticipated that these Senior Technical Advisors will be made available to the SBCC partner and the HPSS partner as needed to ensure adequate technical support for the relevant SBCC and HPSS activities.

Among them, they should have substantial experience in designing, implementing and managing complex health projects, and living and working in developing countries. They should have complementary skills and knowledge in the key technical areas required by the SSD Project, as noted above. All Senior Management staff should have proven track records of collaborations with government counterparts.

The other professional staff proposed should demonstrate the range of practical technical skills necessary for extending and strengthening community-based priority EHP services and systems, and an ability to manage the design and implementation of key components of this program. If they are to hold team leadership positions, they should have a demonstrated capacity to liaise and negotiate with key stakeholders in other organizations, as well as to support and supervise staff.

SECTOR II-SOCIAL & BEHAVIOR CHANGE COMMUNICATION (SBCC) – PROGRAM DESCRIPTION

1. Overview of the SBCC Program

The Social & Behavior Change Communication (SBCC) Program is a $24,200,000 Program for five years to support the development and implementation of integrated SBCC for health priority areas. It is one of three interrelated solicitations USAID/Malawi is issuing to assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the community, health center and district hospital levels with the ultimate aim of improving the heath and well-being of the people of Malawi. The recipient of this award is expected to strengthen effective SBCC strategic planning, coordination and implementation at national, district and community levels through capacity building, development and production of SBCC packaged interventions, and ongoing technical assistance to partners.

The Program will focus on achieving the following key results:

- Coordinated strategic planning and ongoing monitoring and evaluation of SBCC interventions at the national level and targeted districts applied across health with resulting synergies.

- Evidence based SBCC packages developed or adapted for EHP priorities.

- Sustained capacity of national partners to design, implement, manage, and evaluate effective SBCC interventions.

- Direct technical assistance to the Support for Service Delivery Partner(s) (SSD) in targeted districts, in the use of developed communication and mobilization interventions at facility and community level provided.

The SBCC Recipient will be responsible for providing technical leadership on SBCC to ensure EHP behavioral priorities are addressed in a synergized manner through support to national partners, and directly to the SSD Recipient and sub-recipient partners within two to three targeted districts in each of the five zones of Malawi so as to cover a substantial part of the total population of Malawi.

2. Background and Context of the SBCC Response in Malawi

a) National Partners and Mechanisms

MOH provides oversight on a sector wide health response as well as delivers approximately 60% of all health services for the country. At the national level, its various health departments and related technical working groups, develop national policies, protocols and guidelines, and define strategic priorities for delivering health services, including health specific communication priorities to be implemented.

Within the MOH, the Health Education Unit is charged to plan, coordinate, and monitor national health communication activities through use of advocacy events, development of mass media, print, and community mobilization events. It is unique in that its role requires them to support all MOH health departments as its implementation arm for communications development, as

well as engage with a range of multi-sectoral partners within the public and private sector. They produce regular radio programs, develop and print national communication materials to support campaigns and events, plus aid district program implementation within facilities and community settings. District Health Education Officers coordinate and implement SBCC interventions in collaboration with District AIDS Coordinators, Information and Youth Officers, frontline workers including Health Surveillance Assistants (HSAs), Community Based Distribution Agents (CBDAs), Community Based Organizations (CBOs), Faith Based Organizations (FBOs), and Non Governmental Organizations (NGOs) working within the districts. While they receive training and communication materials from the central level, they are not well capacitated or a strong cadre.

Other major SBCC national partners across sectors include the Ministry of Gender, the Ministry of Information, and Ministry of Local Government. Within sexual reproductive health and HIV and AIDS, the MOH works closely with the National AIDS Commission to ensure that the national HIV response is harmonized and focuses on SBCC at all levels, and that priorities are established annually. The coordination bodies within the MOH bring together local partners, such as Christian Health Association in Malawi (CHAM), Banja La Mtsogolo (BLM), other NGOs, and in some cases the private sector – all of which play a critical role in service delivery and SBCC. Donor organizations including UNICEF, UNFPA, DFID, also play an important role in funding behavior change interventions as well as providing technical support to districts in their implementation.

SBCC implementation is guided by national policy documents for EHP priorities and planned and monitored through established mechanisms, which bring key partners together. Several program areas have also specifically developed communication strategies to guide interventions. Key behaviors for nutrition, MCH, family planning, HIV, water and sanitation, TB, and malaria to promote will focus on increased use of preventive and other high-impact health interventions, strengthened provider client communication in all health settings to support adherence, adoption of healthier behaviors within communities and positive changes in gender and other cultural norms that contribute to delays in accessing service or negative health outcomes.

b) Illustrative list of national behavioral health intervention priorities identified

- Maternal Health: early antenatal care, birth preparedness and skilled attendance at birth.
- Child Health: hand washing, use of ORS for diarrheal disease, immunization, treatment of malaria, diarrhea, and early treatment of childhood pneumonia.
- Nutrition: essential nutrition actions, such as exclusive breastfeeding, continued breastfeeding to 2 years, timely and appropriate complementary feeding, Vitamin A supplementation, continued feeding during illnesses, and early detection and management of malnutrition at the community level;
- Family Planning: uptake and sustained use of methods of FP, including condoms for dual protection; healthy timing and spacing of pregnancies.
- Malaria: increased uptake of ITN distribution, including IPTp for pregnant women, and early treatment for malaria.
- HIV: reduction of partners, use of condoms for dual protection, HTC, PMTCT, family planning, timely access to ART, prevention with positives, possible promotion of and access to male circumcision.
- Water and sanitation: increased hand-washing and use of safe water.
- TB: early diagnosis, treatment of TB and adherence.

c) Critical Issues and Programming Opportunities

SBCC is a specialized technical expertise that needs to be applied across intervention areas in a synergistic way. Successes in changing health behaviors in Malawi, such as increases in exclusive breast-feeding and strong uptake of family planning, have been achieved through well-developed and field-tested approaches that use an array of communication channels, training, and support providers and beneficiaries to take up and adhere to desired behaviors. SBCC programs with comprehensive strategies for interventions are rare.

i. Incomplete programming. Currently, most SBCC campaigns are verticalized by disease with varying technical inputs. These are rarely rolled out systematically with limited training and guidance for the health providers who are supposed to implement them. The results are often fragmented due to inconsistent messaging, a focus on health talks and directive messages, rather than utilizing an integrated approach with harmonized messages reinforced through a range of media channels, i.e. there is greater attention to developing job aids around key health areas, whereas dissemination and use of developed aids remains very limited.

ii. Paucity of coherent strategies, approaches and effective materials. SBCC is generally not planned and implemented in a quality multi-level manner. Current efforts generally do not involve the use of multiple channels of communication, including mass media, local and traditional media, and interpersonal communication that are mutually reinforcing and target behavior change at normative and structural levels as well as at individual level. There is overemphasis on print IEC leaving a real need for cohesive programming based on sound behavior change theory. While emphasis on behavior change at community level has been articulated in many communication strategies, few organizations have prioritized the development and use of effective SBCC tools to facilitate community problem-solving around underlying norms and practices that contribute to negative health outcomes, and collective action. Key areas to address include lack of male involvement on family health issues, gender inequity and high-risk cultural practices.

iii. Limited evidence-based approaches and tools. Concerns regarding the quantity and quality of formative research, lack of testing of messages and approaches, and poor targeting of information and campaigns have been raised globally and within Malawi. Best practices for SBCC interventions based on Malawi experience need to be identified through measurable SBCC indicators and operational research. The new Global Health Initiative emphasizes learning and metrics and this will be an important part of this new award.

iv. Limited capacity and engagement of community-level leaders and organizations. At the community (and district) level there are multiple actors (i.e. political, traditional, religious, and CBOs, FBOs, and other NGOs and networks) that should be involved in efforts to promote use of priority EHP services and support individual and community normative behavior change. However, these prospective “partners’ in SBCC have not been effectively engaged to date.

v. Limited skills and time of health providers. Poor provider client interaction as well as lack of friendly health services has been identified as a barrier to uptake of health services, particularly with sexual reproductive health and HIV. Health providers at all levels, including CBDAs, HSAs, and clinical and facility staff, need stronger skills and effective tools to encourage more interactive and effective behavior change communication around priority health messages. Specific efforts need to be made to encourage male attendance at health facilities for both family health and their own. Youth friendly services are also key to reach young men and

women with RH information and services. Missed opportunities for group education while clients wait for health care services need to be tackled effectively. The lack of adequate time and staff to engage in health education and counseling is another barrier that requires creative solutions.

vi. Outstanding underlying barriers to behavior change. Health programs often struggle with gender norms and harmful traditional practices that undermine women's ability to make independent health care decisions as well as limit men's positive involvement in the health of themselves and their families. Issues that will need to be addressed by this SBCC Program across all identified EHP areas include:

- Myths, misconceptions and low risk perception addressed in a relevant manner to personalize individual and community risk, define clear benefits for action, and build self and collective efficacy.
- Gender inequalities and harmful cultural norms: Underlying an individual's ability/agency to act on personalized health information are gender related barriers and social norms that influence men and women's behavior differently. A woman's lack of empowerment and, often, financial dependency, may affect her self-efficacy to make decisions for herself and her family's health. Unequal power dynamics may be exacerbated by social and cultural norms, which perpetuate gender imbalances and facilitate early and unwanted pregnancy, high HIV infection rates and low uptake of health services. To affect changes in individual behavior and harmful cultural norms, SBCC programming needs to reach all of those who affect and are affected by these behaviors, and use multi-pronged and innovative approaches and tools.

vii. The need for greater integration of SBCC efforts through all entry points: There is a long history of vertical programs with little effort to incorporate related health issues through different entry points to reach the same audiences (with the exception of integrated management of childhood illnesses). Areas to strengthen include family planning with HIV, MCH with family planning, malaria with child health, HIV, malaria, and child health, child health with HIV as well as attention to nutrition across all health priorities. There are many challenges remaining, including: coordination of priorities and responsibilities among existing partners at all levels, strengthening links for effective referral, and ensuring that frontline workers have means to provide information in an effective/meaningful manner. Integrated SBCC messages have yet to focus on all key entry points utilizing media channels, facilities, communities, workplaces, and places where people meet. Structural barriers to integration for holistic service delivery such as day specific health services versus provision of the EHP have also yet to be targeted- in general, the holistic health needs of end users have not been considered.

3. SBCC Program Description

The Behavior Change Communication (SBCC) Program is a five-year, $24,200,000 Program. It is the primary mechanism for USAID/Malawi's assistance to the Government of Malawi to strengthen SBCC programming in the health sector. SBCC will work at three levels: national, district and community, with an emphasis on the national and community levels to achieve impact. Given the need for consistent, reinforcing strategies, messages, and tools, for promoting priority EHP services and related behavior change, the SBCC Program will at national level: strengthen SBCC strategic planning, design of SBCC packaged interventions for use by health providers and community groups, and development of approaches for and materials to support capacity building in community mobilization and SBCC package adaptation and use. The SBCC Program also will support improved SBCC coordination and programming at the district level,

with a focus on USAID-targeted districts, those of SSD in particular as this Program is the SBCC technical arm of the other prime recipient. The actual local activity costs of the SBCC activities will be covered SSD as it pertains to SSD needs/activities.

The SBCC recipient will develop the sustained capacity of national partners to design, implement, manage, and evaluate effective SBCC programs that support service delivery efforts by encouraging health seeking practices that increase the use of preventive and other high-impact health interventions, strengthen the quality of provider and client communication within facility settings, and promote adoption of healthy behaviors within communities. Within the targeted districts, they will develop, test and evaluate interventions which reinforce individual and collective action to prevent and manage malaria, pregnancy related complications, childhood illnesses address, chronic child under-nutrition; and unmet FP/RH needs and improve integration of HIV within other relevant health program areas.

4. SBCC Program Objectives:

- Strengthen national and targeted district level strategic behavior change planning and coordination on EHP priorities applied across health with resulting synergies.

- Develop and produce evidenced based SBCC packages under a national multi media communication initiative to support effective and integrated SBCC implementation at facility and community level. This objective may include implementation of small granting.

The SBCC packages would include:

- Strategies that identify the sequencing, timing, and approaches for delivery of key SBCC messages through all media channels
- Approaches that include the means of delivering messages, e.g., interpersonal counseling, group meetings and discussions
- Tools that include materials such as radio programs, toolkits for community dialogue, job aids for health care providers, and "media/advocacy" packages to support multi-channel media Interventions (we need to decide how much involvement this project will have in designing mass media type interventions through leveraging of resources, technical support, and distribution of support media materials for districts.)
- The size of mass media campaigns will depend on the Program's success in leveraging additional resources plus available internal resource availability for execution of mass media (e.g. airtime, mass distribution, etc).
- The intended users of the SBCC packages are facility and community-based service providers, community organizations, leaders and individuals. The purposes are to: promote the priority EHP services so as to increase attendance and use; encourage and reinforce compliance with curative and preventative services, such as following up on referrals, using medicines appropriately, and keeping immunization and family planning appointments; and encouraging and reinforcing related behavior change and community norms, such as frequent hand washing, use of family planning and LLINs.

- Build capacity of key national institutional partners and targeted district SSD partners for effective SBCC strategic planning and delivery through training in the use of developed interventions and packages, mentoring, ongoing technical assistance, and guidance on evaluation and redesign.

- Identify best practices for SBCC implementation through testing of new innovative approaches and materials and operational research.

The Recipient will need to collaborate closely with one or more other USAID-funded and other donor-funded and GOM-mandated and funded programs that may be active in SBCC at the national level and in the target zones and districts, including the USAID/Social Marketing and Private Sector Program (SMPSP), which will expand access to socially marketed commodities.

The Recipient will be responsible for implementing key SBCC-related elements of the major strategies presented in USAID/Malawi's health sector strategy for 2009/15:

- **Comprehensive delivery of selected, high impact interventions.** At both community and health facility levels, the Recipient will ensure that effective SBCC "packages", capacity building activities and materials, and on-going support are available to generate demand for, improve compliance and use of, and appropriate behavior change in relation to the priority EHP interventions.

- **Saturation.** To ensure impact at the district level, the SBCC partner will provide SBCC technical and implementation assistance for full coverage ("saturation," at least 80 per cent) of targeted districts. In close collaboration with the SSD, the SBCC Recipient will develop plans for building capacity and ensuring access to the SBCC packages needed to encourage timely uptake of key EHP commodities and services, and behavior change at individual and community levels. All "package" materials will be open source and a key activity will be to advocate for any other partner or stake holder to use these for their own programs.

- **Multi-level.** The SBCC Recipient will focus, at the national level, on the strengthening of SBCC strategies, build capacity for improved SBCC coordination, with an emphasis on SBCC related to the priority EHP services, the development, as appropriate and needed, of mass and other media approaches and tools, and the development of SBCC priority EHP intervention packages for use at the community and referral facility levels. The SBCC Recipient will support the SSD partners in capacity building for providers and local, community groups in how to mobilize communities and effectively use the SBCC packages and provide on-going guidance and support in SBCC implementation. At the district level, the SBCC partner will provide support in improving coordination of targeted district SBCC programming. Lessons learned from implementation in target districts will be shared with partners at national level. The SBCC partner will also leverage tools and approaches developed to scale out their use in other districts.

- **New/renewed areas of emphasis.** The SBCC partner will invigorate SBCC programming and improve its effectiveness in community and referral level service delivery by applying best practices, drawing on evidence-based approaches and materials already in use in Malawi, the region, and globally, strong technical inputs, and innovative approaches to addressing challenges and measuring the impact of approach in Malawi.

5. SBCC Geographical Coverage:

The SBCC Project will have both national scope and direct impact on behavior change indicators within the targeted districts where prime partners are working. At national level, the SBCC Project will facilitate cohesive and harmonized strategic planning and ongoing coordination around the development of an integrated national communication plan to ensure a combination of an optimal mix of strategies at multiple levels, produce national "umbrella communication

initiative" packages which can be delivered in an integrated manner within targeted districts, and share best practices with all stakeholders based on evidence generated. The Recipient will also incorporate the use of mass media and related support into national level SBCC campaigns and programming and leverage funding with other national level partners for these purposes. Again, all tools developed are open source, and will be available to all Malawi partners at national and district level to use freely.

In close collaboration with the SSD and HPSS Projects, the SBCC recipient will work within 2-3 targeted districts in each of the five zones of Malawi so as to cover a total population of approximately 8,000,000. It is expected they will mirror the coverage of the SSD partner at the district level. The recipient will strengthen strategic planning and coordination of district coordinating bodies, build capacity of SDD partners on the implementation of SBCC interventions within facility and community sites using the developed packaged interventions, and provide ongoing mentoring, and TA support for responsive communications planning. Best practices for SBCC will be identified through testing new innovative approaches and materials in targeted districts, lessons learned and sharing of results at national and across districts.

In addition, the SBCC recipient will be responsible for a granting mechanism which will allow for grants to community-based and faith-based organizations operating at the district, zonal or national level with the capacity to implement integrated malaria SBCC campaigns at the community level. The recipient will solicit for appropriate partners in each district to implement inter-personal communication activities at community level, achieving saturation at the district level. Grantees will receive assistance and capacity building from the recipient in the areas of SBCC expertise and materials, project planning, financial management and monitoring and evaluation of SBCC activities. Grantees will be expected to conduct integrated malaria SBCC campaigns focusing on correct and consistent use of insecticide-treated nets, access to malaria in pregnancy services and prompt and effective treatment of suspected malaria cases. Other technical areas for small granting may be added as funds become available. However, only malaria small grants are envisioned in the start up phase.

6. SBCC Expected Results, Strategic Objectives and Illustrative Activities.

In line with identified priorities of the Government of Malawi for the health sector, the goal of the USAID integrated Health, Population and Nutrition (HPN) program is to raise the level of health status of all Malawians.

The strategic objective of the health program is to increase the availability of quality EHP services as well as increase utilization of services. The SBCC program goal will contribute to progress by enabling men, women, and children to adopt healthy behaviors through timely utilization and adherence to accessible preventive and high impact health interventions and normative and individual and social behavior change within communities.

7. SBCC Project Expected Results

a) Capacity of key national institutional partners and targeted district SSD partners for effective SBCC planning and coordination applied across health with resulting synergies strengthened.

- Functional SBCC planning and coordination mechanisms established at national and targeted district levels.

- Increased adoption of evidence based and innovative methods in the design, implementation, and evaluation of SBCC interventions.

b) Provision of quality multi-level SBCC strategies, interventions and packages to enable behavioral outcomes for EHP health priorities.

- Improved access to evidence based and culturally appropriate SBCC messages through radio programs.

- Minimum packages of effective SBCC packaged interventions based on Malawi-specific data; regional and international best practices (as required) tested, produced and disseminated to targeted SSD partners.

c) Capacity for effective SBCC implementation through partners within facility and community settings strengthened.

- Technical support to SSD partners in targeted districts provided in the use of developed communication interventions through facility and community partners

- Evidence of community norms, and individual and collective action to prevent and manage malaria, pregnancy related complications, childhood illnesses, address unmet FP/RH needs in targeted district communities and strengthen integration of HIV prevention and management within facility and community entry points.

- Contribution to relevant behavior change indicators for EHP areas including cross-cutting social, cultural and gender norms that cause delays in seeking care, and/or impede adoption of healthy behaviors within the family and community.

- Lessons learned from effective interventions shared across all levels to bring them to scale.

The following explores the Program objectives in greater detail and provides illustrative activities.

i. Strengthen national and targeted district level strategic behavior change planning and coordination on EHP priorities applied across health with resulting synergies.

The recipient will take the lead in developing a strategic, integrated, multichannel behavior change strategy which will integrate the key health behavioral priorities under each program area to create a favorable environment for behavior change, and generate timely demand for and use of key health interventions and commodities to support desired health outcomes.

Leveraging funds and communication priorities with national level partners, the SBCC recipient will identify existing strategies, communication initiatives, and tested interventions for scale out, design, test and reproduce evidence-based multichannel health communication activities and packages (which can be disseminated to SSD).

At the national level, the SBCC recipient will work closely with the MOH Health Education Unit and other national coordinating bodies to develop a national communication strategy, drawing on

existing communication strategies developed where available, to design an umbrella communication initiative in which the communication priorities under each EHP priority area is strategically developed in an integrated manner where possible. The recipient will work through existing technical working groups/subcommittees to ensure that strategic communications developed for different channels and sectors, are in place, with a cohesive plan of action for harmonized implementation of standardized messages across different sectors with different partner program inputs.

The SBCC Partner will also work closely with the USAID HPSS Project to ensure district level planners incorporate SBCC priorities within their annual district implementation plans and budgets, capacity building for strategic planning, monitoring and evaluation.

Illustrative Activities

- Facilitate coordinated, coherent, harmonized and mutually supportive activities with Government of Malawi (GOM), SDPSSD and Private Sector and Social Marketing (PSSM) partners, and other national stakeholders to ensure integration and leveraging of program inputs to address gaps in communications.
- Review and refine national SBCC strategies for integrated SBCC programming for priority EHP areas based on assessment of existing strategies, plans, and mechanisms for coordination and planning.
- Develop plans for use of mass media and applications for leveraging funds to support its use for health sector.
- Engage in policy development and/or advocacy as needed to foster effective SBCC approaches and ensure national ownership and use of SBCC packages and other materials developed under the Program.
- Input into systems needed and used at the service delivery level to include key SBCC-related issues, e.g., quality assurance, data collection, training.
- Ensure inclusion of priority SBCC activities in DIPs and annual budgets.
- Input into expanding distribution channels and range of products for social marketing under a national communication plan.
- Develop quality assurance and monitoring approaches for SBCC activities, e.g., improvement collaborations and/or supportive supervision regarding use of SBCC tools and community mobilization.

ii. Develop and produce evidenced based SBCC packages under a multi *level* media campaign to support effective and integrated SBCC implementation through mass media, and at facility and community level.

The recipient will work closely with national partners, and the SSD lead in the targeted district to translate the national umbrella “communication” plan into a workable strategy coordinated by the district partners. They will identify specific communication priorities to be addressed within the SSD Recipient’s work plan with specific deliverables to achieve on an annual basis.

The recipient will provide technical oversight into a comprehensive national communication initiative, which is holistic in approach, multichannel in focus, and has high impact on behavior change for segmented audiences identified. Comprehensive strategies will include program inputs by other national partners, including the social marketing partners, where appropriate. It is envisioned that national interventions and mass media campaign products may need to be developed, but will draw on existing opportunities for integration as well as leveraged funds through national partners in its implementation. The Recipient will be responsible for initial

costs of development and production of SBCC packages and related materials to be used by the SSD recipients in targeted districts. It is anticipated that as the packages and materials gain approval and are promoted for use at the national level, the GOM and other donors will also provide support for production and distribution costs.

Illustrative Activities

- Work with GOM, national partners, and SSD recipients to identify needs, and key audiences for a national umbrella communication initiative.
- Develop culturally and linguistically appropriate and relevant evidence-based multi-channel communication campaigns (e.g. Brochures, flipcharts, job aids, radio spots, training, community based tools)
- As appropriate and needed, conduct formative research, develop new strategies, approaches and tools for priority EHP areas, and test in selected sites.
- Facilitate planning efforts for campaigns, with HEU and other partners, and tracking efforts of activities as implemented by SDPSSD recipients.
- Identify SBCC gaps and needs at the community level and among providers at the community and referral levels in targeted districts.
- Input into formats and types of tools most useful for improving community mobilization and SBCC implementation at the facility and community level.
- Develop SBCC packages for priority EHP areas for which limited or poor materials and tools are available.
- Adapt, as needed, priority EHP SBCC packages for use at district and community and referral levels

iii. Build capacity of key national institutional partners and targeted district SSD partners for effective SBCC strategic planning and delivery through ongoing technical assistance and mentoring on use of developed packaged interventions.

While several offices within the MOH and other institutions have the capacity to implement SBCC activities, they need to strengthen their capacity to design, manage and evaluate these activities. These institutions also need to assess the needs for and results of SBCC activities to strengthen the existing approaches and to develop evidence-based, tailored interventions for different target populations/settings including the engagement of other related sectors like education, gender, education, and agriculture. The SBCC recipient will build capacity of national partners and targeted district SSD recipients through effective use of evidence in the development of the national plans, sharing of demonstrated innovative interventions, and engagement in the development of SBCC packages for integrated use. They will also provide training, ongoing technical support and troubleshooting on the use of developed interventions and packages, including oversight over the monitoring and evaluation activities.

Illustrative Activities

- Provide training, mentoring, and technical and other support to the Health Education Unit and other SBCC-involved organizations at the national level in strategic planning for SBCC, program development, and other areas required for effective development of, oversight for, and monitoring of SBCC activities in the field.

- Set up mechanisms for coordination of plans and synchronized implementation of health themes.

- Set up robust M&E mechanisms, conduct operational research where appropriate, and share lessons learned/best practices through existing forums.
- Identify appropriate national level training facilities, professional associations, and or NGOs to participate in capacity –building activities to design, implement, manage and evaluate SBCC campaigns, messages and materials.
- Develop training strategies, plans and tools needed by District-level and Zonal teams and stakeholders to assure effective coordination of, support for, and monitoring of SBCC activities within the Districts and at facilities and communities.
- Develop easily used monitoring tools for SBCC activities at the community level and facilitate their use by SDPSSD partners.
- Plan for and support training of community and facility based providers and key groups at the community level in the use of priority EHP SBCC packaged interventions.
- Develop guidance for use of already available, effective SBCC approaches and materials for priority EHP services and related behaviors.
- Provide mentoring assistance to organizations and providers in the field, where appropriate and in close collaboration with the SDPSSD partners as needed.
- Ensure training approaches/developed SBCC packages and interventions are shared widely through existing knowledge management initiatives (K4Health).

iv. Identify best practices for SBCC implementation through formative research, testing new innovative approaches and materials and operational research where appropriate.

The SBCC Recipient will demonstrate effectiveness of interventions and packages produced through lessons learned. They will ensure design of interventions and SBCC packages are based on formative research, provide adequate testing of innovative approaches and SBCC packages through partners at different levels, and monitor impact of interventions on behavior through robust M&E tools and operational research where appropriate.

Illustrative Activities

- Conduct formative research where necessary to ensure interventions and packages developed are based on evidence.
- Develop a comprehensive communication plan with clear process, outcome indicators to measure at national level and by SDPSSD partners.
- Conduct formative research where necessary to ensure interventions and packages developed are based on ‘evidence
- Test tools for SBCC developed.
- Identify attitudes, norms, and practices for SBCC to be monitored.
- Develop and conduct robust M&E to test efficacy of interventions tried.

Applicants must propose strategies, approaches and activities that will achieve the objectives, outcomes and results identified above and can be linked to improved health outcomes (at least in target districts). The Applicant will need to conduct and present an in-depth analysis of the challenges and issues associated with effective SBCC programming in Malawi in order to develop and propose an appropriate technical approach to assuring high impact SBCC programming for the priority EHP interventions. The Applicant should consider how to phase implementation so as to achieve SBCC coverage and impact in the targeted districts, support the integration of services and SBCC activities, keep appropriate focus on priority SBCC and

services, and build the capacity of Malawi MOH staff and other partners to assure medium- to long-term sustainability of community level impact. Applicants should review experience to date, identify priority areas for integration as described in this solicitation, and develop approaches for scale out and scale up. Applicants should demonstrate a clear model for monitoring the efficacies of SBCC interventions. Given the distinct issues in each zone and even among different districts in the same zone, it is likely that some SBCC activities that are priorities in certain zones and districts are not as important in others. The applicant should assess entry points within facility and community settings to identify how to effectively integrate communications approaches and messages.

8. SBCC Program Specific Indicators

The Recipient that will implement the Social & Behavior Change Communication Program must be results-focused with an emphasis on behavioral results to be achieved at the community level. USAID/Malawi recognizes that there are challenges in accurately assessing and attributing results from SBCC activities because in most cases they are contributing factors for changes in health status, rather than stand-alone interventions. Moreover, the Recipient is "facilitating" the SBCC activities that will affect behaviors, not directly implementing them. Therefore, the Recipient will need to develop a robust monitoring and evaluation approach that can track the immediate and intermediate effects of program activities, including changes in knowledge, attitudes, and health behaviors. At a minimum, the Recipient must be able to accurately assess baselines in relevant knowledge, attitudes and behaviors, including use of key services, adding information to that available from the MICS, Demographic and Health Surveys, and other data sources, and then track changes in those baselines in the Zones and District intervention areas. Even though the results from SBCC efforts will need to be presented separately, USAID and the GOM understand that the achievement of real health impacts is dependent on these SBCC results as well as on improvements in health systems and services.

Indicators will focus on key behaviors to promote for individuals, couples, community leaders, others, provider – client interactions, demand creation for key services (evidenced by increase in attendance at health facilities for key health issues, increased uptake of specific commodities (i.e. Family planning method, bed nets, hygiene, safe feeding practices (define) behavior change at community level: reported changes in male involvement, positive social norms, modification of high risk cultural norms/practices, community mobilized for emergency transport, monitoring of pregnant women, immunizations, , etc.

The recipient must report on the following (USG) standard indicators. General SBCC and program specific indicators are also reflected below.

Standard USG Indicators:
• Number of health care workers who successfully completed an in-service training program [PEPFAR] • Number of people that have seen or heard a specific USG-supported FP/RH message [OP] • Number of evaluations [OP] • Number of special studies [OP] • Number of baseline or feasibility studies [MOP] • Number of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support [MOP]
The Applicant must also develop additional measurements of Program success (benchmark

indicators) and impact. The following are some *possible illustrative* indicators that may be include in a Program performance monitoring plan:	
General SBCC Indicators:	
• Number of communications produced, by type, during a reference period • Number of communications disseminated, by type, during a reference period • Number of individuals trained on SBCC (development/evaluation) • Number of organizations provided with capacity building for SBCC (development/implementation/evaluation) • Percentage of target audience exposed to SBCC messages, based on respondent recall • Percentage of target audience who correctly comprehend a given message • Percentage of target audience exposed to a specific message who report liking it • Identified changes in community norms	
Program Specific Indicators:	
FP/RH	• Percentage of men and women who report use of modern contraceptives to space or limit their family size. • Number/percentage of target audience who discuss message(s) with others, by type of person • Percentage of target audience who advocate family planning practice • Percentage of men and women who approve of couples using contraception to avoid pregnancy • Mean desired family size: The average number of children that women (or couples) of reproductive age would choose to have if they could have exactly the number of children desired • Desire to space or limit births: Percentage of women currently married or in union who are fecund and who desire not to have additional children or to delay the birth of their next child • Percentage of the target population who can name, without prompting, at least 3 or more modern methods of contraception • Community norms that accept birth spacing
MNCH	• Percent of women who attend ANC during the first trimester in targeted districts • Percent of pregnant women who attended antenatal care at least 3 times before delivery • Percent of men who do not know any signs or symptoms of pregnancy complications. • Percent of pregnant women who intend to give delivery at a health institution (more important to focus on skilled attendance?) • Percent of pregnant women who recognize at least two danger signs that would urge them seek medical care immediately • Percentage of children aged 0-59 months with diarrhea receiving ORT or increased fluids and continued feeding • Percent of pregnant mothers who reported taking their iron-folate supplements in the last seven days • Percent of mothers and newborns visiting health facility for post partum care within three days of delivery. • Percent of individuals (both men and women) who recognize at least 2 danger signs in newborns/mothers that would urge them seek medical care

	immediately. • Per cent of children under 5 years with prompt access to appropriate Community Case Management (CCM) of malaria, diarrhea, and pneumonia • Proportion of under 1 year old children fully immunized • Liters of drinking water disinfected with USG-supported point-of-use treatment products
Nutrition	• Per cent of newborns started with breastfeeding within the first hour of birth • Percentage of infants 0 to 5 months of age who are fed exclusively • with breast milk • Percent of children 6-23 months with appropriate infant and young child feeding practices (continued breastfeeding, age-appropriate dietary diversity, age-appropriate frequency of feeding) • Percentage of child caregivers and food preparers with appropriate food hygiene behaviors • Percent of women who consume foods rich in (iron, vitamin A, calcium) • Percentage of children who receive Vitamin A supplementation every 6 months • Number of children reached by USG-supported nutrition programs • Number of people trained in child health and nutrition through USG-supported health area programs
Malaria	• Household ownership of mosquito nets • Per cent of pregnant women who slept under an ITN the previous night • Percentage of children who slept under an ITN the previous night • Percentage of children with fever who sought treatment from a facility/ provider same day/next day (MIS) • Among eligible women aged 15-49, the percentage who reported having heard of malaria, recognize fever as a symptom of malaria, • Reported mosquito bites as a cause of malaria, reported mosquito nets (treated or untreated) as a prevention method for malaria (MIS) • Number of people reached through community outreach activities that promotes the correct and consistent use ITNs • Number of people reached through community outreach that promotes the treatment of malaria according to national guidelines
HIV/AIDS	• Percent of adults, disaggregated by men and women, aged 15-49 reporting more than one sexual partner within the last twelve months. • Percent of sexually active women and men aged 15-49 years who reported higher risk sex in the last 12 months (DHS) • Condom use at last higher risk sex (with a non-marital, non-cohabiting partner) (DHS) • Accepting attitudes towards those living with HIV (GoM, DHS) • Proportion of all adults that have had concurrent partnerships at any point in the past year • Proportion of sexually active young people who had an HIV test in the last 12 months and know the results • Percent of people in general population exposed to HIV and AIDS media campaign in the past 30 days [GoM, HIV prevention indicator]

As part of the application process and the development of a draft PMP, Applicants are strongly encouraged to develop indicators that effectively manage and report on program activities as developed in their application.

USAID/Malawi recognizes that this Program presents coordination and implementation challenges. To better assess Applicants' understanding of these challenges and practical steps to assure effective implementation, Applicants will be required to present a case study of how they would implement the program in one district. The case study must provide a detailed plan for achieving saturation (at least 80 per cent of traditional authorities) with high quality SBCC for promotion of integrated, priority EHP services and relevant behavior change in that district.

The case study should describe an effective approach for collaboration with all relevant stakeholders and partners; the case should describe in detail the Applicant's approach to collaboration with the SSD partners that will have a lead role in SBCC implementation at the community and referral levels. The case study should be no more than five (5) and be presented as an annex in the response.

9. SBCC Coordination Requirements with Other Partners

At the national level, the SBCC recipient will work in close collaboration and support to the MOH, and other national coordination bodies, to develop a cohesive and harmonized strategic plan which emphasizes integration of communication priorities through key entry points at facility and community levels.

The recipient will draw on national partners and relevant working groups, to design a national branded concept for prioritized, harmonized, and integrated communications interventions to take place at all levels, support the development of national media campaigns through technical input and oversight and leveraging funds to address media gaps, and develop priority SBCC packages for SSD recipients and others to use within facility and community settings.

To reduce duplication of efforts and ensure maximum impact for the resources available, the Applicant must be adept at coordinating with many different organizations. The Recipient of the Social & Behavior Change Communication Program will need to coordinate activities with other technical programs and assistance to be provided by USAID/Malawi and other development partners. Primary areas for this collaboration are:

National level Partners:

a) MOH, the Health Education Unit (HEU), and other national level organizations working on SBCC-related activities, campaigns and programs;

b) PEPFAR funded HIV prevention partners working on SBCC

c) Other health service delivery partners such as CHAM and BLM, and agencies involved with social marketing and mass media.

d) Donor partners to ensure synergy of communication initiatives based on a national SBCC strategy and leveraging of funds to address communication gaps.

District level Partners

a) SSD Prime and Sub-Recipients and the HPSS Recipient, with emphasis at the community and district level planning and implementation;

b) A range of non-governmental organizations, community groups, faith-based organizations, and religious, traditional, community and elected leaders (in close collaboration with the SSD Prime and Sub-Recipients);

The SBCC Project is designed to build capacity at both the national and district level to develop and implement effective SBCC interventions; capacity building, however, is linked to the development, production, and supported use of tested SBCC packages with facility and community sites and evidence of best practices. To facilitate this key outcome, the SBCC RFA is part of three solicitations that will work closely together to achieve results in the targeted districts.

These include the awarded recipients of SSD, HPSS, and the Private Sector and Social Marketing Program.

1. The SSD will be responsible for implementation of the SBCC activities through its sub-recipient partners, and incorporate SBCC packages and capacity building activities into its programming for priority EHP service delivery scale up and scale out and responsible for community mobilization and effective delivery of SBCC packaged interventions.

2. The HPSS , will work closely with national and district institutional partners around policy issues and strategic planning and incorporate SBCC strategic planning priorities within its activities at national and district level.

3. The PSSM Partner strategies and activities will be incorporated into the national SBCC communication plan for social marketing of specific health commodities and services through the private sector and will be reported through mechanisms for coordination.

The table below illustrates key areas for collaboration between the different prime partners.

Support for Service Delivery Program is essential for reaching SBCC results within targeted facilities and communities.	Collaboration will be important for the following: • Assistance in identifying SBCC gaps and needs at the community level and among providers at the community and referral levels • Getting input into formats and types of tools most useful for improving community mobilization and SBCC implementation at the community level • Providing opportunities for testing SBCC messages, approaches and tools for priority EHP services and related behaviors • Getting input into and testing of approaches for capacity building of community groups and leaders, and service providers in community mobilization and use of SBCC packages* • Implementing capacity building activities and then community mobilization and SBCC package* utilization in

	the targeted districts. Local costs will be funded by the SDD.
Health Policy, and Systems Strengthening Program will be important in supporting SBCC implementation at the national, district level and below.	**The SBCC Partner should provide:** • Input into systems needed and used at the service delivery level to include key SBCC-related issues, e.g., quality assurance, data collection. • Input into training for providers and others who need to effectively coordinate implementation of SBCC program activities through technical coordination bodies. • Coordination for community mobilization and SBCC package implementation at the district level and inclusion of priority SBCC activities in DIPs and annual budgets • Support for advocacy for the importance of SBCC at the zonal and district levels.
Private Sector and Social Marketing **Program** will be important in supporting SBCC implementation through the private sector.	**The SBCC Partner should provide:** • Input into the social marketing branding and communication strategies to ensure synergy with broader communication strategic priorities.

10. SBCC personnel desired qualifications

The following are anticipated qualifications for personnel and the illustrative team composition. The Applicant must identify positions that will be considered key positions under the resulting award.

Chief of Party:

The Chief of Party must have at least a Master's degree in a relevant discipline and demonstrated long term experience in designing and managing complex health programs and social and behavioral change communication programs in developing countries. The Chief of Party is expected to have the strategic vision, leadership qualities, depth and breadth of technical expertise and experience, professional reputation, management experience, interpersonal skills and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the program description. S/he will also have experience interacting with other projects, host country governments and international agencies.

Senior Management Team (1-2):

Among these management and program leaders, they should have substantial (8 or more years) experience and the requisite educational and technical background and experience to provide state-of-the-art leadership, management and oversight on: administrative and financial management and accountability; designing and overseeing complex monitoring and evaluation frameworks, research and data quality. Interpersonal skills are critical to the leadership of these awards as they are so closely integrated and USAID/Malawi recognizes the importance of program leadership. This will be reflected in all sector's evaluation criteria. Candidates shall also have excellent writing skills in English. The Applicant may structure these positions as appropriate and feasible given that the proposed Management Team will have varying combinations of the requisite skills that best meet the management needs of the program. The Applicant may choose to draw the advisors from staff of the Sub-Recipient organizations.

Senior Technical Advisors (1-4):
Among these advisors, they should have substantial (8 or more years) experience and the requisite educational and technical background and experience to provide state-of-the-art technical leadership and hands on abilities in: experience to design and carry out mass media campaigns, community-level mobilization activities, and design and implement community-appropriate SBCC activities and packages; advising and supporting capacity building for improved coordination and use of SBCC activities and materials. S/he should have extensive experience in identifying, adapting and guiding the use of SBCC tools and approaches that facilitate effective community-level SBCC activities, developing and delivering targeted training and technical assistance to improve SBCC and community mobilization for priority EHP services, and collaborating with other professionals working in SBCC programming and professional reputation; management experience; interpersonal skills; and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the program description.

The Applicant may structure these positions as appropriate and feasible given that the proposed advisors will have varying combinations of the requisite skills. The Applicant may choose to draw on long term and short term technical advisors to fill the match above. Both types of TA may be proposed as key personnel. S/he will also have experience interacting with other projects, host country governments and international agencies.

The other professional staff proposed should demonstrate the range of practical technical skills necessary for extending and strengthening community-based priority EHP services and systems, and an ability to manage the design and implementation of key components of this program. If they are to hold team leadership positions, they should have a demonstrated capacity to liaise and negotiate with key stakeholders in other organizations, as well as to support and supervise staff.

Among the Chief of Party and Senior Management and Technical Advisors, they should have substantial experience in designing, implementing and managing complex health communications/behavior change projects and in living and working in developing countries. They should have complementary skills and knowledge in the key technical areas required by the SBCC Project, including strategic planning for SBCC; targeted SBCC activities for community level and health providers; community mobilization and gender.

It is not anticipated that the staffing for the SBCC Project will require advanced technical or clinical skills in the priority EHP areas; the Support for Service Delivery Project will be engaging Senior Technical Advisors for these areas that will be made available to the HPSS and SBCC partners as needed to ensure adequate technical support for the relevant HPSS and SBCC activities.

The other professional staff proposed should demonstrate the range of practical technical skills necessary for the different aspects of effective behavior change programming, and an ability to manage the design and implementation of key components of this program. If they are to hold team leadership positions, they should have a demonstrated capacity to liaise and negotiate with key stakeholders in other organizations, as well as to support and supervise staff.

SECTOR III HEALTH POLICY AND SYSTEMS STRENGTHENING (HPSS) PROGRAM DESCRIPTION

1. Overview of the HPSS Project

The Health Policy and Systems Strengthening (HPSS) Project is a $10,684,000 project to be implemented over a period of five years. Overall, the HPSS project seeks to improve functioning of the health system and improve sustainable service delivery impact of the EHP in Malawi through strengthened policies, management, leadership and fiscal responsibility of the MOH. This solicitation seeks to enable policy leaders and stakeholders to use timely and accurate data for evidence-based decision-making and advocacy and to provide national, zonal/ district and local leaders and stakeholders with reliable data to develop policy, make evidence based programmatic decision-making for health service delivery and system priorities and assist USG and in-country stakeholders in network formation and partnership development.

- The HPSS project is one of three interrelated solicitations being issued by USAID/Malawi to support the Government of Malawi's (GOM) health sector strategy. The purpose of these three solicitations is to engage three partners to implement programs that will assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the health centers and district hospitals levels, supported by systems strengthening efforts at central, zonal and district levels, with the aim of improving the health and well-being of the population of Malawi. The three projects will work in targeted districts in all five zones of Malawi.

Although each Recipient will have its distinct scope of work and roles and responsibilities, this solicitation should ensure collaboration with the other two and position itself to coordinate the advocacy around the key policies that the other two projects identify. In addition to these three projects, USAID/Malawi has two other project components that will be implemented during this HPN Strategy period 2009/15. These are: **Private Sector/Social Marketing and Supply Chain Management.**

It is envisaged that as a result of its support to national policy environment, zones and districts, the HPSS Recipient will improve the effectiveness of health service delivery for the entire population of Malawi. The HPSS Recipient will also work intensively to ensure effective functioning of health systems in USAID-targeted districts (two-three per zone). Over the first three years of the project, it is anticipated that the HPSS partner will, in conjunction with the SSD Partner and relying on them for systematic follow up, achieve improved systems in human resource management, coordination of in service trainings, M&E systems, finance management and accountability systems and strengthened performance in at least 80 per cent of the targeted facilities within the targeted districts.

USAID/Malawi is committed to the same health sector results as those agreed under the Malawi Health Sector Wide Approach (SWAp I) Program of Work (POW). More specifically the HPSS Project will provide support to SWAp "Building blocks" identified as crucial to health system performance in Malawi. A national evaluation of the POW is currently scheduled for 2010 to inform a new five year POW (the second phase of the SWAp) from 2011 onwards. The HPSS Project will also directly contribute data and results for USAID/Malawi's Operational Plan (OP), Malaria Operational Plan (MOP), and Country Operational Plan (COP).

To achieve its results, the HPSS Recipient will need to coordinate its activities with a variety of partners, and organizations relevant to its outputs and objectives. The recipient will collaborate with all other key USAID projects and partners. The recipient will work with the MOH especially at central, zonal and district levels. HPSS is expected to identify meaningful engagement with a range of local non-governmental organizations, community groups, faith-based organizations, and traditional, community and elected leaders in a joint effort to support implementation of the project, provide oversight for and improve health programs and outcomes. The recipient is encouraged to innovatively address crosscutting issues that affect health programming including gender considerations and capacity building.

2. Overview of Health Systems in Malawi

The main health service provider in is the MOH, which provides approximately 60% of all services. The Christian Health Association of Malawi (CHAM) is responsible for the provision of about 37% of all services. Other providers include private-for-profit and private not-for-profit entities, local government, the military and police health services and small clinics offering care for company employees and their families. CHAM facilities are not private sector institutions in the conventional sense, as the MOH governs policy at these facilities and is their major source of funds. MOH is in the process of establishing service agreements with CHAM facilities to ensure free delivery of the EHP in those centers. Two percent of health care is provided through the private sector including the not for profit NGO e.g. Banja La Mtsogolo.

In 2004, the MOH adopted the SWAp model of working and the first Program of Work (POW) for the period 2004 -2010 was developed. The SWAp took over from previous National Health Plans, which the Ministry used to develop every five years. The SWAp serves as an overarching strategy to improve efficiency in the utilization of available resources to achieve health sector goals of reducing mortality, morbidity, and fertility and improving the health of all Malawians. The SWAp is implemented through a joint Program of Work, which guides the investments and activities of all partners and focuses on the delivery of an Essential Health Package (EHP) designed to meet the basic health needs of Malawians, with particular emphasis on equity and the poorest of the poor.

The SWAp assists the MOH to jointly work with its development partners in a coordinated and integrated manner through pooling of funds, moving away from the earlier project focused way of working which tended to silo activities according to source of funding and minimized integration and referral efforts. The SWAp also assists the MOH to coordinate its policy formulation and implementation processes to develop appropriate policies that support implementation of the Essential Health Package. Key to these processes are the Joint Health Sector Reviews which occur at the beginning and at mid point of each Government of Malawi (GOM) fiscal year and draws participation from a wide range of donor partners, NGOs, FBOs, CBOs, training and research institutions, zonal officers, local government leadership and departments and community service users representatives to review progress of SWAp implementation each year and set new milestones for the following year.

The agreement to finance and support the POW was formalized in a SWAp MOU. This provided a common framework for health sector planning, budgeting, financial management and reporting and monitoring and evaluation. The MOU outlines the governance structures of the SWAp, which are fully integrated into the MOH structure.

Crosscutting within the EHP, is HIV and AIDS, another key programming area that Ministry of Health addresses. However to manage and effectively mobilize resources for specific HIV and AIDS activities, a HIV and AIDS partners pool was developed. This mechanism supports the MOH to implement HIV and AIDS activities through the National AIDS Commission (NAC), which is the coordinating body for HIV and AIDS activities in Malawi. The HIV and /AIDS pool is also managed through joint annual and mid term reviews of the annual NAC implementation plans that draw participation from the wide range of HIV and AIDS implementing partners in Malawi.

NAC has a five year joint National Action Framework (NAF) from which annual implementation plans are drawn. NAC is the Prime Recipient of Global funds in Malawi and the MOH is currently a Sub-Recipient of Global Funds through NAC. The Ministry of Health also collaborates with the department of Nutrition and HIV and AIDS which is under the Office of President and Cabinet to develop, enforce and monitor implementation of policies concerning nutrition and HIV and AIDS.

The GOM adopted a policy direction to decentralize health services to district assemblies, which are local governance structures in early 2000 after the formulation of the national decentralization policy in 1998 and this has resulted in increased budgetary allocation to the district assemblies. Between the district and central structures is the zonal health structure (North; Central East and Central West; South East and South West). Each zone coordinates the activities of a cluster of up to seven districts in the most effective and efficient manner possible. Health care delivery as mentioned in earlier sections is provided at three levels; primary, secondary and tertiary and is complemented by CHAM and other private sector providers.

Despite such established structures, the Malawi health system still needs strengthening at all levels, both in terms of providing essential supplies and reorienting the skills and knowledge of health care workers to enable them address new health challenges. The Malawi health system is also affected by recurrent shortages of financial resources and uncoordinated systems varying from procurement, logistics and human resource management. The 2004- 2010 health SWAp Program of Work has put emphasis on the strengthening of existing procurement processes and procedures, the development of annual procurement plans and the enhancement of managerial capacity at all levels of the health system. The POW also mentions and recognizes that the major challenge for the MOH remains to strengthen and improve performance of district health systems and to develop integrated EHP delivery systems to move away from vertical or *siloed* programs.

As the role of Ministry of Health continues to evolve from that of direct implementation of services to that of stewardship, capacity at the central level still needs to be enhanced to reliably formulate, enforce and review policies, coordinate and regulate health service implementation, improve resource mobilization and provide effective support to district health management teams and district health offices. Districts also require strengthened capacity to effectively plan, budget, manage and effectively implement their responsibility of direct provision of services.

3. Critical Issues and Programming Opportunities in the Malawi Health Sector.

Numerous analyses have identified challenges in the delivery of health services that constrain Malawi's ability to meet its own health goals, objectives, and the MDGs. In relation to Health Policy and Systems Strengthening, Ministry of Health has a number challenges that call for the Ministry to address as priorities.

a) Influencing Health Policy.

Despite progress in developing and embracing new policy positions and decisions, the Ministry of Health still faces limited leadership and policy development capacity at the central level. This in turn affects all levels of performance; Within the Ministry's structure, key positions may remain vacant for long periods and in some cases key individuals may not have the skills needed for their assigned positions. Effective oversight and accountability are not always optimal and these result in limited priority setting of interventions for the greatest public health impact, particularly pertaining to the EHP, uneven application of best practices in policymaking and implementation, limited policy support for private sector participation and no policy that allows contributions from those with ability to pay for services.

This solicitation therefore seeks to position itself at the national level to coordinate, monitor and influence formulation of, in addition to the above identified gaps, specific policies that will bring results in the implementation of EHP. Some outstanding policies that have potential for great impact if addressed and were embarked on by the Ministry but have not been brought to fruition include but are not limited to:

i. The rationalization of the roles of HSAs at community level to review and reconsider how HSAs can offer effective services across the EHP spectrum. The job description of HSAs has been reviewed several times, however with uneven or non-consensus from various players in the health sector on how effective and inclusive it is of 'other' responsibilities that take up the HSAs time from their intended primary health care role.

ii. Engaging with policy makers in the nutrition sector to help identify ways of addressing the lack of a suitable cadre of staff to implement community-based nutrition programs, where there is the greatest need.

iii. The role of the common civil service and its implications for capacity building. The common civil service is responsible for the rotation of staff classified as 'common service staff' across all Ministries in Malawi. This continuous rotation process affects government officers in administrative and managerial positions and impacts on investments particularly in leadership development and health staff retention by continuously removing or rotating key personnel whose capacity has been built over time to improve performance of the Ministry of Health. This solicitation seeks to explore how the common service can positively impact programs and address the unintended negative effects of staff rotation.

iv. Investigating the possibility of elevating Reproductive Health Unit (RHU) and National Malaria Control Program (NMCP) to directorate levels. These units within the MOH have great impact in service provision for Reproductive Health and Malaria programming and elevating them to directorate level would provide the much needed visibility and authority that can drive their programs forward.

v, Re defining Health Education Unit's role in coordination, strategic planning and oversight of integrated BCC implementation more clearly within the MOH policy framework.

vi. Formalizing and advocating for increased task shifting to 'new' or 'other' lower level cadres to improve delivery of services. The MOH already adopted task shifting as one way of addressing staff shortages at service delivery points. However, various task shifting models have been proposed and others have met with resistance due to limiting policies and regulations for health service delivery. In addition to task shifting from nurses/clinicians to HSAs, task shifting

from HSAs to Home Based Care and OVC volunteers in the hard to reach areas offers opportunity to improve access to care and support services. Community volunteers already manage community drug boxes for management of HIV-related illnesses (opportunistic infections including malaria) and utilizing them for other health services could improve access to services at community level. Ministry has yet to discuss this and consider its implementation.

vii. Full adoption of community-based provision of injectable contraceptives through Community Based Distribution Agents (CBDAs). A pilot project using HSAs to administer injectable contraceptives at community level is underway and Ministry of Health is still debating regulatory issues around community based distribution of injectable contraceptives. Continued advocacy is still required at policy level to influence decision making to adopt this methodology. Community based distribution has demonstrated great results in countries like Madagascar where it is implemented and this model of delivering family planning will greatly benefit women who have challenges to access service delivery points and will raise awareness of family planning, particularly among men at community level. Malawi's fertility rate is currently at 6.0 and this distribution strategy has potential to reduce this high fertility rate as more women and families will be given the chance to take control of their fertility.

Overall, the HPSS project seeks to promote advocacy for development or implementation of policies that improve equitable and affordable access to high quality services and information. This solicitation also seeks to enable policy leaders and stakeholders to use timely and accurate data for evidence-based decision-making in policy formulation. As well as provide central, zonal and district leaders and stakeholders with reliable data to develop or review policies.

b) Leadership, Management Capacity and Zonal Supervision

Effective leadership is more important than ever in the current health care environment. Evolving health reforms, such as decentralization and inadequate funding for the health sector, present formidable external challenges to health care organizations. At the same time, MOH continues to face critical staff shortages, generally weak systems, difficulty in sustaining high-quality services, and other internal challenges. To address these challenges, MOH needs managers who can not only manage, but also lead their staff through change.

As alluded to above, leadership and management skills are some of the capacity gaps for some key positions in the Ministry. Some of the policies highlighted above, once implemented will address some of these leadership gaps, however, targeted capacity building in management and leadership skills for identified key positions will also go a long way in improving the Ministry's effectiveness and efficiency at central, zonal and district levels in the areas of finance management, monitoring and evaluation, human resources management, zone supervision and senior strategic leadership.

This solicitation therefore is positioned to empower health managers at all levels of the health system in the public sector to lead teams to face challenges and achieve results; work with the Ministry of health in a joint capacity building and systems development initiative; offer a coordination role for Ministry of Health central level, zonal level and district level. An assessment of crucial leadership and management gaps in MOH HQ would be necessary to assess management performance, identify gaps and needs in leadership capacities and develop a concrete action plan that will result in organization-wide improvements. The solicitation also aims at strengthening management and supervision in the context of decentralization.

c) Health Financing

This is a critical time for Malawi as SWAp II is currently being designed. As new stakeholders and Ministry partners come on board SWAp II, there is need to ensure availability of strong capacities in health planning and costing in the new environment of SWAp II in order to learn and apply lessons. As noted from SWAp I, the health sector faces an absolute inadequacy in financial resources in order to meet EHP requirements. The HPSS project will support Ministry of Health to identify opportunities and gaps as well as strengthen capacities for leveraging, absorbing, and accounting for allocated funds to address priority needs

Inadequate staffing in the planning and finance departments of the Ministry of Health lead to insufficient financial planning and management oversight therefore challenging mechanisms for the releasing of MOH funds for activities. Capacity building with the aims of improving financial management and monitoring SWAp budget execution rates could significantly improve the impact of MOH interventions at the community level. This solicitation will explore measures aimed at improving efficiency in resource allocation and use at all levels.

The HPSS project will also support the institutionalization, utilization and monitoring of key health financing processes such as the National Health Accounts (NHAs) and monitoring budget execution processes at district level. Performance Based Financing (PBF) in Malawi has not been fully explored and utilized. This solicitation therefore seeks to support Ministry of Health to improve performance of health workers, projects and programs by providing direct financial support, based on performance, to selected MOH initiatives/projects/services within the districts to be identified through a capacity assessment. PBF has potential of strengthening both systems and services and is one of the future directions for implementing health programs in Malawi.

4. The HPSS Program Objective

The purpose of the HPSS project is to improve functioning of the health system and improve sustainable service delivery impact of the EHP in Malawi through strengthened policies, management, leadership, supervision, fiscal responsibility and monitoring capacities of the MOH. In order to achieve the objectives of the award, the Recipient will undertake various activities necessary to accomplish the results outlined. The approaches and activities provided are presented only as an indication of the types of approaches and activities likely to achieve the results listed below. In preparing an Application for and then implementing this project, the Recipient and Sub-Recipients will need to present how their strategies and approaches are adapted to the needs, challenges, and context of health systems in Malawi. This is projected to be a $10,684,000 award. The activity objective will be accomplished through the achievement of the major result areas listed below:

Result I – Increased coordinated advocacy for and implementation of evidence-based policies that impact on priority areas in all USAID/Malawi projects as appropriate
Illustrative Activities

- Assess and identify key barriers, gaps in policy formulation process
- Capacity building for key health managers to utilize existing and available data for decision making and policy formulation across all levels of the health sector
- Coordination of USG policy advocacy efforts at national and district levels
- Supporting systematic reviews of key programs in MOH
- Strengthening M&E units at central, district health offices, facilities to effectively feed into HMIS
- Supporting periodic data analysis at all levels of the health system

- Create a conducive legal and policy environment that will promote private sector participation and relationship with government
- Develop a pool of evidence and reliable Malawi health systems data for MOH and its partners to use for policy decisions
- Review and, if necessary, update policies to international best practice guidelines regarding community-level and referral facility services**.**

Result II - Strengthened strategic leadership and management capacity of MOH
Illustrative Activities

- Assess central, zonal and district management capacity gaps and make concrete plans for improvement
- Strengthen coordination of policy structures at all levels of health care
- Training of key managers/individuals in strategic leadership, financial management and management of relevant health systems at all levels
- Supporting capacity building and skills transfer to key managers' counterparts in strategic leadership and management of health systems at all levels for sustainability
- Supporting MOH leadership to review, implement existing and new health sector reforms
- Support for national level coordination meetings and MOH national and international conference attendance costs across technical areas

Result III – Improved and strengthened zonal supervision structures of MOH
Illustrative Activities

- Assess central, zonal and district supervision capacity and make concrete plans for improvement
- Development of innovative approaches to strengthen supervision and reporting between the central, zonal and district levels.
- Develop a national supervision framework
- Support the development of on-site mentoring programs for service providers
- Support DHMTs to implement quality improvement mechanisms including regular supervision, implementing performance- based contracts and on site mentoring of health care workers to strengthen quality of services
- Implement a national supervision framework extending to all levels of health care
- Strengthen quality assurance teams at health facilities through supervision and on-site mentoring

Result IV – Improved leadership and management of Human Resources for Health
Illustrative Activities

- Support MOH in the development of the Human Resources Management Information System and rolling out to district level
- Enhance the capacity of HR managers at all levels to utilize the HRMIS to improve decision making for staff recruitment, deployment, performance assessment and retention
- Provide USG supported training to HR managers at central level in effective Human resource Management
- Strengthen HRH strategic planning
- Support the central level HR department to develop planning tools (HRH projections) to inform training needs of different cadres of health professionals
- Improve coordination of in service trainings at district and zonal levels to reduce duplication of efforts and improve availability of service providers at service delivery posts
- Continuation of support for a Monitoring and Evaluation Technical Advisor to the NMCP

Result V – Improved decentralized management of health services at district levels
Illustrative Activities

- Improve management and leadership capacity for key Local assembly officers at district level to support health services financing, programming and management
- Strengthen coordination and reporting lines between district health offices and local assembly authorities to improve district implementation plan formulations.
- Innovative and meaningful engagement with local civil society to influence health sector priorities and services that will positively impact progression of the health sector

Result VI – Strengthened health financing mechanisms, financial planning and management and budget execution capability at national, zonal and district levels for sustainability
Illustrative Activities

- Pilot Performance Based Financing to support key activities at district level
- Strengthen MOH capacity for resource mobilization, cost reduction, revenue generation, and cost-sharing for services
- Develop improved and innovative mechanisms for central and district levels to generate, plan, manage and account for allocated funds
- Improve timely finance reporting systems at all levels
- Monitor health sector spending and budget execution rates through utilization of NHAs and monitoring of budget execution rates at national and district level and engage communities in this process and oversight and accountability
- Generate a pool of budget execution data to support and influence MOH financial planning and projections
- Increase MOH technical capacity in financial management at all levels of health care

5. HPSS Illustrative Indicators

Applicants should refer to the SWAp Program of Work Monitoring, Evaluation and Research (ME&R) Indicators, with particular emphasis on M&E indicators and targets for the Pillars for Health Systems and USAID/Malawi's Operational Plan, Country Operational Plan and Malaria Operational Plan required indicators to better understand the outcomes and anticipated results for the HPN Program and its partner organizations. Key areas for health systems oversight and HPSS priorities are drawn from the zone supervisor policy guidelines. The applicant shall report on the following standard USAID indicators for the HPSS program:

a) Indicators for HPSS

The applicant shall report on the following standard USAID indicators for the HPSS program:

- Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support
- Number of policies referencing research results
- Number of people covered by USG supported health financing arrangements
- Number of people trained in health financing
- Number of sector assessments
- Number of people trained in monitoring and evaluation at all levels of health care
- Number of people trained in leadership, management and supervision
- Number of people trained in policy development

- Number of people trained in institutional capacity development
- Number of people trained in quality assurance
- Number of people trained in financial management and accounting
- Number of quality assurance mechanisms developed
- Number of people enrolled in Leadership Development Program
- Existence of SOPs for district and facility supportive supervision (Yes/No)

HIV/AIDS

- Number of local organizations provided with technical assistance for HIV-related policy development [Country Operational Plan (COP)]
- Number of individuals trained in HIV-related policy development (COP)
- Monitoring policy reform and development of PEPFAR supported activities:
  - HRH
  - Gender
  - OVC
  - HCT
  - Access to high-quality, low cost medications
  - Stigma and discrimination
  - Strengthening a multi-sectoral response and linkages with other health and development programs
- Number of health care workers who successfully completed an in-service training program (PEPFAR)
- Number of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support (COP)

Malaria

- Number of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support (OP)
- Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs (OP)

MCNH

- Number of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support (OP)
- Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs (OP)
- Number of technologies under development (OP)
- Number of health facilities rehabilitated (OP)

FP

- Number of policies or guidelines developed or changed to improve access to and use of FP/RH services;
- Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs (OP)

Nutrition

- Number of improvements to laws, policies, regulations or guidelines related to improved access to and use of health services drafted with USG support (COP)

b) Additional Illustrative Indicators:

- Number of (newly) adopted/implemented/reviewed key policies by Ministry of Health
- Number of health finance assessments conducted/supported and results utilized to support SWAp implementation
- Existence of policies for priority health interventions (Yes/No)
- Number of zonal supervision visits to districts and facilities per year
- Percent of health facilities regularly supervised by extended DHMT using integrated supervision checklist
- Existence of designated mechanisms charged with analysis of health statistics (Yes/No)
- Percent of districts that received written feedback on their quarterly reports
- Training coordination plans developed at central, zone and district levels
- Existence of HR data system (Yes/No)
- Presence of functioning HR planning system (Yes/No)
- Percent of districts with evidence of data use for decision making

c) Improved functioning in key areas (systems)

- Percent of districts using agreed on (mandated) set of management practices and tools (e.g., team planning, plans have all required components, mandated supervision tools being used)
- Percent of SDPs with full complement of assigned staff
- Number of unfilled positions
- Percent of funds at district level received on time based on agreed cash flow for the year
- Expenditure rates at the district level
- Percent of districts that had regular review of stock data for key commodities
- Percent of districts that submit timely, complete, accurate reports to national level
- Quarterly zonal reviews held that include review of HMIS data across the districts
- Availability of district summary reports
- Percent of referral services completed
- Percent of districts that have completed at least one cycle of QA among the SDPs of the district during the year
- Percent of health facilities with functioning Health Facility Advisory Committee
- Engagement with civil society, political and other, relevant institutions
- Per cent of districts where local government institutions provide financial and other support for health services and BCC programs
- Number of SLAs that are effectively functioning by district
- Percent of districts and traditional authorities where local NGOs, CBOs and/or FBOs actively participate in community and facility level health committees
- Percent of districts and traditional authorities where other sectoral programs undertake health-related promotional activities, e.g., agricultural institutions promote improved nutrition and FP

6. HPSS Illustrative Approaches/Activities

Applicants must propose strategies, approaches and activities to achieve the overall objectives, outcomes and results identified above. Given its role in working with the policy, zonal and district managers, the HPSS Recipient will increase the leadership and management capacity and strengthen systems that will affect all districts in the zones. At the same time, the HPSS Partner will work with the SSD partners more intensively in the USAID-targeted districts. The Applicant, therefore, should consider how to phase implementation so as to achieve strengthened

leadership, management and systems for all districts in the zones. For the USAID-targeted districts, the Applicant should propose approaches, which, in collaboration with the SSD partners, will assure stronger HPSS for the community and referral facility levels in at least 80 percent of traditional authorities.

The Recipient will need to build the capacity of Malawi MOH central, zone and district-level staff and partners to assure medium- to long-term sustainability of the health systems. The Recipient will also need to work with the SSD and BCC partners to develop and support the implementation of effective approaches for capacity-building for leadership, management and systems strengthening at the community and referral levels (health centers and district hospitals) so as to assure that effective systems are in place to maintain and increase health impact. Applicants should review experience to date, identify priority areas for systems strengthening, and develop approaches for scale out and scale up.

To be successful, the Recipient must collaborate with other partners (other USAID recipients and partners, other donors, implementing agencies and GOM) to identify lessons learned, apply practical, innovative approaches and tools, and coordinate support so as to reduce duplication of effort and provide consistent guidance at all levels. The HPSS Recipient must work closely with the other USAID solicitations in facilitating communication from the zone and below levels to the MOH, and from the MOH to the zones and below. The HPSS Recipient will rely heavily on the SSD partners for systems strengthening capacity building and implementation at the community and referral levels. The highest priority should be given to those needs and systems that will assure the greatest access to high quality, integrated priority EHP services at the community level. Given the distinct issues in each zone and among different districts in the same zone, it is likely that some activities that are priorities in certain zones and districts are not as important in others.

The Recipient for the HPSS Project will participate in the Management Advisory Group (MAG) that will help to provide support, advice, advocacy, monitoring and problem solving for the USAID/Malawi interrelated projects that are solicited simultaneously. The MAG will be chaired by the COP of SDD and the HPSS Recipient's COP will serve as vice -chair of the MAG, which will include members from USAID/Malawi's Health Team responsible for managing the Agreements and the Health Team Leader (up to six members), the Chiefs of Party for the BCC, HPSS, SBCC and USAID/Private Sector and Social Marketing projects; and from five to seven members drawn from key stakeholder organizations, such as the MOH, NGOs and civil society. The MAG will have, at a minimum, semi-annual meetings; key agenda items for these meetings will be to review and comment on joint work plans, review and comment on progress, identification of opportunities for promoting the program and dissemination of results, and identification and resolution of bottlenecks to implementation.

7. HPSS personnel desired qualifications

The following are anticipated qualifications for personnel and the illustrative team composition. The Applicant must identify positions that will be considered key positions under the resulting award.

Chief of Party:

The Chief of Party (COP) must have at least a master's degree in a relevant discipline and demonstrated experience in designing and managing complex health programs with an emphasis on health systems strengthening and management in developing countries. The COP is expected

to have strategic vision, leadership qualities, depth and breadth of technical expertise and experience, professional reputation, management experience, interpersonal skills and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the program description. S/he will also have experience interacting with other projects, host country governments and international agencies. The COP will have at least 10 years of program management experience including managing complex programs in the developing world.

Senior Management Team (1-2):
Among these management and program leaders, they should have substantial (8 or more years) experience and the requisite educational and technical background and experience to provide state-of-the-art leadership, management and oversight on: administrative and financial management and accountability; designing and overseeing complex monitoring and evaluation frameworks, and data quality. Interpersonal skills are critical to the leadership of these awards as they are so closely integrated and USAID/Malawi recognizes the importance of program leadership. This will be reflected in all sector's evaluation criteria. Candidates shall also have excellent writing skills in English. The Applicant may structure these positions as appropriate and feasible given that the proposed Management Team will have varying combinations of the requisite skills that best meet the management needs of the program. The Applicant may choose to draw the advisors from staff of the Sub-Recipient organizations.

Senior Technical Advisors (1-3):
Among these advisors, they should have substantial (8 or more years) experience and the requisite educational and technical background and experience to provide state-of-the-art technical leadership and hands on abilities in: management of health systems and systems strengthening in developing countries plus the ability to find and implement solutions to systems problems including- human resources issues, planning and management in decentralized systems, and health financing. They should capacity building for improved health systems and management performance. They should have extensive experience in identifying, adapting and guiding the use of tools and approaches that facilitate health systems operations, developing and delivering targeted training and technical assistance to improve management and problem-solving and other skills of health systems leaders and managers. The technical team should also present policy expertise in policy analysis, advocacy, and/or strategic planning for health. They should all hold excellent interpersonal skills; and written and oral presentation skills to fulfill the diverse technical and managerial requirements of the program description.

Among them, they should have substantial experience in designing, implementing and managing systems strengthening health projects in developing countries. They must have substantial experience living and working in developing countries. They should also demonstrate experience in integrating cross cutting issues such as gender in programming. They should have complementary skills and knowledge in the key technical areas required by the HPSS Project, as noted above.

The other professional staff proposed should demonstrate the range of practical technical skills necessary for improving policy, leadership and management capacity and strengthening decentralized health systems, and an ability to manage the design and implementation of key components of this program. If they are to hold team leadership positions, they should have a demonstrated capacity to liaise and negotiate with key stakeholders in government and other organizations, as well as to support and supervise staff.

D. AUTHORIZING LEGISLATION/APPLICABILITY OF 22 CRF 226

This award is authorized in accordance with the Foreign Assistance Act of 1961, as amended. 22 Code of Federal Regulation (22 CFR) 226 is applicable to an award to a U.S. organization made under this RFA and to any sub-award to a U.S. entity resulting from this RFA. The following provision will be included in any award to a U.S. entity resulting from this RFA.

Applicability of 22 CFR part 226 (May 2005)

(a) All provisions of 22 CFR Part 226 and all Standard Provisions attached to this agreement are applicable to the recipient and to sub recipients which meet the definition of "Recipient" in Part 226, unless a section specifically excludes a sub recipient from coverage. The recipient shall assure that sub recipients have copies of all the attached standard provisions.

(b) For any sub awards made with Non-US sub recipients the Recipient shall include the applicable "Standard Provisions for Non-US Nongovernmental Grantees." Recipients are required to ensure compliance with monitoring procedures in accordance with OMB Circular A-133.

F. AWARD ADMINISTRATION

For U.S. organizations, 22 CFR 226, OMB Circulars, and the *Standard Provisions for U.S. Nongovernmental Recipients (US NGOs)* will be applicable. For non-U.S. organizations, the *Standard Provisions for Non-U.S., Nongovernmental Recipients* (Non-US NGOs) will apply. While 22 CFR 226 does not directly apply to non-U.S. applicants, the Agreement Officer will use the standards of 22 CFR 226 in the administration of the award. For Public International Organizations (PIOs), the Standard Provisions for Grants to PIOs, along selected provisions from the Standard Provisions for Non-U.S., NGOs and other negotiated provisions will be used. These documents may be accessed through the internet as follows:

22CFR226: http://www.access.gpo.gov/nara/cfr/waisidx_06/22cfr226_06.html

OMB Circulars http://www.whitehouse.gov/omb/circulars/index.html

Standard Provisions for U.S. NGOs: http://www.usaid.gov/policy/ads/300/303maa.pdf

Standard Provisions for Non-U.S., NGOs: http://www.usaid.gov/policy/ads/300/303mab.pdf

Standard Provisions PIOs: http://www.usaid.gov/policy/ads/300/308mab.pdf

You may contact Beatrice Lumande at blumande@usaid.gov for copies of these regulations.

SECTION II – AWARD INFORMATION

1. ESTIMATED FUNDS AVAILABLE AND CONTEMPLATED NUMBER OF AWARDS

A. Subject to the availability of funds, USAID intends to provide approximately $100,173,911 in total USAID funding for the life of the activity pursuant to this RFA. USAID intents to issue three awards as indicated below, and reserves the right to fund any or none of the applications submitted.

SECTOR I: Support for Service Delivery (SSD)- a five-year, $65,289,911.00 award to implement an integrated service delivery program that will assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the community and referral (health centers and District hospitals) levels with the aim of improving the health and well-being of the population of Malawi; **SECTOR II**: Social and Behavior Change Communication (SBCC)-a five year $24,200,000 award to support social and behavior change communication comprehensive package of technical assistance to the GOM and to the local partners named within the SSD activity above; and **SECTOR III**: Health Policy and Systems Strengthening (HPSS)- a five-year, $10,684,000 award to improve functioning of the health system and improve sustainable service delivery impact of the EHP in Malawi through strengthened policies, management, leadership and fiscal responsibility of the MOH.

The award ceiling indicated for each Sector has been established to reflect available fiscal year (FY) 2010 funding, and to accommodate any potential funding increases through Global Health Initiative (GHI) for health and systems related activities in Malawi. Successful applicants should note that there is no guarantee that an award will be funded to the level of the ceiling, and yearly budgets are subject to funding availability. The first year (June 2011 to September 2012) funding level is estimated at $11,948,911 for all sectors. Sector I, $4,964,911; Sector II $6,000, 000 and Sector III $984,000. Applicants should note that the first year funding levels are estimates. The actual funding level for the first year of the Sector Agreement is subject to the acceptance of a request for a waiver (limited to Year 1) of the Single-Partner Award Limitation (described below). Please note the 8% rule only applies to PEPFAR, HIV/AIDS funding and not other accounts.

DATA TABLE 1: FUNDS AVAILABILITY/YEAR

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL PROGRAM
BCC	6,000,000.00	4,550,000.00	4,550,000.00	4,550,000.00	4,550,000.00	**24,200,000.00**
SSD	4,964,911.00	12,300,000.00	15,650,000.00	16,125,000.00	16,250,000.00	**65,289,911.00**
HPSS	984,000.00	2,075,000.00	2,375,000.00	2,375,000.00	2,875,000.00	**10,684,000.00**
	11,948,911.00	**18,925,000.00**	**22,575,000.00**	**23,050,000.00**	**23,675,000.00**	**100,173,911.00**

DATA TABLE 2: TOTAL FUNDING (PROGRAM/CLUSTER)

	BCC	SSD	HPSS	TOTAL/CLUSTER
FP	2,150,000.00	17,500,000.00	1,550,000.00	**21,200,000.00**
MCH	4,200,000.00	19,879,911.00	3,029,000.00	**27,108,911.00**
NUTRITION	2,550,000.00	8,250,000.00	230,000.00	**11,030,000.00**
MALARIA	15,300,000.00	6,500,000.00	2,875,000.00	**24,675,000.00**
HIV	-	13,160,000.00	3,000,000.00	**16,160,000.00**
	24,200,000	**65,289,911**	**10,684,000**	**100,173,911**

As shown above, these projects are expected to receive family planning, MCH, malaria, Nutrition, and HIV/AIDS funding. A modest level of funding may come from special WATSAN funding under MCH; this funding level is not indicated above. The Recipient (and Sub-Recipients) will need to comply with the requirements for the use of these funding sources and be able to account for results so as to relate overall proportions of funding to the results. In short, the Recipient will be responsible for ensuring that activities and the funding being managed are appropriately tracked and attributed to the relevant funding sources.

B. Single-Partner Award Limitations

PEPFAR seeks to promote sustainability for programs through the diversification of partners. To achieve this goal, the Office of the Global AIDS Coordinator (OGAC) establishes an annual funding guideline for grants and cooperative agreement planning. Within the annual PEPFAR country budget for Malawi, OGAC establishes a limit for the total amount of USG funding for HIV/AIDS activities provided to a single partner organization under all grant and cooperative agreements for that country. For FY 2010, the limit is not more than eight (8) percent of the Malawi's FY 2010 PEPFAR program funding (excluding U.S. Government management and staffing costs), or $2 million, whichever is greater.

The total amount of funding received by a partner organization includes any PEPFAR funding provided to the partner, whether directly as prime partner or indirectly as sub-grantee. In addition, subject to the exclusion for umbrella awards discussed below, all funds provided to a prime partner, even if passed through to sub-partners, are applicable to the limit. PEPFAR funds provided to an organization under contracts are not applied to the 8 percent/$2 million single partner ceiling.

PEPFAR publishes the single-partner funding limits annually. The current limit applicable to this RFA is $2 million. Please note that the current limit is based on an estimated Malawi Country Budget developed for planning purposes; thus, the limit is also an estimate and subject to change based on actual appropriations and the final approved country budget.

Exclusions from the 8 percent/$2 million single-partner ceiling are made for (a) umbrella awards, (b) commodity/drug costs, and (c) Government Ministries and parastatal organizations. Grants officers will determine whether an organization is serving as an umbrella for purposes of exception from the cap on an award-by-award basis. Agreements for which the primary objective is for the organization to make sub-awards will be considered umbrellas and, therefore, exempted from the cap. Agreements that merely include sub-grants as one of many activities in implementation of the award will not be considered umbrellas, and the full amount of the award will count against the cap. All commodity/drug costs will be excluded from partners' funding for the purpose of the cap. The remaining portion of awards, including all overhead/management costs, will be counted against the cap.

Applicants should be aware that evaluation of applications will include an assessment of grant/cooperative agreement award amounts applicable to the applicant by Fiscal Year in Malawi. The combined budget for the three sectors described in this RFA is expected to exceed the ceiling for any one partner for the PEPFAR Malawi program. While individual organizations may submit separate applications to carry out all three activities, all prospective applicants should be aware that they will likely be ineligible to receive multiple awards since this would automatically place the recipient over the threshold. The U.S. Global AIDS Coordinator may approve an exception to the cap in appropriate circumstances.

2. START DATE AND PERIOD OF PERFORMANCE

The period of performance for the three anticipated awards is five (5) years, and the estimated start date is on or **about January 1, 2011.**

3. TYPE OF AWARD

USAID plans to negotiate and award an assistance instruments known as a Cooperative Agreement with the successful Applicant for each of the three sectors. A Cooperative Agreement implies a level of "substantial involvement" by USAID. This substantial involvement will be through the Agreement Officer, except to the extent that the Agreement Officer delegates authority to the Agreement Officer's Technical Representative (AOTR) in writing. The intended purpose of the substantial involvement during the award is to assist the recipient in achieving the supported objectives of the agreement. The substantial involvement elements for this award are listed below (this list does not include approvals required by 22 CRF 226 or other applicable law, regulation or provision):

- Review and approval of key personnel and changes in key personnel;
- Review and approval of annual implementation plan, performance monitoring plan and exit strategy;
- Collaborative involvement of AOTR in selection of any planned advisory committees and participation in any technical or programmatic reviews;
- Approval of the Monitoring and Evaluation (M&E) Program;
- Review and approval of proposed subcontracts and sub awards in excess of $100,000; and
- Review and approval of all subcontractors and sub-recipients where the subcontract or sub award exceeds $100,000.
- Approval of all programmatic communication materials developed under the program by the AOTR prior to their publication and use.

4. PROGRAM ELIGIBILITY REQUIREMENTS

A. APPLICANTS

Qualified applicants may be U.S. or non-U.S. Non-governmental organizations (NGOs), private voluntary organizations (PVOs), for-profit companies willing to forego profit, and Public International Organizations. Faith-based and community organizations that fit the criteria above are also eligible to apply. In support of the Agency's interest in fostering a larger assistance base and expanding the number and sustainability of development partners, USAID encourages applications from potential new partners.

B. COST SHARE

Cost sharing is an important element of the USAID-recipient relationship. In addition to USAID funds, applicants are encouraged to contribute resources from own, private or local sources for the implementation of each of this program sector. Cost sharing is defined at 22 CFR 226.23. Cost share is required to be at least 15% of the total estimated amount. If the applicant proposes a cost share of less than 15%, it will be deemed as not responsive, and will be removed from further consideration. Cost-sharing may be cash or in-kind contributions but, by definition, may not include USG funds or USG-funded in-kind contributions. Cost-sharing must be used for the accomplishment of program objectives, and must consist of allowable costs under the applicable USG cost principles (see OMB Circular A-110 and 22CFR 226.23 for discussion of allowable in-kind contributions.

SECTION III – APPLICATION AND SUBMISSION INFORMATION

1. POINTS OF CONTACT

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2. REQUIRED FORMS

All Applicants must submit the application using the SF-424 series, which includes the:

• SF-424, Application for Federal Assistance

• SF-424A, Budget Information - Nonconstruction Programs,

• SF-424B, Assurances - Nonconstruction Programs,

The program description includes non-construction elements. Therefore, these mandatory forms for non-construction programs must be completed. Costs to non-construction activities should be included on the SF-424A. Copies of these forms may be found as an attachment to this RFA.

3. PRE-AWARD CERTIFICATIONS, ASSURANCES AND OTHER STATEMENTS OF THE RECIPIENT

A. In addition to the certifications that are included in the SF 424, both U.S. and non-U.S. organizations (except as specified below) must provide the following certifications, assurances and other statements. Complete copies of these Certifications, Assurances, and Other Statements may be found as an attachment to this RFA.

1. For U.S. organizations, a signed copy of the mandatory reference, Assurance of Compliance with Laws and Regulations Governing Nondiscrimination in Federally Assisted Programs.

2. A signed copy of the certification and disclosure forms for "Restrictions on Lobbying" (see 22 CFR 227);

3. A signed copy of the "Prohibition on Assistance to Drug Traffickers" for covered assistance in covered countries;

4. A signed copy of the Certification Regarding Terrorist Funding required by the Internal Mandatory Reference AAPD 04-14;

5. A signed copy of "Key Individual Certification Narcotics Offenses and Drug Trafficking"

6. Survey on Ensuring Equal Opportunity for Applicants; and

7. All applicants must provide a Data Universal Numbering System (DUNS) Number.

4. APPLICATION FORMAT GUIDELINES AND ASSUMPTIONS

The application shall be split into two separate parts: a. Technical Application; and b. Cost/ Business Application. All applications shall be in English. The formats for each of these parts of the application are set forth below.

A. Technical Application Format

The technical application will be the most important item of consideration in selection for award of the proposed activity. It shall demonstrate the applicant's capabilities and expertise with respect to achieving the goals of this program. It shall be specific, complete and presented concisely. The application shall take into account and be arranged in the order of the technical evaluation criteria found in Section IV.

The Technical Application shall contain the following sections: 1. Cover Page; 2. Executive Summary; 3. Technical Application/Program Description; and 4. The Annex.

The Technical Application Body shall include the following sections: A. Technical Approach/Intended Results; B. Program Management; C. Past Performance; D. Monitoring and Evaluation; and E. Gender Equity Plan. The overall page limitation for the technical application is 20 pages.

Applications shall be written in English and typed on standard 8 1/2" x 11" (216mm by 297mm paper) or A4 paper, single spaced, 12 characters per inch with each page numbered consecutively1.

The Annex, PMP, implementation plans, and items such as the cover page, dividers and the table of contents are not included in the 20-page limitation.

[1] Footnotes, charts, tables and other similar types of graphic displays can use font that differs from that specified herein. However, USAID reserves the right to not review pages in the application if this practice is abused.

1. Cover Page

The Cover Page shall include the applicant's name, identification of the primary contact person and the identification of the alternate contact person (by name, title, organization, mailing address, telephone number and email address). The Cover Page must also include proposed project title and Sector, e.g.

"Support for Integrated Service Delivery, USAID/Malawi RFA # 674-A-10-0051;
SECTOR I: -Support for Service Delivery (SSD)", or

"Support for Integrated Service Delivery, USAID/Malawi RFA # 674-A-10-0051;
SECTOR II:-Social and Behavior Change Communication (SBCC)", or

"Support for Integrated Service Delivery, USAID/Malawi RFA # 674-A-10-0051;
SECTOR III:-Health Policy and Systems Strengthening (HPSS)".

Applicants who 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, should mark the cover page with the following legend:

"This application includes data that shall not be disclosed outside the U.S. Government and shall not be duplicated, used, or disclosed - in whole or in part - for any purpose other than to evaluate this application. If, however, an agreement is awarded to this applicant as a result of this RFA, a final determination will be made regarding the extent to which data included in the cooperative agreement can be disclosed."

The Applicant can include any other information or graphics on the cover page that it determines are beneficial.

2. Program Abstract/Executive Summary

The Program Abstract shall be a one-page summary of the application. The Program Abstract shall describe, in brief obviously, what the program will do and how. In addition, USAID suggests that addressing some combination of the following topics may be beneficial:

A brief description of the critical elements of the application, highlighting the most salient features of the applicants' technical vision and approach, the key personnel and management plan proposed, and the capabilities of the partners to accomplish the desired results, a summary of results that may be achieved; the bottom line funding request from USAID; and any aspects of the Applicant's approach that significantly increases its likelihood of success.

3. Technical Application

The Technical Application will contain the main parts of the technical application. The maximum number of pages in this section will be nineteen (19). The basic purpose of this section is to provide an explanation necessary to allow USAID to fairly and completely evaluate the Applicant under each of the evaluation criteria specified in Section IV. of this RFA, and to meet the minimum results described in the performance indicators and targets section for the USAID program description. Additional specified guidance for each section of the Technical Application is set forth below.

a) Technical Approach

In this subsection, the Applicant should address the considerations related to and provide all of the information necessary for USAID to effectively and fairly evaluate the criterion specified in Section IV.

The application must include a clear description of the approach and general strategy (i.e. activities, implementation, methodology, and techniques) proposed to implement the program and each of the components detailed in the Program Description and should propose realistic strategies which clearly link challenges and gaps with achievable solutions as well as plans to address opportunities. The applicant will demonstrate a thorough understanding of the implementing environment and reflect it at all stages of design, implementation and evaluation, including:

i. Flexibility to respond to changes in the SWAP as it moves into SWAP II starting on/a 2011 and outline a strategy and activities that support the Government of Malawi's (GOM) health sector strategy and implement integrated programs that will assure significant expansion and improved quality of priority Essential Health Package (EHP) services at the community and referral levels with the aim of improving the health and well-being of the population of Malawi. Flexibility will also be needed as the United States Government rolls out the new Global Health Initiative.

ii. Sub-agreements: Applicants shall identify and describe any sub-recipients and/or sub-contractors indicating the extent of utilization intended, and the tasks/functions they will perform. Describe how those organizations were selected and how they will effectively contribute to the implementing team. Technical application information for proposed sub-recipients and/or sub-contractors should follow the same format as that submitted by the applicant. Applications should describe in detail implementation plans related to the methodologies included in the project description, showing the phasing or dates by which planned activities would be carried out as well as proposed indicators to assess the progress of the program. The implementation plan should include or describe in detail the following:

- Description of all planned activities including
- Sequence of activities;
- Timeframes for implementing each activity;
- Outcome of each activity;
- Impact on gender;
- Impact on disadvantaged communities;
- Involvement of alliances/partners/twinning;
- Sustainability plan

b) Coordination with others' previous experiences

It is strongly requested that Applicants share best practices from each others' previous experiences and areas of expertise and look towards outside expertise for areas where value can be added through specialized services/skills. One component of the overall evaluation criteria will consider how Applicants demonstrate past impact in focus areas. USAID urges applicants to link with other USG funded initiatives in HIV/AIDS; malaria; nutrition; MCH and Family

Planning wherever possible and with other donor and private funds to maximize impact. Proposed interventions under this RFA initiative shall be compatible with any government sponsored programs and shall compliment them as such, being careful not to create market distortions when coordinating with government programs.

c) Personnel and Management Plan

In this subsection, the Applicant should address the considerations related to and provide all of the information necessary for USAID to effectively and fairly evaluate the criterion specified in Section IV. In addition, the Applicant should also specifically address the following in this subsection:

i. Applications must include a detailed management plan/implementation schedule in support of proposed activities. The applicant must present the relevant, specialized competence that itself and each member will contribute. This shall include demonstrated accomplishments and institutional capability to carry out activities of the type required under this project. The management plan must include descriptions of the following elements:

ii. Organizational Structure – Proposed staffing Plan and organizational chart (including any proposed local sub-recipients). The plan shall specify the composition and organizational structure of the proposed implementation team and describe each staff member's role, technical expertise and the estimated amount of time each member of the team will devote to the Program and long and short-term technical assistance needs. Identify by title and name each position to be supported under the project, as well as for any support staff based abroad. Exact titles, qualifications and scopes of work of long-term technical and professional support staff must be provided. Include job descriptions and resumes of proposed key personnel in the narrative. Identify additional technical staff consistent with the overall staffing plan considered essential to achieving the results. In an annex, provide an organogram showing the organizational structure and coverage of all key technical and managerial areas. Also in the annex, for each proposed key staff provide a Letter of Commitment, CVs of no more than 3 pages and at least 3 professional references. Include CVs of no more than 2 pages each for other proposed technical staff. The use of local and regional technical expertise is desirable and engagement of qualified Malawian staff is encouraged whenever possible

iii. The application shall propose a qualified technical team. Its composition will depend on the proposed technical approach and the result may be a combination of short and long-term technical expertise.

- Key Positions-Personnel - Applications shall include an explanation on how the background and expertise needed for proposed key positions and personnel will complement each other and benefit to the project. Applicants must include as part of its application a statement signed by each person proposed as key personnel confirming their present intention to serve in the stated position, their present availability to serve for the term proposed, and the full contact information of all employers of each proposed key personnel since January 2006. Applicants should include three references for each key personnel candidate.

- Short-Term Technical Assistance - To the maximum extent possible, the Application shall describe short-term technical and advisory assistance that will be needed over the life of project to supplement or complement the work of the long-term advisors and depending on the technical approach.

- Policies and Procedures - Proposed policies and procedures for managing and directing the effort to ensure productivity, quality, cost control and early identification and resolution of difficulties. Standard corporate policies and practices documentation submitted for Agreement Officer responsibility determination may be referenced; however the intent here is to highlight (unique) policies that may be created specifically in responding to the RFA.

- Implementation Planning – This must illustrate how the applicant intends to implement a management plan that contributes to the achievement of the stated results. The application shall contain a detailed Mobilization Plan staff will be mobilized in Malawi. This plan should present a schedule for mobilizing and staffing the project over the initial three months following the Award, as well as a strategy to ensure a smooth transition for existing USAID-funded health support activities involved in the targeted and neighboring districts. The second section shall be a less detailed initial Annual Work plan that includes how the recipient envisions assuming responsibilities of project activities. A detailed work plan submission will be expected within 60 days of the award. USAID will request a series of lessons learned presentations be given twice a year to USAID, the host country and donor working group on achievements to date that can be replicated and expanded.

d) Past Performance

The Applicant should briefly address examples of any relevant performance issues in this section. Examples of past performance by itself or its team and how this performance record demonstrates that the Applicant will be able to successfully implement the program specified in this RFA should be included here. The Applicant shall also discuss how this experience is relevant to the success of the program specified in Paragraph a. above. This Section shall also include a discussion of the existing capabilities and capacities of the Applicant and its major subcontractors and sub-recipients to conduct the activities required in Section a. above and to effectively manage this large effort.

In the Annex, the Applicant shall include one information sheet for each such program identified pursuant to the instructions above. The information sheets shall include all of the following information: i. The identity of the entity involved (e.g. the Applicant, a major subcontractor or major sub-recipient); ii. A description of the project's scope, magnitude and period of performance; iii. Location of the project; and iv. Details as to the Applicant's (or that of a major subcontractor or sub-recipient) role and activities during the project;

Contact information (names, telephone numbers, email addresses, etc.) for the entity that funded the program or contract. Names and contact information should be provided for both technical and contracting/grant administration personnel, preferably for personnel who directly oversaw the program or contract. The Applicant shall also provide, in the Annex, a list of <u>all</u> programs that it has undertaken in the last three years (detailed descriptions may be provided in the Annex). The same information as set forth immediately above shall be provided for each program listed.

e) Gender Considerations

USAID/Malawi considers the impact of gender equality, as a cross cutting issue, on the overall socioeconomic status of individuals, households and communities. In recognition of the impact of gender inequality on all the project interventions, applicants are encouraged to promote participation of all members of most at risk populations at the community and national level by providing them with equal access to and control over resources and mainstream the issue at different levels. Gender mainstreaming in all activities to empower women and girls, promote

male responsibility, promote ownership among both men and women at the community level, and ensure gender issues are considered at the central/policy level.

4. Annex

The technical application annex shall contain resumes, letters of commitments from personnel or partners, teaming agreements, past performance references, letters of recommendation, awards, testimonials and any other supporting documentation requested in the RFA.

B. Cost/Business Application Format

The Cost/Business Application is to be submitted separately from the technical application. While there is no page limit for this portion, applicants are encouraged to be as concise as possible, but still provide the necessary details. The Cost Application must be completely separate from the applicant's technical application. The application must include completed SF-424 forms as set forth in Subsection III.2 above.

1. The cost application should be for a period of 60 months.

2. Applicants should assume notification of an award approximately forty-five (60) days after the date established as a deadline for receipt of applications.

An overall summary budget should be included in the Cost/Business Application as well as detailed annual budgets that provides, in detail to the individual line item, a breakdown of the types of costs anticipated. The types of costs should be organized based on the cost categories in the SF-424 budgets listed in section III above. All budgets shall include a sheet relating to the entire 60 month period and separate spread sheets for each of the three program years. It is strongly preferred that these budgets include a breakdown of the costs allocated to any sub-recipient involved in the program, as well as the breakdown of the financial and in-kind contributions of all such organizations (the applicant can also include separate subcontract budgets for the sake of clarity). The electronic version of the budgets should be provided in Microsoft Excel format.

3. Budget notes are required. These budget notes must provide an accompanying narrative by line item which explains in detail the basis for how the individual line item costs were derived.

4. The following Section provides guidance on line item costs.

Salary and Wages - Direct salaries and wages should be proposed in accordance with the organization's personnel policies.

Fringe Benefits - If the organization has a fringe benefit rate that has been approved by an agency of the Government, such rate should be used and evidence of its approval should be provided. If a fringe benefit rate has not been so approved, the application should propose a rate and explain how the rate was determined. If the latter is used, the narrative should include a detailed breakdown comprised of all items of fringe benefits (*e.g.*, unemployment insurance, workers compensation, health and life insurance, retirement, etc.) and the costs of each, expressed in dollars and as a percentage of salaries.

Travel and Transportation - The application should indicate the number of trips, domestic and international, and the estimated costs. Specify the origin and destination for each proposed trip, duration of travel, and number of individuals traveling. *Per diem* should be based on the applicant's normal travel policies; applicants may choose to refer to the Federal Standardized Travel Regulations for cost estimates).

Equipment: Estimated types of equipment (i.e., model #, cost per unit, quantity).

Supplies: Office supplies and other related supply items related to this activity.

Contractual: Any goods and services being procured through a contract/grant mechanism.

Other Direct Costs - This includes communications, report preparation costs, passports and visas fees, medical exams and inoculations, insurance (other than insurance included in the applicant's fringe benefits), equipment (procurement plan for commodities), office rent abroad, etc. The narrative should provide a breakdown and support for all and each other direct costs.

Indirect Costs –Local/ regional or other organizations that do not have a Negotiated Indirect Cost Rate Agreement (NICRA) letter with the US Government, these organizations should treat all indirect costs as direct costs and provide a fully-developed and supported rational for allocating or estimating how much of the indirect costs should be allocated to the program.

Seminars and Conferences - The applicant should indicate the subject, venue and duration of proposed conferences and seminars, and their relationship to the objectives of the program, along with estimates of costs.

Training Costs - If there are any training costs to be charged to this Agreement, they must be clearly identified and supported with detailed narrative.

Foreign Government Delegations to International Conferences: Funds in this agreement may not be used to finance the travel, per diem, hotel expenses, meals, conference fees or other conference costs for any member of a foreign government’s delegation to an international conference sponsored by a public international organization, except as provided in ADS Mandatory Reference “Guidance on Funding Foreign Government Delegations to International Conferences or as approved by the AOTR[http://www.info.usaid.gov/pubs/ads/300/refindx3.htm].

Source and Origin Requirements - The authorized Geographic Code for this Agreement will be 935.

5. In the case of a an application where the entity receiving the award is a joint venture, partnership or some other type of group where the proposed applicant is not a legal entity, the Cost Application must include a copy of the legal relationship between the prime applicant and its partners. The application document should include a full discussion of the relationship between the applicant and its partners, including identification of the applicant with which USAID will directly engage for purposes of Agreement administration, the identity of the applicant which will have accounting responsibility, how Agreement effort will be allocated and the express Agreement of the principals thereto to be held jointly and severally liable for the acts or omissions of the other.

6. The required Certifications, including the SF 424s, should be included with the Cost Application.

7. As written above, the proposed budget should provide separate cost estimates for the management of the program (including program monitoring). Applicants should minimize their administrative and support costs for managing the project to maximize the funds available for project activities.

8. The cost/business portion of the application should describe headquarters and field procedures for financial reporting. Discuss the management information procedure you will employ to ensure accountability for the use of U.S. Government funds. Describe program budgeting, financial and related program reporting procedures.

9. Indicate if financial commitments were made among partners during the preparation of the application. Budgets shall indicate the amounts committed to each member of the team. Letters of commitments from partners should be included.

10. If requested by USAID after submission of applications, please provide information on the Applicant's financial status and management, or that of major subcontractors and sub-recipients, including:

(a) Audited financial statements for the past three years,

(b) Organization chart, by-laws, constitution, and articles of incorporation, if applicable,

(c) If the applicant has made a certification to USAID that its personnel, procurement and travel policies are compliant with applicable OMB circular and other applicable USAID and Federal regulations, a copy of the certification should be included with the application. If the certification has not been made to USAID/Washington, the applicant should submit a copy of its personnel (especially regarding salary and wage scales, merit increases, promotions, leave, differentials, etc.), travel and procurement policies, and indicate whether personnel and travel policies and procedures have been reviewed and approved by any agency of the Federal Government. If so, provide the name, address, and phone number of the cognizant reviewing official.

(d) If applicable, approval of the organization's accounting system by a U. S. Government agency including the name, addresses, and telephone number of the cognizant auditor.

11. The Cost/Business Application should also address the applicant's resources and capacity in the following areas in narrative form:

(a) Have adequate financial resources or the ability to obtain such resources as required during the performance of the Agreement;

(b) Has the ability to comply with the agreement conditions, taking into account all existing and currently prospective commitments of the applicant, non-governmental and governmental;

(c) Has a satisfactory record of performance (only a brief discussion of this issue is required in the cost/business application since past performance is an evaluation factor – the applicant

may wish to discuss any notable issues re its record of performance that were not discussed in the technical application);

(d) Has a satisfactory record of integrity and business ethics; and

(e) Is otherwise qualified and eligible to receive a cooperative agreement under applicable laws and regulations (e.g., EEO).

If requested by USAID after submission of applications, please provide any additional evidence of responsibility considered necessary in order for the Agreement Officer to make a determination of responsibility. Please note that a positive responsibility determination is a requirement for award, and all organization shall be subject to a pre-award survey to verify the information provided and substantiate the determination.

13. Cost Sharing: Cost sharing is required, in addition to USAID funds, applicants are required to contribute resources from their own, private or local sources for the implementation of this program.

14. Unnecessarily elaborate applications: unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective application in response to this RFA 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.

5. SUBMISSION DEADLINES

Applications shall be due at 17:00 hours Pretoria, South Africa Time on August 32, 2010. USAID will determine that any applications that are not received by the Agreement Officer by one of the methods specified below by the time and date indicated will be late. Because making an award is critical to USG foreign policy goals, time is important and late applications may not, at the sole discretion of the Agreement Officer, be considered.

6. FUNDING RESTRICTIONS

There are no funding restrictions applicable to this RFA at this time.

7. GENERAL INSTRUCTIONS

USAID will accept applications from the qualified entities as defined in Section II of this RFA. The Applicant should follow the instructions set forth herein. If an applicant does not follow the instructions, the Applicant’s application may be down-graded and may not receive full credit under the applicable evaluation factors, or, at the discretion of the Agreement Officer, may be eliminated from the competition. All applications received by the deadline will be reviewed against the evaluation factors in Section IV.

The preferred delivery method is electronically via email with up to 10 attachments (2MB limit) per email compatible with MS WORD, and Excel environment to applications4@usaid.gov.

If the application is submitted electronically, the Applicant should also mail an original and two (2) copies of both the technical application and cost application to the following address:

USAID/Southern Africa
Attention: Beatrice Lumande,
Senior Acquisition and Assistance Specialist
Regional Office of Acquisition and Assistance
Box 43, Groenkloof, 0027, Pretoria, South Africa

If the electronic submission is timely, the delivery of the courtesy hard copies are not required to arrive by the date and time specified for submission of applications in paragraph 5 above. However, it is requested that they arrive by August 30, 2010. Alternatively, applications can be delivered by hand/courier to the following address:

USAID/Southern Africa
Attention of Beatrice Lumande,
Senior Acquisition and Assistance Specialist
Regional Office of Acquisition and Assistance
100 Totius Street, Groenkloof 0027,
Pretoria, South Africa

If an applicant does not submit an application electronically, an original and two (2) copies each of the separate technical and cost applications must be provided.

Telegraphic or faxed applications are not authorized for this RFA and will not be accepted.

Consistent with ADS 303.3.6.7, Applications that are submitted late may by eliminated from the competition. If a late application is evaluated and considered for award, all similarly-situated late applications (in terms of time of receipt) will also be evaluated and considered for award.

8. BRANDING STRATEGY AND MARKING PLAN

Pursuant to ADS 303.3.6.3.f and ADS 320.3.1.2, the apparently successful applicant will be requested to submit a Branding Strategy and Marking Plan that will have to be successfully negotiated before a cooperative agreement will be awarded. These plans shall be prepared in accordance with the guidance in ADS 320.3.1.2, 22 CFR 226.91 and the references therein. Please note that the Branding Strategy and Marking Plan shall not be included with the original application but shall be provided only after a written request of the Agreement Officer.

In developing the Branding Strategy and Marking Plan, each full application must include a plug figure in the Application Budget for USAID's Branding Strategy and Marking Plan requirements pursuant to the policy directives stated above. Should your application be recommended for award under this RFA, the cognizant Mission or Regional Agreement Officer will request your organization to submit (1) a Branding Strategy that describes how the program, project, or activity is named and positioned, how it is promoted and communicated to beneficiaries and cooperating country citizens, and identifies all donors and explains how they will be acknowledged; and (2) a Marking Plan that will detail the public communications, commodities, and program materials intended to visibly bear the USAID identity together with a negotiable budget for each. Once submitted, the Branding Strategy and Marking Plan and their costs, must be negotiated and approved by the USAID Mission and the Regional Agreement Officer prior to award. **The Branding Strategy and Marking Plan only have to be submitted if you are selected for award.**

SECTION IV–APPLICATION REVIEW INFORMATION/EVALUATION CRITERIA

The evaluation criteria for the three sectors are located on the following pages:

1. EVALUATION CRITERIA- SECTOR I: Support for Service Delivery (SSD)

The criteria presented below have been tailored to the requirements of this particular RFA to enable USAID/Malawi to select the highest quality application. These criteria identify significant areas that applicants should address in their applications and the standard against which all applications will be evaluated. Applicants should note that these criteria serve to:

Identify the significant matters which applicants should address in their applications; and

Set the standard against which all applications will be evaluated.

A maximum total of 100 points is possible this sector.

A. Technical approach – (SSD) 45 points

The Applicant's technical approach to the program and the results proposed will be evaluated. The following considerations may be, but are not required to be, considered in the evaluation of this criterion:**.**

- The overall vision/strategy shows clear understanding of project results and country context, including gender, cultural norms and environmental considerations, and priority needs.

- The Application presents clearly appropriate approaches and activities to address the major challenges and achieve improved, integrated, priority EHP information, products and services for target district populations.

- The technical approach reflects state-of-the art technical knowledge (including regarding methods for monitoring and evaluation), creativity, flexibility to the needs of the country and responsiveness to all technical areas and requirements.

- The Applicant's approach fosters engagement of NGOs and other community groups, local and elected leaders, and households in health services delivery.

- The approach for capacity building of local health services partners in the communities and districts is reasonable for developing long-term sustainability of quality, priority EHP services.

- The Applicant's district case study demonstrates a practical, realistic, approach to achieving district level impact of integrated, priority EHP services.

B. Personnel and Management Plan/Organizational capacity – (SSD) 35 points

The Applicant's plan to manage the program proposed will be evaluated. The following considerations may be, but are not required to be, considered in the evaluation of this criterion:

Management Plan and proposed organizational chart provides assurance that the Applicant and Sub-Recipients will manage the program in a sound, efficient and collaborative fashion. Roles and relationships are clearly defined and indicate clear lines of communication and authorities.

EVALUATION CRITERIA-SECTOR I: Support for Service Delivery (SSD) (Continued)

- Applicant's approach for fostering collaboration and managing across the SSD partners, with the two other prospective solicitation partners (SBCC and HPSS) demonstrates understanding of the challenges, benefits and potential for success.

- Key personnel proposed have demonstrated knowledge, skills, and qualifications required to accomplish the program.

- Draft PMP is results-oriented and provides a comprehensive approach to measure the accomplishment of relevant project results as well as key tasks over the course of the project.

- The Application includes plans for Implementation as well as Exit that is clear, ambitious and achievable with a practical plan to scale up activities and scale down at a pace that will allow sustainability of expected results by the end of the program period. The applicant and any proposed sub-partners demonstrate clear capacity and experience to accomplish the range of technical interventions described in the RFA in collaboration with a range of partners.

The Applicant and proposed Sub-Recipients demonstrate the capacity to strengthen health service delivery and performance at community and facility levels in decentralized health systems in developing countries.

C. Past Performance- (SSD) 20 Points

Applicants shall be evaluated on how well they performed on relevant programs. Recent programs of similar size and scope and type will be of greater relevance in this evaluation. The information presented in the Applicant's submittal, together with any other sources available to USAID, will comprise the input for evaluation of this factor. The following considerations will be evaluated under this evaluation criterion:

- Success in meeting goals, targets and results;

- Adherence to schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient completion of tasks;

- Customer satisfaction with performance, including end user or beneficiary wherever possible; and

- Effectiveness of key personnel

USAID will assign a neutral rating to an application which, through no fault of its own, has no past performance history (for example, a new business). The past performance of the Applicant's major sub-recipients and subcontractors will also be considered.

(This section is Continues on Page 82 of 100)

1. EVALUATION CRITERIA- SECTOR II: Social and Behavior Change Communication (SBCC)

The criteria presented below have been tailored to the requirements of this particular RFA to enable USAID/Malawi to select the highest quality application. These criteria identify significant areas that applicants should address in their applications and the standard against which all applications will be evaluated. Applicants should note that these criteria serve to:

Identify the significant matters which applicants should address in their applications; and

Set the standard against which all applications will be evaluated.

A maximum total of 100 points is possible this sector.

A. Technical approach -(SBCC) 30 points

The Applicant's technical approach to the program and the results proposed will be evaluated. The following considerations may be, but are not required to be, considered in the evaluation of this criterion:**.**

1. The overall vision/strategy demonstrates a practical approach for effective national level strategic planning and coordination for SBCC and addressing the challenges for SBCC in Malawi.

2. Presents a convincing strategy and set of activities for developing SBCC packaged interventions for priority EHP services and for extending their implementation (scaling up and scaling out) to improve SBCC coverage in all targeted districts.

3. Reflects understanding of the country context, including gender and cultural norms, and how to use of state-of-the-art technical knowledge, creativity, and best practices in SBCC for achieving results.

4. Provides a practical strategy to build and maintain the capacity of all organizations and individuals engaged in health SBCC to effectively mobilize communities and implement SBCC activities, use SBCC packages effectively, and coordinate SBCC activities and share lessons learnt.

5. Provides a practical strategy for main pillar of on-going technical assistance to SSD partners at the district and community level as well as effective collaboration with all major SBCC-related partners and organizations.

6. Case study presents practical and appropriate steps to effective implementation of SBCC programming in a selected district.

B. Management Plan, Staffing/Implementation Plan (SBCC) 50 points

The Applicant's plan to manage the program proposed will be evaluated. The following considerations may be, but are not required to be, considered in the evaluation of this criterion:

EVALUATION CRITERIA- SECTOR II: Social and Behavior Change Communication (SBCC) (Continued)

Management Plan and proposed organizational chart provides assurance that the Applicant and any sub-recipients will manage the program in a sound, efficient and collaborative fashion. Roles and relationships are clearly defined and indicate clear lines of communication and authorities. This is particularly relevant to presenting a very clear plan outlying the role of the program Vis a Vis SSD and how that relationship would be implemented through activities.

- Key personnel proposed have demonstrated knowledge, skills, and qualifications required to accomplish the program.

- Draft PMP provides comprehensive approach to measure the accomplishment of key tasks as well as the relevant project results over the course of the project.

- The Application includes plans for Implementation as well as Exit that is clear, ambitious and achievable with a practical plan to scale up activities and scale down at a pace that will allow sustainability of expected results by the end of the program period.

- Applicant and proposed sub-partners demonstrate the capacity to strengthen SBCC programming in developing countries.

- Past performance references document successful performance of programs of similar size and complexity.

C. Past Performance - (SBCC) 20 points

Applicants shall be evaluated on how well they performed on relevant programs. Recent programs of similar size and scope and type will be of greater relevance in this evaluation. The information presented in the Applicant's submittal, together with any other sources available to USAID, will comprise the input for evaluation of this factor. The following considerations will be evaluated under this evaluation criterion:

- Success in meeting goals, targets and results;

- Adherence to schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient completion of tasks;

- Customer satisfaction with performance, including end user or beneficiary wherever possible; and

- Effectiveness of key personnel

USAID will assign a neutral rating to an application which, through no fault of its own, has no past performance history (for example, a new business). The past performance of the Applicant's major sub-recipients and subcontractors will also be considered.

(This section Continues on Page 82 of 100)

1. EVALUATION CRITERIA- SECTOR III: Health Policy and Systems Strengthening (HPSS)

The criteria presented below have been tailored to the requirements of this particular RFA to enable USAID/Malawi to select the highest quality application. These criteria identify significant areas that applicants should address in their applications and the standard against which all applications will be evaluated. Applicants should note that these criteria serve to:

Identify the significant matters which applicants should address in their applications; and

Set the standard against which all applications will be evaluated.

A maximum total of 100 points is possible this sector.

A. Technical understanding and approach- (HPSS) 40 points

The Applicant's technical approach to the program and the results proposed will be evaluated. The following considerations may be, but are not required to be, considered in the evaluation of this criterion:**.**

- Demonstrates a clear and comprehensive understanding of the Malawian national health system and the opportunities, challenges and key issues related to policy formulation, management and systems strengthening across the central, zonal and district levels.

- Appropriateness of the technical approaches and interventions to achieve results and integration of cross cutting issues.

- Provides a practical strategy that builds the management and leadership capacity of central, zonal and district teams and local organizations to strengthen health systems.

- Provides an innovative and creative strategy to strengthen policy advocacy and coordination at all implementation levels.

- Presents a clear and innovative plan to strengthen supervision, coordination and management of human resources including trainings.

- Demonstrates an understanding of health financing support and presents a convincing strategy to strengthen and consolidate health financing support in the Malawi health sector.

- Proposes an approach that fosters close collaboration with USAID projects and partners, particularly with SSD project, SBCCS project, BCC project, as well as other relevant USAID partners active in Malawi.

- Presents an effective strategy for sharing information, knowledge and lessons learned within the health sector. This includes a description of a methodologically appropriate means of evaluating the program's relevance, effectiveness, efficiency, impact and sustainability, including the steps to be taken, such as collection of baseline information, at the time of the program inception.

EVALUATION CRITERIA- SECTOR III: Health Policy and Systems Strengthening (HPSS) (Continued)

B. Management plan and Organizational capacity (HPSS) 40 points

The Applicant's plan to manage the program proposed will be evaluated. The following considerations may be, but are not required to be, considered in the evaluation of this criterion:

- Management Plan and proposed organizational chart provides assurance of how well the Recipient would be organized, managed, and its activities coordinated with other program components. Roles and relationships are clearly defined and indicate clear lines of communication and authorities. This is particularly relevant to presenting a very clear plan outlying the role of the program Vis a Vis SSD and how that relationship would be implemented through activities.
- Key personnel proposed have demonstrated knowledge, skills, and qualifications required to accomplish the program.
- Draft PMP is results-oriented and provides a comprehensive approach to measure the accomplishment of relevant project results as well as key tasks over the course of the project.
- The Application includes an Implementation Plan that is clear, ambitious and achievable with a practical plan to scale up activities at a pace that will allow full achievement of expected results by the end of the project period.
- Applicant and proposed Sub-Recipients demonstrate the institutional capacity to strengthen health systems performance in decentralized health systems in developing countries.

- Past performance references document: successful performance of programs of similar size and complexity. Successful performance of programs in the areas of health systems strengthening in developing countries and effective performance in health sector leadership capacity building.

C. Past performance - (HPSS) 20 points

Applicants shall be evaluated on how well they performed on relevant programs. Recent programs of similar size and scope and type will be of greater relevance in this evaluation. The information presented in the Applicant's submittal, together with any other sources available to USAID, will comprise the input for evaluation of this factor. The following considerations will be evaluated under this evaluation criterion:

- Success in meeting goals, targets and results;
- Adherence to schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient completion of tasks;
- Customer satisfaction with performance, including end user or beneficiary wherever possible; and
- Effectiveness of key personnel

USAID will assign a neutral rating to an application which, through no fault of its own, has no past performance history (for example, a new business). The past performance of the Applicant's major sub-recipients and subcontractors will also be considered.

(This section Continues on Page 82 of 100)

2. BRANDING STRATEGY AND MARKING PLAN

It is a federal statutory and regulatory requirement that all USAID programs, projects, activities, public communications, and commodities that USAID partially or fully funds under a USAID grant or cooperative agreement or other assistance award or sub award, must be marked appropriately overseas with the USAID Identity. See Section 641, Foreign Assistance Act of 1961, as amended; **22 CFR 226.91**.

Under the regulation, USAID requires the submission of a Branding Strategy and a Marking Plan, but only by the "apparent successful applicant," as defined in the regulation.

The apparent successful applicant's proposed Marking Plan may include a request for approval of one or more exceptions to marking requirements established in **22 CFR 226.91**. The Agreement Officer is responsible for evaluating and approving the Branding Strategy and a Marking Plan (including any request for exceptions) of the apparently successful applicant, consistent with the provisions "Branding Strategy," "Marking Plan," and "Marking of USAID-funded Assistance Awards" contained in **AAPD 05-11** and in **22 CFR 226.91**.

Please note that in contrast to "exceptions" to marking requirements, waivers based on circumstances in the host country must be approved by Mission Directors or other USAID Principal Officers, see **22 CFR 226.91(j)**.

3. COST SHARING

Cost share is required to be **at least 15%** of the total estimated amount. If the applicant proposes a cost share of less than 1**5%**, it will be removed from further consideration. Cost-sharing may be cash or in-kind contributions but, by definition, may not include USG funds or USG-funded in-kind contributions. Cost-sharing must be used for the accomplishment of program objectives, and must consist of allowable costs under the applicable USG cost principles (see OMB Circular A-110 and 22CFR 226.23 for discussion of allowable in-kind contributions).

4. REVIEW AND EVALUATION PROCESS

The technical applications will be evaluated in accordance with the evaluation criteria set forth above by a Technical Evaluation Committee (TEC) comprised of U.S. Government representatives and Malawian experts.

The cost applications will be evaluated by the Agreement Officer based on the considerations specified under "Cost Effectiveness and Realism" Criterion above. To the extent that they are necessary (if award is not made based on initial applications), communications with those applicants that are determined to have the greatest chance for award will occur.

Award will be made to the responsible applicant whose application offers the greatest value based on the criteria specified above. The final award decision is made, while considering the recommendations of the TEC, by the Agreement Officer.

Authority to obligate the Government: the Agreement Officer is the **only** individual who may legally commit the U.S. Government to the expenditure of public funds. No costs chargeable to the proposed Agreement may be incurred before receipt of either an Agreement signed by the Agreement Officer or a specific, written authorization from the Agreement Officer.

The required format and content for the application are described below. A team shall review and score applications received in response to this RFA. Applicants responsive to the requirements of this RFA, that have demonstrated technical skills, experience and the necessary management competence to plan and efficiently execute the program using mutually agreed, international standards of accountability are eligible to apply.

IV. COST EFFECTIVENESS AND COST REALISM/REASONABLENESS:

While there are no assigned points for the cost evaluation criteria, the review of the cost application shall entail cost effectiveness and cost realism/reasonableness of the applications. Additional information on each of these considerations is set forth below.

- Cost effectiveness –

The Applicant's demonstration that proposed results will be achieved with the most efficient use of available resources (amounts included as cost share may be considered in this analysis). Cost effectiveness may include analyzing the cost per result proposed.

- Cost realism –

That the Applicant's technical approach supports the costs proposed. In addition, the cost realism analysis will evaluate whether the costs estimated accurately reflect the costs that would be incurred during the actual performance of the program, and whether those costs are reasonable.

The cost realism analysis will:

a) verify the Applicant's understanding of the requirements and regulations;

b) assess the degree to which the cost application reflects the approaches in the technical application; and

c) assess the degree to which the cost included in the cost application accurately represents the work effort included in the technical application.

- Reasonableness and fairness of proposed costs, including all costs.

- Consistency of budget line items and amounts with the resource requirements of the different activities.

- Clarity and conformity of the applicant’s Cost/Business Application to the instructions will be considered.

SECTION V – AWARD AND ADMINISTRATION INFORMATION

1. NOTIFICATION TO OFFERORS

The Notice of Award (ADS 303.3.7.1.a) signed by the Agreement Officer is the authorizing document that will be provided to the successful applicant to inform the applicant of its selection to be further considered to negotiate a cooperative agreement. USAID will provide this Notice electronically to the person designated to receive this information in the application. Notification will also be made electronically to unsuccessful applicants pursuant to ADS 303.3.7.1.b.

2. DEVIATIONS

No deviations are currently contemplated to the standard provisions for the cooperative agreements contemplated by this RFA.

3. GENERAL INFORMATION ON REPORTING REQUIREMENTS

The following reports and related requirements will be included in the cooperative agreement issued as a result of this RFA: a). Monitoring and Evaluation Program; b). Annual Implementation Plans; c). Progress Reports; d). Annual Reports; e). Final Agreement Completion Report; f). Miscellaneous Reports and; g) Success Stories.

A. Performance Monitoring Plan (PMP)/Monitoring and Evaluation (M&E) Plan

The performance of the program will be monitored according to the Performance Management Plan. The monitoring and evaluation of this program would be critical both at its formative and implementation phases of programs. All activities are envisioned to strongly rely on evidence-based approaches including operational researches as well as appropriate use of routine program data. The Recipient shall submit the PMP/M&E plan to the AOTR within 60 days from the effective date of the Agreement. The PMP/M&E plan shall cover the full period of the Agreement. It is envisioned that the M&E plan will include a detailed plan for managing and collection of the required data, the results to be achieved by the project; the indicators to be used to measure achievement of the results; the method of data collection to be used to obtain the indicator data; schedule of data collection, and describe the critical assumptions, baseline and targets for each indicator; a description of data quality assessment and assurance and schedule of how data reported will comply and meet the USAID data quality standards of validity, reliability, timeliness, precision and integrity using the data quality standards in ADS 203.3.5.1, and the extent to which the data integrity can be trusted to influence management decisions. The PMP / M&E Plan shall include collection of data within geographic areas / communities not subject to program implementation (or included in later phases of the program) to permit valid comparisons of with / without program. The PMP / M&E Plan shall include a discussion of the methodologies for evaluation of program relevance, efficacy, effectiveness (including cost-effectiveness), impact and sustainability.

The PMP/M&E Plan must include the required F and PEPFAR standard indicators and any additional (custom) indicators that measure the achievement of results and progress/performance. All performance data, performance indicators, performance targets, and methodologies must be gender-sensitive, and the PMP/M&E Plan must address how this will be accomplished. Where disaggregated data are not feasible, the PMP/M&E Plan shall include a discussion of how the proposed indicators will assess impact on women and girls directly.

The Recipient must use effective and efficient mechanisms to monitor progress, outcomes, and successes of their activities and performance at all levels. USAID expects that the Recipient will be innovative and creative in its efforts to capture, document and report on all outcomes of USAID assistance, while strengthening and using relevant national, zonal, and district level reporting systems. The Recipient will be expected to measure net changes in targeted attitudes, knowledge, norms, and behavior. The PMP should present the connections between activities, outcomes and expected impacts. The Recipient shall also identify, document and share best practices in SBCC for scale up in more districts than initial project areas. Data quality is important; therefore the Recipient must develop systems to ensure data quality and be prepared for data quality audits. The PMP should indicate how data collected through both routine and non-routine information systems will be utilized to inform smooth implementation of programs, measure impact and meet reporting requirements. The AOTR will provide comments within 15 days after receipt of the draft PMP/M&E Plan, and the Recipient shall then submit three copies of the final PMP/M&E Plan within 15 days of receipt of the AOTR's comments to the AOTR for approval. If, at any time, it becomes necessary to revise the approved PMP/M&E Plan, the Recipient shall submit proposed changes to the AOTR, and the procedures described above for approval of the PMP shall apply. If the PMP/M&E Plan is revised, then the Recipient shall submit a revised work plan, as necessary, for approval by the AOTR. The recipient may consult with the USAID AOTR in the development of the M&E plan.

B. Annual Implementation Plans

i) First Year Work Plan: The Recipient is required to prepare and submit an annual implementation plan on a schedule established by the USAID Agreement Officer's Technical Representative (AOTR) following the Award. The first draft of the Year One work plan will be due within 60 days of the award of the Cooperative Agreement. The actual period covered by Year 1 should be adjusted as necessary so it and subsequent annual work plans coincide with the USG fiscal year. This work plan shall be reviewed and USAID will provide written comments forwarded to the Recipient with one month of submission. It will be finalized by the Recipient and three (3) bound copies and an electronic copy shall be submitted to the AOTR no later than two (2) weeks after the Recipient's receipt of USAID's written comments. The first year work plan must include activities that generate appropriate baseline information for future evaluation.

ii) Annual Work Plan: Within one month prior to the end of each activity year, the recipient shall submit to the AOTR an annual work plan for the following year. The Annual Work Plan shall include planned activities, inputs to be provided by the Recipient (including financial information), the sites where activities will be conducted, activity level outputs/outcomes and the performance targets the Recipient expects to achieve. The Annual Work Plan shall include time frame for implementation of activities; and information on how activities will be implemented. The Annual Work Plan is subject to AOTR approval.

The Annual Work Plan and changes/revisions thereto must be within the scope of the Program Description of the Agreement, reflect the Recipient's objectives, resources and targets for the program as identified in the Monitoring and Evaluation Plan and obtain the AOTR's approval prior to implementing or undertaking such changes or revisions. Should a revised Performance Management Plan (PMP)/Monitoring and Evaluation Plan (M&E) become necessary, the Recipient shall, if necessary, submit a revised work-plan covering the remaining period of the work plan year.

The AOTR shall review the draft annual work plan and provide comments within 15 days of receipt. Thereafter, the Recipient shall submit three copies of the final work plan within 15 days of receipt of the AOTR's comments for approval. Where necessary, the AOTR shall hold a meeting with the Recipient to discuss the work plan within 15 days of receiving the Recipient's draft work plan. The Recipient shall submit draft annual work plans for subsequent years of the Agreement.

C. Progress Reporting

Recipient must adhere to all the reporting requirements in the Agreement. The exact format for the preparation of all reports will be jointly determined between the Recipient and the AOTR. All reports must include gender sensitive SO- and IR-level indicators and numerical performance targets, benchmarks and milestones, and progress / performance-related data when the activity (ies) or its/ their intended results involve or affect boys and girls or women and men differently, and the difference is potentially significant for managing toward sustainable program impact.

The Recipient must provide timely responses to any and all requests pertaining to the annual submission of the USAID and State Department Operation Plan, Country Operational Plan, Malaria Operational Plan and subsequent semi- and annual reports. The Recipient must also adapt internal systems, primarily monitoring and evaluation systems, to the needs and requirements from the U.S. State Department Office of the Director of Foreign Assistance, PMI and OGAC.

i) Quarterly Program Reports: The Recipient shall submit three copies of concise quarterly program performance reports to the AOTR and one copy to the AO 30 days after the end of each reporting quarter. However, if the reporting period ends 45 days from the effective date of the Agreement, or less than 30 days from the estimated completion date of the Agreement and the Agreement is not being extended, no submission shall be required. The program report shall present the information required in 22 CFR 226.51.d. Electronic submissions are preferred over hard copies.

The reports shall include qualitative and quantitative information which describes activities conducted and specific results achieved during the quarter. Each report should include quarterly and cumulative (current year and total) data. In addition, the reports shall indicate key implementation challenges encountered and how they were or are planned to be resolved. The quarterly program report shall inform USAID of any weaknesses in the data submitted, as determined by applying the data quality standards provided in ADS 203.3.5.1. The Recipient shall discuss with the AOTR any data quality challenges to determine appropriate follow-up actions.

The AOTR will provide comments to the Recipient within 15 days after receipt of the quarterly progress report. Where necessary, the AOTR will arrange a meeting to review the quarterly progress report within 15 days of receipt of the quarterly progress to discuss and resolve issues contained in the report.

ii) Quarterly Financial Reports: The recipient will prepare and submit a quarterly financial report within 30 days after the end of the first fiscal year quarter to the USAID/Malawi AOTR, and quarterly thereafter. The report should contain, at a minimum:

- Total funds awarded to date by USAID/Malawi into the cooperative agreement
- Total funds previously reported as expended by recipient main line items

- Total funds expended in the current quarter by the recipient by main line items
- Total unliquidated obligations by main line items
- Unobligated balance of USAID/Malawi funds
- Expenditure -The recipient must keep separate accounting for PEPFAR and non-PEPFAR funds, and must disaggregate expenditures by funding cite and FY tranche of funds i.e. by PEPFAR budget codes (e.g. HVAB and HVOP), and by sub-types of non-PEPFAR funds (malaria, FP/RH, Nutrition, and MCH)

D. Annual Report

Within one month after the close of each fiscal year, the recipient shall submit to the AOTR an annual report, inclusive of the final quarter report, which reflects the progress of the program activities over the last year against the work plan. The report should indicate the outputs and impact the program is having on the target beneficiaries. Annual and cumulative to date data should be included. Anecdotal stories and case studies, pictures and any other information that gives insight into the success of the program should be included. The Recipient shall submit three copies of an annual report to the AOTR and one copy to the AO. These results reports shall cover the period October 1st through September 30th of each year, or parts thereof. If the Agreement expires during the reporting period, the Recipient shall submit a final report not later than 90 days after the expiration of the agreement date.

E. Final Agreement Completion Report

The recipient shall prepare and submit three copies of a final/completion report to the AOTR which summarizes the accomplishments of this agreement, methods of work used, budget and disbursement activity, and recommendations regarding unfinished work and/or program continuation. The final/completion report shall also contain an index of all reports and information products produced under this agreement. The report shall be submitted no later than the estimated completion date of this agreement.

F. Miscellaneous Documents

i) Start-up and Transition Plan: Within the first two weeks of the notification of the Award, the Recipient (with its sub-partners) will prepare and submit a start-up and transition plan for USAID approval. This plan should present a schedule for mobilizing and staffing the project over the initial three months following the Award, as well as a strategy to ensure a smooth transition for existing USAID-funded health support activities involved in the targeted and neighboring districts.

ii) HIV/AIDS Results Reports: Reports regarding HIV/AIDS results relative to PEPFAR and USAID indicators will be submitted on a semi-annual and annual basis. These reports, due within 30 days after March 31 and September 30, should report results against the standard set of indicators. The semi-annual and annual reports are to document HIV/AIDS activities and results from the preceding 6 and 12 months, respectively.

iii) Ad Hoc Reporting: The Recipient may be requested, from time to time, to report separately on specific issues or in greater detail on particular areas in regular reports.

vi) De-mobilization Plan: Six months prior to the completion date, the Recipient shall submit a de-mobilization plan for AOTR approval. The plan will include, at a minimum, an illustrative Property Disposition Plan; and plan for the phase-out and/or transition of in-country

operations; a delivery schedule for all reports and other deliverables required under the Cooperative Agreement; and a timetable for all other required actions.

G. Success Stories

The recipient will submit a minimum of three success stories on a semi-annual basis per guidance outlined on **www.usaid.gov**.

4. ENVIRONMENTAL COMPLIANCE

A. General

The Foreign Assistance Act of 1961, as amended, Section 117 requires that the impact of USAID's activities on the environment be considered and that USAID include environmental sustainability as a central consideration in designing and carrying out its development programs. This mandate is codified in Federal Regulations (22 CFR 216) and in USAID's Automated Directives System (ADS) Parts 201.5.10g and 204 (*http://www.usaid.gov/policy/ads/200/*), which, in part, require that the potential environmental impacts of USAID-financed activities are identified prior to a final decision to proceed and that appropriate environmental safeguards are adopted for all activities. The Recipient's environmental compliance obligations under these regulations and procedures are specified in the following paragraphs:

B. Compliance with the IEE

An Initial Environmental Examination (IEE) for Health portfolio was cleared by the Global Health Bureau Environmental Officer in November, 2008 for the Activity funding the cooperative agreement expected as a result of this RFA. The IEE covers activities expected to be implemented under this cooperative agreement. USAID has determined that a Negative Determination with conditions applies to the testing component of VCT; PMTCT to the extent that this involves generation of bio-hazardous wastes; provisions of drugs, and Anti-Retroviral Therapy (ART); ARV Drugs use and treatment; surveillance and monitoring of pandemic diseases and possible response to disease outbreaks; vaccination and immunization; construction and/or rehabilitation of health care facilities; procurement and supply of TB drugs; new born care and treatment to the extent it involves supply of drugs, and generation of bio-hazardous wastes; and household water and sanitation activities. The IEE provides specified determination on these activities on the likelihood that they will negatively impact the environment. This indicates that if these activities are implemented subject to the specified conditions, they are expected to have no significant adverse effect on the environment. The recipient shall be responsible for implementing all IEE conditions pertaining to activities to be funded under the cooperative agreement. The Health Team will provide a copy of the IEE conditions and the activities to which they apply.

C. Mitigation and Monitoring Plans

Accordingly, the Implementing partner will develop an environmental Mitigation and Monitoring Plan (EMMP) describing how the project will, in particular terms, implement those conditions in the IEE that apply to project activities, including monitoring to assure appropriate implementation and sufficiency of environmental compliance measures. This shall include training of staff and partners, where appropriate.

The Implementing Partner shall integrate these environmental compliance measures into the initial work plan and subsequent project annual work plans and performance management plans,

report on them in the normal basis of project reporting. USAID/Malawi Health Team shall assure that this integration occurs. The Implementing Partner will be required to submit an annual environmental monitoring report to the AOTR or activity manager by the end of each year. The implementers' periodic reports to USAID/Malawi Health Team will include a brief update on mitigation and monitoring measures being implemented, results of environmental monitoring, and any other major modifications/revisions in the development activities, and mitigation and monitoring procedures.

The Implementing partner will notify USAID/Malawi of any work plan activities outside the scope of the IEE, and the Health Team will independently audit the work plan against the scope of the IEE.

The Implementing Partner, in consultation with USAID/Malawi Health Team or AOTR, and the Mission Environmental Officers (MEO), as appropriate, will actively monitor and evaluate whether environmental consequences unforeseen under activities covered by this IEE arise during implementation, and modify activities as appropriate. If additional activities are added that are not described in this document, an amended IEE must be prepared by the Implementing Partner for USAID's approval. Any grants or fund transfers from the implementing partner to other organizations must incorporate provisions stipulating that:

i. an annual environmental monitoring report will be completed, and

ii. activities to be undertaken will be within the scope of the environmental determinations and recommendations of this IEE. This includes assurance that any mitigating measures required for those activities be followed.

Implementation of the proposed activities will as much as possible adhere to applicable Malawian environmental laws and policies.

5. USAID DISABILITY POLICY - ASSISTANCE (DECEMBER 2004)

a. The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website: **http://pdf.dec.org/pdf_docs/PDABQ631.pdf**

b. USAID therefore requires that the recipient not discriminate against people with disabilities in the implementation of USAID funded programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing the program under this grant or cooperative agreement. To that end and to the extent it can accomplish this goal within the scope of the program objectives, the recipient should demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

SECTION VI – OTHER INFORMATION

1. BRANDING STRATEGY - ASSISTANCE (December 2005)

(a) Definitions

Branding Strategy means a strategy that is submitted at the specific request of a USAID Agreement Officer by an apparently successful applicant after evaluation of an application for USAID funding, describing how the program, project, or activity is named and positioned, and how it is promoted and communicated to beneficiaries and host country citizens. It identifies all donors and explains how they will be acknowledged.

Apparently Successful Applicant(s) means the applicant(s) for USAID funding recommended for an award after evaluation, but who has not yet been awarded a grant, cooperative agreement or other assistance award by the Agreement Officer. The Agreement Officer will request that the Apparently Successful Applicants submit a Branding Strategy and Marking Plan. Apparently Successful Applicant status confers no right and constitutes no USAID commitment to an award.

USAID Identity (Identity) means the official marking for the Agency, comprised of the USAID logo and new brandmark, which clearly communicates that our assistance is from the American people. The USAID Identity is available on the USAID website and is provided without royalty, license, or other fee to recipients of USAID-funded grants or cooperative agreements or other assistance awards or sub awards.

(b) Submission.

The Apparently Successful Applicant, upon request of the Agreement Officer, will submit and negotiate a Branding Strategy. The Branding Strategy will be included in and made a part of the resulting grant or cooperative agreement. The Branding Strategy will be negotiated within the time that the Agreement Officer specifies. Failure to submit and negotiate a Branding Strategy will make the applicant ineligible for award of a grant or cooperative agreement. The Apparently Successful Applicant must include all estimated costs associated with branding and marking USAID programs, such as plaques, stickers, banners, press events and materials, and the like.

(c) Submission Requirements

At a minimum, the Apparently Successful Applicant's Branding Strategy will address the following:

(1) Positioning

What is the intended name of this program, project, or activity?

Guidelines: USAID prefers to have the USAID Identity included as part of the program or project name, such as a "title sponsor," if possible and appropriate. It is acceptable to "co-brand" the title with USAID's and the Apparently Successful Applicant's identities. For example: "The USAID and [Apparently Successful Applicant] Health Center."

If it would be inappropriate or is not possible to "brand" the project this way, such as when rehabilitating a structure that already exists or if there are multiple donors, please explain and

indicate how you intend to showcase USAID's involvement in publicizing the program or project. *For example: School #123, rehabilitated by USAID and [Apparently Successful Applicant]/ [other donors].* Note: the Agency prefers "made possible by (or with) the generous support of the American People" next to the USAID Identity in acknowledging our contribution, instead of the phrase "funded by." USAID prefers local language translations.

Will a program logo be developed and used consistently to identify this program? If yes, please attach a copy of the proposed program logo.

Note: USAID prefers to fund projects that do NOT have a separate logo or identity that competes with the USAID Identity.

(2) Program Communications and Publicity

Who are the primary and secondary audiences for this project or program?

Guidelines: Please include direct beneficiaries and any special target segments or influencers. *For Example: Primary audience: schoolgirls age 8-12, Secondary audience: teachers and parents–specifically mothers.*

What communications or program materials will be used to explain or market the program to beneficiaries?

Guidelines: These include training materials, posters, pamphlets, Public Service Announcements, billboards, websites, and so forth.

What is the main program message(s)?

Guidelines: *For example: "Be tested for HIV-AIDS" or "Have your child inoculated."* Please indicate if you also plan to incorporate USAID's primary message – this aid is "from the American people" – into the narrative of program materials. This is optional; however, marking with the USAID Identity is required.

Will the recipient announce and promote publicly this program or project to host country citizens? If yes, what press and promotional activities are planned?

Guidelines:
These may include media releases, press conferences, public events, and so forth. Note: incorporating the message, "USAID from the American People", and the USAID Identity is required.

Please provide any additional ideas about how to increase awareness that the American people support this project or program.

Guidelines: One of our goals is to ensure that both beneficiaries and host-country citizens know that the aid the Agency is providing is "from the American people." Please provide any initial ideas on how to further this goal.

(3) Acknowledgements

Will there be any direct involvement from a host-country government ministry? If yes, please indicate which one or ones. Will the recipient acknowledge the ministry as an additional co-sponsor?

Note: it is perfectly acceptable and often encouraged for USAID to "co-brand" programs with government ministries.

Please indicate if there are any other groups whose logo or identity the recipient will use on program materials and related communications.

Guidelines: Please indicate if they are also a donor or why they will be visibly acknowledged, and if they will receive the same prominence as USAID.

(d) Award Criteria.

The Agreement Officer will review the Branding Strategy for adequacy, ensuring that it contains the required information on naming and positioning the USAID-funded program, project, or activity, and promoting and communicating it to cooperating country beneficiaries and citizens. The Agreement Officer also will evaluate this information to ensure that it is consistent with the stated objectives of the award; with the Apparently Successful
Applicant's cost data submissions; with the Apparently Successful Applicant's project, activity, or program performance plan; and with the regulatory requirements set out in 22 CFR 226.91. The Agreement Officer may obtain advice and recommendations from technical experts while performing the evaluation.

2. MARKING PLAN – ASSISTANCE (December 2005)

(a) Definitions

Marking Plan means a plan that the Apparently Successful Applicant submits at the specific request of a USAID Agreement Officer after evaluation of an application for USAID funding, detailing the public communications, commodities, and program materials and other items that will visibly bear the USAID Identity. Recipients may request approval of Presumptive Exceptions to marking requirements in the Marking Plan.

Apparently Successful Applicant(s) means the applicant(s) for USAID funding recommended for an award after evaluation, but who has not yet been awarded a grant, cooperative agreement or other assistance award by the Agreement Officer. The Agreement Officer will request that Apparently Successful Applicants submit a Branding Strategy and Marking Plan. Apparently Successful Applicant status confers no right and constitutes no USAID commitment to an award, which the Agreement Officer must still obligate.

USAID Identity (Identity) means the official marking for the Agency, comprised of the USAID logo and new brandmark, which clearly communicates that our assistance is from the American people. The USAID Identity is available on the USAID website and USAID provides it without royalty, license, or other fee to recipients of USAID funded grants, cooperative agreements, or other assistance awards or sub awards.

Presumptive Exception exempts the applicant from the general marking requirements for a *particular* USAID-funded public communication, commodity, program material or other deliverable, or a *category* of USAID-funded public communications, commodities, program materials or other deliverables that would otherwise be required to visibly bear the USAID Identity. The Presumptive Exceptions are:

Presumptive Exception (i). USAID marking requirements may not apply if they would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials, such as election monitoring or ballots, and voter information literature; political party support or public policy advocacy or reform; independent media, such as television and radio broadcasts, newspaper articles and editorials; and public service announcements or public opinion polls and surveys (22 C.F.R. 226.91(h)(1)).

Presumptive Exception (ii). USAID marking requirements may not apply if they would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent (22 C.F.R. 226.91(h)(2)).

Presumptive Exception (iii). USAID marking requirements may not apply if they would undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better positioned as "by" or "from" a cooperating country ministry or government official (22 C.F.R. 226.91(h)(3)).

Presumptive Exception (iv). USAID marking requirements may not apply if they would impair the functionality of an item, such as sterilized equipment or spare parts (22 C.F.R. 226.91(h)(4)).

Presumptive Exception (v). USAID marking requirements may not apply if they would incur substantial costs or be impractical, such as items too small or otherwise unsuited for individual marking, such as food in bulk (22 C.F.R. 226.91(h)(5)).

Presumptive Exception (vi). USAID marking requirements may not apply if they would offend local cultural or social norms, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities (22 C.F.R. 226.91(h)(6)).

Presumptive Exception (vii). USAID marking requirements may not apply if they would conflict with international law (22 C.F.R. 226.91(h)(7)).

(b) Submission.

The Apparently Successful Applicant, upon the request of the Agreement Officer, will submit and negotiate a Marking Plan that addresses the details of the public communications, commodities, program materials that will visibly bear the USAID Identity. The marking plan will be customized for the particular program, project, or activity under the resultant grant or cooperative agreement. The plan will be included in and made a part of the resulting grant or cooperative agreement. USAID and the Apparently Successful Applicant will negotiate the Marking Plan within the time specified by the Agreement Officer. Failure to submit and negotiate a Marking Plan will make the applicant ineligible for award of a grant or cooperative agreement. The applicant must include an estimate of all costs associated with branding and marking USAID programs, such as plaques, labels, banners, press events, promotional materials,

and so forth in the budget portion of its application. These costs are subject to revision and negotiation with the Agreement Officer upon submission of the Marking Plan and will be incorporated into the Total Estimated Amount of the grant, cooperative agreement or other assistance instrument.

(c) Submission Requirements.

The Marking Plan will include the following:

(1) A description of the public communications, commodities, and program materials that the recipient will be produced as a part of the grant or cooperative agreement and which will visibly bear the USAID Identity. These include:

(i) program, project, or activity sites funded by USAID, including visible infrastructure projects or other programs, projects, or activities that are physical in nature;

(ii) technical assistance, studies, reports, papers, publications, audio-visual productions, public service announcements, Web sites/Internet activities and other promotional, informational, media, or communications products funded by USAID;

(iii) events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences, and other public activities; and

(iv) all commodities financed by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs, and all other equipment, supplies and other materials funded by USAID, and their export packaging.

(2) A table specifying:

(i) program deliverables that the recipient will mark with the USAID Identity,

(ii) the type of marking and what materials the applicant will be used to mark the program deliverables with the USAID Identity, and

(iii) when in the performance period the applicant will mark the program deliverables, and where the applicant will place the marking.

(3) A table specifying:

(i) what program deliverables will not be marked with the USAID Identity, and

(ii) the rationale for not marking these program deliverables.

(d) Presumptive Exceptions.

(1) The Apparently Successful Applicant may request a Presumptive Exception as part of the overall Marking Plan submission. To request a Presumptive Exception, the Apparently Successful Applicant must identify which Presumptive Exception applies, and state why, in light of the Apparently Successful Applicant’s technical application and in the context of the program

description or program statement in the USAID Request For Application or Annual Program Statement, marking requirements should not be required.

(2) Specific guidelines for addressing each Presumptive Exception are:

(i) For Presumptive Exception (i), identify the USAID Strategic Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why the program, project, activity, commodity, or communication is 'intrinsically neutral.' Identify, by category or deliverable item, examples of program materials funded under the award for which you are seeking exception 1.

(ii) For Presumptive Exception (ii), state what data, studies, or other deliverables will be produced under the USAID funded award, and explain why the data, studies, or deliverables must be seen as credible.

(iii) For Presumptive Exception (iii), identify the item or media product produced under the USAID funded award, product, is better positioned as an item or product produced by the cooperating country government.

(iv) For Presumptive Exception (iv), identify the item or commodity to be marked, or categories of items or commodities, and explain how marking would impair the item's or commodity's functionality.

(v) For Presumptive Exception (v), explain why marking would not be cost-beneficial or practical.

(vi) For Presumptive Exception (vi), identify the relevant cultural or social norm, and explain why marking would violate that norm or otherwise be inappropriate.

(vii) For Presumptive Exception (vii), identify the applicable international law violated by marking.

(3) The Agreement Officer will review the request for adequacy and reasonableness. In consultation with the Agreement Officer's Technical Representative and other agency personnel as necessary, the Agreement Officer will approve or disapprove the requested Presumptive Exception. Approved exceptions will be made part of the approved Marking Plan, and will apply for the term of the award, unless provided otherwise.

(e) Award Criteria:

The Agreement Officer will review the Marking Plan for adequacy and reasonableness, ensuring that it contains sufficient detail and information concerning public communications, commodities, and program materials that will visibly bear the USAID Identity. The Agreement Officer will evaluate the plan to ensure that it is consistent with the stated objectives of the award; with the applicant's cost data submissions; with the applicant's actual project, activity, or program performance plan; and with the regulatory requirements of 22 C.F.R. 226.91. The Agreement Officer will approve or disapprove any requested Presumptive Exceptions (see paragraph (d)) on the basis of adequacy and reasonableness. The Agreement Officer may obtain advice and recommendations from technical experts while performing the evaluation.

3. MARKING UNDER USAID-FUNDED ASSISTANCE INSTRUMENTS (December 2005)

(a) Definitions

Commodities mean any material, article, supply, goods or equipment, excluding recipient offices, vehicles, and non-deliverable items for recipient's internal use, in administration of the USAID funded grant, cooperative agreement, or other agreement or sub-agreement.

Principal Officer means the most senior officer in a USAID Operating Unit in the field, e.g., USAID Mission Director or USAID Representative. For global programs managed from Washington but executed across many countries, such as disaster relief and assistance to internally displaced persons, humanitarian emergencies or immediate post conflict and political crisis response, the cognizant Principal Officer may be an Office Director, for example, the Directors of USAID/W/Office of Foreign Disaster Assistance and Office of Transition Initiatives. For non-presence countries, the cognizant Principal Officer is the Senior USAID officer in a regional USAID Operating Unit responsible for the non-presence country, or in the absence of such a responsible operating unit, the Principal U.S Diplomatic Officer in the non-presence country exercising delegated authority from USAID.

Programs mean an organized set of activities and allocation of resources directed toward a common purpose, objective, or goal undertaken or proposed by an organization to carry out the responsibilities assigned to it.

Projects include all the marginal costs of inputs (including the proposed investment) technically required to produce a discrete marketable output or a desired result (for example, services from a fully functional water/sewage treatment facility).

Public communications are documents and messages intended for distribution to audiences external to the recipient's organization. They include, but are not limited to, correspondence, publications, studies, reports, audio visual productions, and other informational products; applications, forms, press and promotional materials used in connection with USAID funded programs, projects or activities, including signage and plaques; Web sites/Internet activities; and events such as training courses, conferences, seminars, press conferences and so forth.

Sub recipient means any person or government (including cooperating country government) department, agency, establishment, or for profit or nonprofit organization that receives a USAID sub award, as defined in 22 C.F.R. 226.2.

Technical Assistance means the provision of funds, goods, services, or other foreign assistance, such as loan guarantees or food for work, to developing countries and other USAID recipients, and through such recipients to sub recipients, in direct support of a development objective – as opposed to the internal management of the foreign assistance program.

USAID Identity (Identity) means the official marking for the United States Agency for International Development (USAID), comprised of the USAID logo or seal and new brandmark, with the tagline that clearly communicates that our assistance is "from the American people." The USAID Identity is available on the USAID website at www.usaid.gov/branding and USAID provides it without royalty, license, or other fee to recipients of USAID-funded grants, or cooperative agreements, or other assistance awards.

(b) Marking of Program Deliverables

(1) All recipients must mark appropriately all overseas programs, projects, activities, public communications, and commodities partially or fully funded by a USAID grant or cooperative agreement or other assistance award or sub award with the USAID Identity, of a size and prominence equivalent to or greater than the recipient's, other donor's, or any other third party's identity or logo.

(2) The Recipient will mark all program, project, or activity sites funded by USAID, including visible infrastructure projects (for example, roads, bridges, buildings) or other programs, projects, or activities that are physical in nature (for example, agriculture, forestry, water management) with the USAID Identity. The Recipient should erect temporary signs or plaques early in the construction or implementation phase. When construction or implementation is complete, the Recipient must install a permanent, durable sign, plaque or other marking.

(3) The Recipient will mark technical assistance, studies, reports, papers, publications, audio-visual productions, public service announcements, Web sites/Internet activities and other promotional, informational, media, or communications products funded by USAID with the USAID Identity.

(4) The Recipient will appropriately mark events financed by USAID, such as training courses, conferences, seminars, exhibitions, fairs, workshops, press conferences and other public activities, with the USAID Identity. Unless directly prohibited and as appropriate to the surroundings, recipients should display additional materials, such as signs and banners, with the USAID Identity. In circumstances in which the USAID Identity cannot be displayed visually, the recipient is encouraged otherwise to acknowledge USAID and the American people's support.

(5) The Recipient will mark all commodities financed by USAID, including commodities or equipment provided under humanitarian assistance or disaster relief programs, and all other equipment, supplies, and other materials funded by USAID, and their export packaging with the USAID Identity.

(6) The Agreement Officer may require the USAID Identity to be larger and more prominent if it is the majority donor, or to require that a cooperating country government's identity be larger and more prominent if circumstances warrant, and as appropriate depending on the audience, program goals, and materials produced.

(7) The Agreement Officer may require marking with the USAID Identity in the event that the recipient does not choose to mark with its own identity or logo.

(8) The Agreement Officer may require a pre-production review of USAID-funded public communications and program materials for compliance with the approved Marking Plan.

(9) Sub recipients. To ensure that the marking requirements "flow down" to sub recipients of sub awards, recipients of USAID funded grants and cooperative agreements or other assistance awards will include the USAID-approved marking provision in any USAID funded sub award, as follows:

"As a condition of receipt of this sub award, marking with the USAID Identity of a size and prominence equivalent to or greater than the recipient's, sub recipient's , other donor's or third party's is required. In the event the recipient chooses not to require marking with its own identity or logo by the sub recipient, USAID may, at its discretion, require marking by the sub recipient with the USAID Identity."

Any 'public communications', as defined in 22 C.F.R. 226.2, funded by USAID, in which the content has not been approved by USAID, must contain the following disclaimer:

"This study/report/audio/visual/other information/media product (specify) is made possible by the generous support of the American people through the United States Agency for International [insert recipient name] and do not necessarily reflect the views of USAID or the United States Government."

(11) The recipient will provide the Agreement Officer's Technical Representative (AOTR) or other USAID personnel designated in the grant or cooperative agreement with two copies of all program and communications materials produced under the award. In addition, the recipient will submit one electronic or one hard copy of all final documents to USAID's Development Experience Clearinghouse.

(c) Implementation of marking requirements.

(1) When the grant or cooperative agreement contains an approved Marking Plan, the recipient will implement the requirements of this provision following the approved Marking Plan.

(2) When the grant or cooperative agreement does not contain an approved Marking Plan, the recipient will propose and submit a plan for implementing the requirements of this provision within [*Agreement Officer fill-in*] days after the effective date of this provision. The plan will include:

(i) A description of the program deliverables specified in paragraph (b) of this provision that the recipient will produce as a part of the grant or cooperative agreement and which will visibly bear the USAID Identity.

(ii) the type of marking and what materials the applicant uses to mark the program deliverables with the USAID Identity,

(iii) when in the performance period the applicant will mark the program deliverables, and where the applicant will place the marking,

(3) The recipient may request program deliverables not be marked with the USAID Identity by identifying the program deliverables and providing a rationale for not marking these program deliverables. Program deliverables may be exempted from USAID marking requirements when:(i) USAID marking requirements would compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials; (ii) USAID marking requirements would diminish the credibility of audits, reports, analyses, studies, or policy recommendations whose data or findings must be seen as independent;(iii) USAID marking requirements would undercut host-country government "ownership" of constitutions, laws, regulations, policies, studies, assessments, reports, publications, surveys or audits, public service announcements, or other communications better

positioned as “by” or “from” a cooperating country ministry or government official;(iv) USAID marking requirements would impair the functionality of an item;(v) USAID marking requirements would incur substantial costs or be impractical;(vi) USAID marking requirements would offend local cultural or social norms, or be considered inappropriate;(vii) USAID marking requirements would conflict with international law.

(4) The proposed plan for implementing the requirements of this provision, including any proposed exemptions, will be negotiated within the time specified by the Agreement Officer after receipt of the proposed plan. Failure to negotiate an approved plan with the time specified by the Agreement Officer may be considered as noncompliance with the requirements is provision.

(d) Waivers.

(1) The recipient may request a waiver of the Marking Plan or of the marking requirements of this provision, in whole or in part, for each program, project, activity, public communication or commodity, or, in exceptional circumstances, for a region or country, when USAID required marking would pose compelling political, safety, or security concerns, or when marking would have an adverse impact in the cooperating country. The recipient will submit the request through the Cognizant Technical Officer. The Principal Officer is responsible for approvals or disapprovals of waiver requests.

(2) The request will describe the compelling political, safety, security concerns, or adverse impact that require a waiver, detail the circumstances and rationale for the waiver, detail the specific requirements to be waived, the specific portion of the Marking Plan to be waived, or specific marking to be waived, and include a description of how program materials will be marked (if at all) if the USAID Identity is removed. The request should also provide a rationale for any use of recipient’s own identity/logo or that of a third party on materials that will be subject to the waiver.

(3) Approved waivers are not limited in duration but are subject to Principal Officer review at any time, due to changed circumstances.

(4) Approved waivers “flow down” to recipients of sub awards unless specified otherwise. The waiver may also include the removal of USAID markings already affixed, if circumstances warrant.

(5) Determinations regarding waiver requests are subject to appeal to the Principal Officer’s cognizant Assistant Administrator. The recipient may appeal by submitting a written request to reconsider the Principal Officer’s waiver determination to the cognizant Assistant Administrator.

(e) Non-retroactivity.

The requirements of this provision do not apply to any materials, events, or commodities produced prior to January 2, 2006. The requirements of this provision do not apply to program, project, or activity sites funded by USAID, including visible infrastructure projects (for example, roads, bridges, buildings) or other programs, projects, or activities that are physical in nature (for example, agriculture, forestry, water management) where the construction and implementation of these are complete prior to January 2, 2006 and the period of the grant does not extend past January 2, 2006

SECTION VII REFERENCES

The following attachments and annexes are provided:

SF-424 Forms; The SF-424 forms referenced can be found at:

http://www.grants.gov/agencies/aapproved_standard_forms.jsp

Certifications, Assurances and Other Statements can be found at:

http://inside.usaid.gov/M/OAA/policy/news/USNGO_CoopAgree2of3RepsCerts042007.doc for U.S. Non – Governmental Organizations

http://inside.usaid.gov/M/OAA/policy/news/NonUSNGO_CoopAgree2of3RepsCerts042007.doc for Non-U.S. Non – Governmental Organizations