



USAID | ETHIOPIA

FROM THE AMERICAN PEOPLE

Issuance Date: June 16, 2009-----
Deadline for Questions: June 25 2009 cob
Closing Date: July 16, 2009 cob-

Subject: Request for Application (RFA) No. 663-A-09-019 for the implementation of the Community Prevention of Mother to Child Transmission (Community PMTCT)

Dear Prospective Applicants:

The United States Agency for International Development (USAID) is seeking applications for an Assistance Agreement for funding a program for the implementation of the Community PMTCT. The authority for this RFA is found in the Foreign Assistance Act of 1961, as amended.

The Recipient will be responsible for ensuring achievement of the program objectives as described in the program description. The overall goals of the program are to strengthen community systems and structures to improve the wellbeing of HIV positive pregnant women, their families and prevent the spread of HIV to their children. The program also aims to follow-up HIV exposed babies and HIV positive mothers to ensure they receive appropriate care and treatment. Please refer to the Program Description in Section C for a complete description 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 program and are in accordance with applicable cost standards (22 CFR 226, OMB Circular A-122 for non-profit organization, OMB Circular A-21 for universities, and the Federal Acquisition Regulation (FAR) Part 31 for for-profit organizations), may be paid under the agreement.

Subject to the availability of funds, USAID intends to provide approximately **\$30 million** in total funding to be allocated **over the five (05) year period**.

USAID reserves the right to fund any or none of the applications submitted.

For the purposes of this program, this RFA is being issued and consists of this cover letter and the following:

1. Section A – Application Instructions;
2. Section B – Selection Criteria;
3. Section C – Program Description;
4. Section D – Certifications, Assurances, and other Statements of Applicant/Grantee

For the purposes of this RFA, the term "Grant" is synonymous with "Cooperative Agreement"; "Grantee" is synonymous with "Recipient"; and "Grant Officer" is synonymous with "Agreement Officer."

If you decide to submit an application to be considered for award, it must be received by the closing date and time indicated at the top of this cover letter at the place designated below for receipt of applications. Applications and modifications thereof shall be submitted with the name and address of the applicant and USAID-ETHIOPIA RFA # 663-A-09-019 RFA inscribed thereon, to the Acquisition & Assistance Management (AAM) Office as noted below:

Applications shall be submitted either:

- (i) **Electronically - Option 1** – Application by email compatible with MS WORD and Excel to caddis@usaid.gov and request for acknowledgement without application to twolde@usaid.gov, mcsow@usaid.gov and rschmidt@usaid.gov or
- (ii) **Electronically – Option 2** - The federal grant process is now web-enabled, allowing for applications to be received on-line. This RFA and any future amendments can be downloaded from the following web site: <http://www.grants.gov>. In order to use this method, an applicant must first register on-line with Grants.gov. If you have difficulty registering or accessing the RFA, please contact the Grants.gov Helpdesk at 1-800-518-4726 or via e-mail at support@grants.gov for technical assistance. The Contact Center hours of operation are Monday-Friday, 7 a.m. to 9 p.m., Eastern Time; help is unavailable on Federal Holidays. USAID bears no responsibility for data errors resulting from transmission or conversion processes associated with electronic submissions. If this option is selected, please send an email of information only to caddis@usaid.gov, twolde@usaid.gov, mcsow@usaid.gov and rschmidt@usaid.gov.
- (iii) **Via regular mail to US Postal Address** – Sending one original and two copies of a technical application and one original and two copies of a cost application including both technical and cost application on CD-ROM to: AAM Office-RFA-663-A-09-019, USAID/Ethiopia, 2030 Addis Ababa Place, Washington D.C. 20521-2030.
NOTE: Pouch can take up to two (02) weeks; also all mail is subject to US Embassy electronic imagery scanning methods, physical inspections, and is not date and time stamped prior to receipt by USAID Acquisition & Assistance Office; or
- (iv) **Local - Hand delivery/Int'l Courier Address** (including commercial courier) of 3 paper copies of a technical application and one original and 2 copies of a cost application including both technical and cost application on CD-ROM to: USAID/Ethiopia, AAM Office-RFA-663-A-09-019, River Side Building, Off Haile Gebreselassie & Olympia Road, Addis Ababa, tel. 251-11-5510776.

Regardless of the method used Applicants are requested to submit both technical and cost portions of their applications in separate volumes. Technical Applications must not make reference to pricing data in order that the technical evaluation may be made strictly on the basis of technical merit.

NOTE 1: Facsimile Submissions are not authorized.

NOTE 2: Delivery to the post office or air courier representative does not constitute meeting the statutory requirement that applications are received on time at the designated office. For purposes of recording the official receipt of applications, the date/time stamp of the procurement office at USAID/Ethiopia will govern. Applicants shall retain for their records one copy of the application and all enclosures that accompany their application.

To be eligible for award, the applicant must provide all required information in its application, including the requirements found in any attachments to the Grants.gov opportunity.

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 cooperative agreement(s) 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; shall circumstances prevent award of a cooperative agreement, all preparation and submission costs are at the applicant's expense.

In the event of an inconsistency between the documents comprising this RFA, it shall be resolved by the following descending order of precedence:

- (a) Section B – Selection Criteria;
- (b) Section A – Application Instructions;
- (c) Section C – Program Description;
- (d) This Cover Letter.

Questions:

Any questions concerning this RFA shall be submitted in writing via email to caddis@usaid.gov, with copy to twolde@usaid.gov, mcsow@usaid.gov and rschmidt@usaid.gov and reference the RFA number in the subject line. Answers to all questions received by the time specified will be issued as an amendment to the RFA. For all inquiries and questions, please provide a contact person's name, phone number and email address. **To allow adequate response time, questions must be received by Monday June 25, 2009 close of business.**

Sincerely,



Robert P. Schmidt, Jr.
Agreement Officer

Attachments:

1. Section A – Application Instructions;
2. Section B – Selection Criteria;
3. Section C – Program Description;
4. Section D – Certifications, Assurances, and other Statements of Applicant/Grantee

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ACRONYMS

AFASS	Acceptable, Feasible, Accessible, Sustainable, and Safe
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
ANECCA	Regional Centre for Quality of Health Care/African Network for Care of Children Affected by HIV/AIDS
AOTR	Agreement Officer's Technical Representative
ART	Anti-Retroviral Therapy
BCC	Behavioral Change and Communication
CBD	Community Based Distributors
CBO	Community Based Organization
CBRHA	Community Based Reproductive Health Agents
CDC	Communicable Diseases Control
CHA	Community Health Agent
CHCT	Couple HIV Counseling and Testing
COP	Country Operational Plan
CTC	Community based Therapeutic Care
COTR	Contracting Officer's Technical Representative
CTX	Cotrimoxazole
EDHS	Ethiopian Demographic and Health Survey
EGLDAM	Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber
EID	Exposed Infant Diagnosis
EmOC	Emergency Obstetric Care
FANC	Focused Anti-natal Care
FDC	Fixed Dose Combination
FHD	Family Health Department
FMOH	Federal Ministry of Health
FP	Family Planning
FY08	Fiscal Year 2008.
GBV	Gender Based Violence
GFATM	The Global Fund for HIV, TB and Malaria
GFDRE	Government of the Federal Democratic Republic of Ethiopia
GOE	Government of Ethiopia
HAART	Highly Active Anti-Retroviral Therapy
HAPCO	HIV/AIDS Prevention and Control Office
HBCG	Home Based Care Givers
HC	Health Center
HCT	HIV Counseling and Testing
HCW	Health Care Workers
HCSP	HIV Care and Support Program
HDSP	Health Sector Development Program
HEP	Health Extension Package
HEW	Health Extension Workers
HIV	Human Immuno-Deficiency Syndrome
HMIS	Health Management and Information System
HP	Health Post
HTP	Harmful Traditional Practices
ICAP	International Center for AIDS Care and Treatment Programs (Mailman School of Public Health)
IEC	Information Education and Communication
IFHP	Integrated Family Health Project
IGA	Income Generating Activity
IMAI	Integrated Management of Adolescent and Adult Illnesses
IR	Intermediate Result

I-TECH	International Training and Education Center on HIV
ITN	Insecticide Treated Net
Jhpiego	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU-TSEHAI	Johns Hopkins Blumberg School of Public Health University-Technical Support for the Ethiopian HIV/AIDS ART Initiative
KOOW	Kebele Oriented Outreach Workers
LAM	Lactation Amenorrhea Method
LOE	Level of Effort
L10K	Last 10 Kilometers
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDT	Multi Disciplinary Team
MNCH	Maternal, Neonatal and Child Health
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSG	Mothers Support Group
OI	Opportunistic Infection
OVC	Orphan and Vulnerable Children
PC3	Children, Communities and Care (PC3) Program
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PPC	Post Partum Care
QI	Quality Improvement
RFA	Request for Application
RH	Reproductive Health
RHBs	Regional Health Bureau
SCMS	Supplies Chain Management System
sdNVP	Single Dose Nevirapine
SNNPR	Southern Nations and Nationalities and Peoples Region
SPS	Strengthening Pharmaceutical System
STI	Sexually Transmitted Infection
TA	Technical Assistant
TB	Tuberculosis
TBA	Traditional Birth Attendant
TDY	Temporary Duty
TOT	Training of Trainers
TTBA	Trained Birth Attendant
TWG	Technical Working Group
UCSD	University of California San Diego
UHEP	Urban Health Extension Package
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization

SECTION A – APPLICATION INSTRUCTIONS

PART I - PREPARATION GUIDELINES

Applications must be submitted not later than the date and time indicated on the cover page of this RFA, the location indicated on page 2 of the Cover Letter accompanying this RFA. All applications received by the deadline will be reviewed for responsiveness to the specifications outlined in these guidelines and the Selection Criteria presented in Section B. Section B addresses the technical evaluation procedures for the applications. Applications which are submitted late or are incomplete run the risk of not being considered in the review process. "Late applications will not be considered for award" or "Late applications will be considered for award if the Agreement Officer determines it is in the Government's interest."

Applications shall be submitted in two separate volumes: (a) technical and (b) cost or business application. If submitting a hard copy application, applications shall be submitted as follows: technical portions of applications in an original and 2 copies, and cost portions of applications in an original and 2 copy including both technical and cost applications on a CD ROM.

The application shall be prepared according to the structural format and organized according to the selection criteria set forth in Section B.

Applicants shall retain for their records one copy of the application and all enclosures which accompany their application. Erasures or other changes must be initialed by the person signing the application. To facilitate the competitive review of the applications, USAID will consider only applications conforming to the format prescribed below.

USAID/Ethiopia expects to award one cooperative agreement for a period of five (05) years. USAID/Ethiopia reserves the right to make any number of awards or none at all. Issuance of this RFA does not constitute an award commitment on the part of USAID, nor does it commit USAID to pay for costs incurred in the submission of an application.

Explanation to Prospective Applicants - Any prospective applicant desiring an explanation or interpretation of this RFA must request it in writing on/before due date designated for questions (see cover letter) to allow a reply to reach all prospective applicants before the submission of their applications. Oral explanations or instructions given before award of a Grant will not be binding. Any information given to a prospective applicant concerning this RFA will be furnished promptly to all other prospective applicants as an amendment of this RFA, if that information is necessary in submitting applications or if the lack of it will be prejudicial to any other prospective applicants.

PART II - TECHNICAL APPLICATION FORMAT AND CONTENT

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 B.

Application Contents: The technical application may contain the following sections, as more fully explained below: Cover Page, Table of Contents, Executive Summary, Technical Application/Applicant Program Description including an Illustrative Implementation Plan – First Year Annual Work Plan outline (detailed to be submitted within 30 days upon award) and Monitoring and Evaluation Plan, and Annexes (Curriculum Vitae/Resumes, Past Performance References, and Letters of Commitment from implementing partners, if any). The technical application may not

exceed 30 pages in length, on A4 size paper exclusive of the annexes (curriculum vitae/resumes, past performance references, and letters of commitment from any implementing partners).

A Technical Evaluation Committee will evaluate the technical applications in accordance with the evaluation criteria in Section B. The format for the technical application is the following:

1. Cover Page:

Include proposed Project title, “**Community PMTCT, USAID/Ethiopia RFA # 663-A-09-019**”, name of organization submitting application, authorized individual, telephone and fax numbers, e-mail, and physical address.

2. Executive Summary (no more than 3 pages):

This section shall allow technical reviewers to quickly understand 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.

3. Technical Application – Applicant’s PD (no more than 30 pages)

The technical application must provide an explanation of the proposed approach to continue to improve and meet the minimum results described in the Performance Indicators and Targets Section of the USAID Program Description and address the Technical Evaluation Criteria. This section shall include:

a. Proposed Program Approach

USAID/Ethiopia’s Office of Health, AIDS, Population and Nutrition requests applications to implement a set of activities designed to increase MCH/PMTCT uptake and mother and child case follow-up at the community level. This will involve increasing community-based MCH/PMTCT services; creating awareness about MCH/PMTCT services among the community; strengthening community mechanisms to support MCH/PMTCT; and enhancing MCH/PMTCT service linkages.

The main program goal is to increase MCH/PMTCT service uptake and case follow-up through the provision of PMTCT services at the community level.

The guiding principles of this project are to build a program that:

1. Integrates and strengthens MCH, FP, and PMTCT services at public sector sites;
2. Complements and supports overall government and other donor programs;
3. Enhances PEPFAR and USAID investments in MCH and other health systems;
4. Strengthens the capacity of local institutions; and
5. Improves the coordination and planning of stakeholders at the regional, zonal and woreda levels for increased service coverage and support for community based HEWs and volunteers.

In keeping with the recent GOE efforts to integrate PMTCT into mainstream Maternal and Child Health, prospective applicants should propose to focus primarily on PMTCT but as part of a bigger MCH component. The successful applicant is expected to work with the Regional Health Bureaus and federal Government, primarily at the Health Post level and with Urban Health Extension Workers. In addition to urban HEW, the program may work with other cadres of health providers, such as Community Based Reproductive Health Agents (CBRHAs), Community Health Agents (CHAs), Trained traditional birth attendants (TTBAs), Community Based Distributors (CBDs), Home Based Care Givers (HBCGs), KOOWS, Iddirs (Social support mechanism for bereavement) and other community health workers as further outlined in this RFA.

In reviewing the application, the evaluation committee will more specifically look at the following:

- Logic, coherence and feasibility of the overall plan to achieve expected results;
- Understanding of the Ethiopian health sector, successes, constraints, institutions, programs, opportunities, and the required interventions that will significantly impact service delivery;
- Clarity of proposed approach and explanations on how it will contribute to: (a) achieving the results, including how the proposed interventions will maintain and build on prior and current successes of the USAID and PEPFAR supported HIV/AIDS and health programs; (b) build on the current work by the Ministry of Health, other USAID partners, other donors, local NGOs and health facilities to create synergy;
- Specific, measurable, results outlined to demonstrate significant program impact;
- Development of a plan that clearly shows number of Health Centers to provide direct services in, number of UHEWs and cities to work in and number of rural HEWs and woreda's to be served per project region;
- Proposed innovative pilot studies and a pre-service component;
- Proposed follow-up of mother and child in the community;
- Proposed strategy to ensure sustainability of the process after the project, through ability to hand over program management to various RHB and or CBOs by the third year of program implementation; and demonstration of how men would be involved more in PMTCT.

b. Coordination with others' previous experiences:

It is strongly requested that Applicants share best practices from their previous experiences and areas of expertise and look for outside expertise in 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/Ethiopia urges applicants to link with other USAID funded initiatives in health and nutrition, education, democracy and governance wherever possible and with other donors 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. Proposed staffing pattern

The USAID is expecting a well articulated staffing pattern reflecting the maximum proportion of Ethiopian management and technical officers to manage and implement the program, and will look at: expatriate residential staff proposed, possessing strengths and skills that cannot be found among available Ethiopian professionals; names and bio-data for proposed key personnel as well as major responsibilities that key personnel will have under this activity; the proposed staff have demonstrated success in delivering technical assistance, in working in collaboration with host country governments and partner organizations, and demonstrated expertise in managing the administrative and financial aspects of a complex program; the roles and responsibilities of consortium partners (if applicable) are clear and demonstrate appropriate delegation of authorities; the proposed staffing plan reflects demonstrated expertise and coverage for the range of comprehensive MCH/PMTCT components as required in the program description; description of the performance monitoring plan including specific indicators for each result and the appropriate systems required to monitor outcomes of the project; feasibility of proposed lines of communication, responsibilities and planned procedures to ensure the highest quality coordination and collaboration with the federal, regional and local governments and health partners; and a transition and mobilization plan from current health programs clearly articulated.

d. Management Plan/Implementation Schedule – Partners Roles & Responsibilities

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 Program. The management plan must include descriptions of the following elements:

- Participating Organizations - Proposed prime organization, other organizations, if any, and their relationships shall be clearly described. This shall include a description of the comparative advantage that each organization brings to this activity. Applications proposing a consortium or joint-venture-like mechanism rather than a prime/sub need to include a description of the management procedures to be followed regarding each member, and what operational arrangements for coordination with USAID/Ethiopia and other institutional partners will be made. Note that the USAID will only commit to a bilateral relationship so consortium and joint-venture arrangements must designate (authorize) one legal entity/individual able to bind all partners in the offer to the Government;
- Organizational Structure - Proposed overall staffing plan and organizational chart indicating the organization planned for the field (including any proposed sub-recipients) and headquarters. 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. Identify by title and name each position to be supported under the Program for the field office, as well as for any support staff based abroad. To comply with USAID/Ethiopia's commitment to use existing local capacity to the greatest extent possible, the implementer will hire local staff for its field offices. Detailed description of the credentials, skills, prior successful experience and accomplishments of proposed key personnel must be provided. 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 which will address the following:
 - i. 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 program. Applicants must include as part of their 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 3-4 years.
 - ii. 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.
- Backstopping According to desired results the Application shall describe regional and/or headquarters resources that will be made available to ensure maximum technical and administrative support.
- 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 showing when field staff will be mobilized in Ethiopia, as well as the start up of field office(s). 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 30 days of the award. USAID will request a series of lessons learned presentations be given twice a year to USAID, Federal Government of Ethiopia, and donor working group on achievements to date that can be replicated and expanded. It is also expected that two briefing papers will be presented throughout the course of the project highlighting implementations achievements, failures and successes.

e. Gender Considerations

USAID/Ethiopia 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 women's participation at the community and national level by providing them with equal access to and control over resources and mainstream the issue at different levels. Program interventions which focus on the improvement of women's capital will increase livelihood opportunities for women and households in general. Accordingly, USAID/Ethiopia requests applicants to demonstrate how gender mainstreaming will be implemented and gender inequality is addressed within the context of the program.

f. USAID Disability Policy Consideration

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

USAID therefore requires that the recipient of any award 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 applicant shall demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

4. Annexes - Past Performance

The U.S. Government will evaluate the quality of the applicant's past performance. This evaluation is separate and distinct from the Agreement Officer's responsibility determination. The assessment of the applicant's past performance will be used to evaluate the relative capability of the applicant and other competitors to successfully carryout the program. Past performance of significant and critical subs and other types of partnership in applications will be considered to the extent warranted by their involvement in the proposed effort.

Applicants must provide a list of Federal awards (prime contracts and grants) active in the last 3 to 4 calendar years. Include at least one reference (e.g. name, title, organization name, phone and fax number, and email address) for each award. Performance as a subcontractor and/or sub grantee may also be provided with contact (reference) information of a knowledgeable representative from the prime and the U.S. Federal agency –cognizant technical office(r). The U.S. Government reserves the right to obtain information for use in the evaluation of past performance from any and all sources outside of the U.S. Government. Applicants lacking relevant past performance history will receive a neutral rating for past performance.

The Evaluation-Selection committee will review more specifically the following:

Reported quality of product service, including consistency in meeting goals and targets; timeliness of performance, including 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; effectiveness of key personnel, including appropriateness of personnel for the job and prompt and satisfactory changes in personnel when problems with clients where identified; business relations, addressing the history of professional behavior and overall business-like concern for the interests of the customer, including coordination among grantees, subcontractors and

developing country partners, cooperative attitude in remedying problems, and timely completion of all administrative requirements; cost control, including forecasting costs as well as accuracy in financial reporting; and customer satisfaction with performance, including end user or beneficiary wherever possible.

PART III - COST APPLICATION AND FORMAT

The Cost or Business Application is to be submitted as separate document/package from the technical application. Certain documents are required to be submitted by an applicant in order for an Agreement Officer to make a determination of responsibility. However, it is USAID policy not to burden applicants with undue reporting requirements if that information is readily available through other sources.

NOTE: The Total Estimated Amount to undertake this program over the next five (05) years is \$30 million in “core” funding.

The following sections describe the documentation that applicants for Assistance awards must submit to USAID prior to award. While there is no page limit on the Financial Plan/Business Management Application, applicants are encouraged to be as concise as possible, but still provide the necessary detail to address the following:

- A. A copy of the applicant's business/cost application on a compact disk, formatted in Excel.
- B. Present the summary budget by year for proposed activity including uses of USAID funds and any other cost share. Clearly indicate the applicant's commitment to match funds separate from other donor support. The portion of this matching fund which will qualify as cost-share under 22 CFR 226.
- C. Include a detailed budget, in US dollars, with an accompanying budget narrative in MS Word which can facilitate USAID's determination that costs are allowable, allocable and reasonable. The budget must be submitted using Standard Form 424 and 424A which can be downloaded from the USAID web site: http://www.usaid.gov/procurement_bus_opp/procurement/forms/sf424/
- D. Required certifications and representations (as attached) are required for the prime and sub-recipients.
- E. A copy of current Negotiated Indirect Cost Rate Agreement (NICRA) if any is required for the prime and sub-recipients.
- F. Applicants who do not currently have a NICRA with a cognizant USG agency also submit the following information:
 1. The applicant's financial reports for the previous 3-year period, which have been audited by a certified public accountant or other auditor satisfactory to USAID;
 2. Budget, cash flow and organizational chart; and
 3. A copy of the organization's accounting manual.
- G. Applicants shall submit any additional evidence of responsibility deemed necessary for the Agreement Officer to make a determination of responsibility. This information is required for the prime and sub-recipients.
- H. Applicants shall submit any additional evidence of responsibility deemed necessary for the Agreement Officer to make a determination of responsibility. The information submitted shall substantiate that the Applicant:
 1. Has adequate financial resources or the ability to obtain such resources as required during the performance of the award;
 2. Has the ability to comply with the award conditions, taking into account all existing and currently prospective commitments of the applicant, nongovernmental and governmental;
 3. Has a satisfactory record of performance. Past relevant unsatisfactory performance is ordinarily sufficient to justify a finding of non-responsibility, unless there is clear evidence of subsequent satisfactory performance;
 4. Has a satisfactory record of integrity and business ethics; and
 5. Is otherwise qualified and eligible to receive a grant under applicable laws and regulations (e.g., EEO).

- I. Applicants that have never received a grant, cooperative agreement or contract from the U.S. Government are required to submit a copy of their accounting manual. If a copy has already been submitted to the U.S. Government, the applicant shall advise which Federal Office has a copy.
- J. **Cost sharing** - Cost share is encouraged but not required.

PART IV – SPECIAL CONSIDERATIONS

IN ADDITION TO THE AFOREMENTIONED GUIDELINES, THE APPLICANT IS REQUESTED TO TAKE NOTE OF THE FOLLOWING:

- A. **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 art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.
- B. **Acknowledgement of Amendments to the RFA** - Applicants shall acknowledge receipt of any amendment to this RFA by signing and returning the amendment. The Government must receive the acknowledgement by the time specified for receipt of applications.
- C. **Preparation of Applications:**
 1. Applicants are expected to review, understand, and comply with all aspects of this RFA. Failure to do so will be at the applicant's risk.
 2. Each applicant shall furnish the information required by this RFA. The applicant shall sign the application and print or type its name on the Cover Page of the technical and cost applications. Erasures or other changes must be initialed by the person signing the application. Applications signed by an agent shall be accompanied by evidence of that agent's authority, unless that evidence has been previously furnished to the issuing office.
 3. 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, shall:
 - a. Mark the title 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, a grant is awarded to this applicant as a result of - or in connection with - the submission of this data, the U.S. Government shall have the right to duplicate, use, or disclose the data to the extent provided in the resulting grant. This restriction does not limit the U.S. Government's right to use information contained in this data if it is obtained from another source without restriction. The data subject to this restriction are contained in pages____;" and
 - b. Mark each sheet of data it wishes to restrict with the following legend:

"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this application."
- D. **Submission of Applications:**
 1. After you have sent your application by email, please immediately check your own email to confirm that the attachments you intended to send were indeed sent. If you discover an error in your transmission, please send the material again and note in the subject line of the email that it

is a "corrected" submission. Please do not wait for USAID to advise you that certain documents intended to be sent were not received, or that certain documents contained errors in formatting, missing sections, etc. Each applicant is responsible for its submissions, so please inspect your own emails.

2. Please do not send the same email to us more than one time unless there has been a change, and if so, please note that it is a corrected email. Multiple copies of the same email can make it difficult to know if there has been any change from one email to the next.

3. USAID prefers that the Applicant will appoint one person to send in the email submissions. If USAID receives email submissions from more than one person from the Applicant, it can make it difficult and USAID cannot tell whether there has been a change from one email to the next without considerable effort on our part.

4. If the application is sent by multiple emails, please indicate in the subject line of the email whether the email relates to the technical or cost application, and the desired sequence of multiple emails (if more than one is sent) and of attachments (e.g. "no. 1 of 4", etc.). For example, if the Applicant's name is ABXY Consulting, and the cost application is divided and being sent in as two emails, the first email shall have a subject line which says this clearly; otherwise USAID may not be sure of the correct order of the separate parts of the application. USAID's preference will be that each technical and each cost application be submitted as a single email attachment, e.g. that the Applicant need to consolidate the various parts of a technical application into a single document before sending it. But if this is not possible, please provide instructions on how the multiple parts are supposed to fit together, especially the sequence. What is obvious to the Applicant as the preparer of the document may not be obvious to USAID. The application may not get optimal treatment if USAID is confused regarding the order and composition of the application.

5. The hard copies of applications and modifications thereof shall be submitted in sealed envelopes or packages (1) addressed to the office specified in the Cover Letter of this RFA, and (2) showing the time specified for receipt, the RFA number, and the name and address of the applicant.

6. Faxed applications will not be considered.

E. Receipt of Applications - Applications must be received at the place designated and by the date and time specified in the cover letter of this RFA.

F. Award

1. The Government may award one or multiple Cooperative Agreement(s) resulting from this RFA to the responsible applicants whose application conforms to this RFA and offers the greatest value (see Section B). The Government may (a) reject any or all applications, or (b) accept other than the lowest cost application.

2. The Government may award Cooperative Agreement(s) resulting from this RFA on the basis of initial applications received, without discussions. Therefore, each initial application shall contain the applicant's best terms from a technical and business (cost) standpoint. However, as part of its evaluation-selection process, USAID may elect to discuss technical, cost or other pre-award issues with one or more applicants.

3. Applicants are reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts/sub-awards issued under this Agreement.

4. Foreign Government Delegations to International Conferences - Funds in this [contract, agreement, amendment] 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 [<http://www.info.usaid.gov/pubs/ads/300/refindx3.htm>.] or as approved by the Agreement Officer.

G. Authority to Obligate the Government: The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Cooperative Agreement may be incurred before receipt of either a fully executed Cooperative Agreement or a specific, written authorization from the Agreement Officer.

H. Environmental compliance: the Applicant will submit **An Initial Environmental Examination (IEE)** or appropriate environmental documentation for the proposed activities under this RFA in accordance with the USAID environmental regulation for approval, as follows:

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 implementers must comply with host country environmental regulations unless otherwise directed in writing by USAID. In case of conflict between host country and USAID regulations, the latter shall govern. No activity funded under this RFA will be implemented unless an environmental threshold determination, as defined by 22 CFR 216, has been reached for that activity, as documented in a Request for Categorical Exclusion (RCE), Initial Environmental Examination (IEE), or Environmental Assessment (EA) duly signed by the Bureau Environmental Officer (BEO). The implementers are therefore asked to submit an environmental management plan (EMP) which will permit USAID to make a threshold determination concerning the proposed activities. The EMP shall list the proposed activities under the RFA, identify their potential impacts, and suggest mitigative and monitoring protocols to ensure that environmental impact is duly considered and that monitoring and mitigation, as appropriate, will be implemented as the program goes forward. Recipient environmental compliance obligations under these regulations and procedures will be specified in the Cooperative Agreement.

J. Branding Strategy and Marking Plan

(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 brand mark, 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.** The Marking Plan will include the following:

- (1) A description of the public communications, commodities, and program materials that the recipient will produce 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, audiovisual 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) the 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.**

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 shall not be required.

(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.

SECTION B – SELECTION CRITERIA

The criteria presented below have been tailored to the requirements of this particular RFA. Applicants shall note that these criteria serve to: (a) identify the significant matters which applicants shall address in their applications, and (b) set the standard against which all applications will be evaluated. To facilitate the review of applications, applicants shall organize the narrative sections of their applications in the same order as the selection criteria.

The technical applications will be evaluated by a Technical Committee in accordance with the Technical Evaluation Criteria set forth below. Thereafter, the cost application of all applicants submitting a technically acceptable application will be opened and costs will be evaluated for general reasonableness, allowability, and allocability. To the extent that they are necessary, if an award is not made based on initial applications, negotiations will be conducted with all applicants whose applications have a reasonable chance of being selected for award. A Cooperative Agreement may be awarded to responsible applicant(s) whose Application(s) offer the greatest value, cost and other factors considered.

Awards will be made based on the ranking of applications according to the selection criteria identified below. To make an objective evaluation possible, applications must clearly demonstrate how the organization and the application meet these criteria. Applications shall address and will be evaluated based on the following categories.

Category	Maximum Point
1. Technical Approach	45
2. Personnel and Management Plan	40
3. Past Performance	15
Total points possible	100

PART I - TECHNICAL EVALUATION CRITERIA

A technical evaluation committee will evaluate applications based on the following criteria:

1. Technical Approach (45%)

Application will be assessed in using detailed instructions and criteria in Section A and will focus on:

- the extent of demonstrated understanding of the USAID program description,
- the quality of the overall design, and
- the comprehensiveness and effectiveness of the proposed technical approach.

2. Personnel and Management Plan (40%)

Application will be assessed in using detailed instruction and criteria in section A and will focus on:

- A well articulated staffing pattern reflecting the maximum proportion of Ethiopian management and technical contribution to the program implementation;
- The proposed staff have demonstrated success in delivering similar services for a complex program;
- the roles and responsibilities of consortium partners (if applicable) are clear and demonstrate appropriate delegation of authorities;
- Appropriate description of the performance monitoring plan including specific indicators for each result
- feasibility of proposed lines of communication, responsibilities and planned procedures; and
- clearly articulated transition and mobilization plan from current health programs

3. Past Performance (15%)

Applicant's capability will be assessed on the extent to which the application demonstrates successful experience in the areas described in the program description emphasizing an applicant's organizational, management, and technical actions under previous contracts, grants, or cooperative.

PART II - COST EVALUATION CRITERIA

Cost Effectiveness and Realism

Proposed costs will be analyzed for cost realism, reasonableness, completeness, and allowability in accordance with USAID's cost principles. In its analysis USAID will assess; Are the costs realistic for the effort? Do the proposed costs demonstrate that the applicant understands the RFA requirements, and are consistent with the applicant's technical application?

PART III - TECHNICAL VERSUS COST CONSIDERATION

For this RFA, technical evaluation is more important than cost.

Applicants will be ranked in accordance with the selection criteria identified above. USAID reserves the right to determine the resulting level of funding for the cooperative agreement.

END OF SECTION B –

SECTION C – PROGRAM DESCRIPTION

I. Purpose

The purpose of this program description is to define the parameters and objectives for a new Prevention of Mother to Child Transmission (PMTCT) program to improve the uptake and quality of HIV and Maternal Child Health (MCH) services for pregnant women in Ethiopia through community-based approaches. The overall goals of the program are to strengthen community systems and structures to improve the well-being of HIV positive pregnant women, their families and prevent the spread of HIV to their children. The program also aims to follow-up HIV exposed babies and HIV positive mothers to ensure they receive appropriate care and treatment.

II. Background

Ethiopian Context

Ethiopia has the second largest population in sub-Saharan Africa with over 77 million people; 85 percent live in rural areas and approximately one-fifth are aged 15 – 24 years. The average woman in Ethiopia gets married at age 16.5. She has her first birth at age 19 and has an average of 5.4 children during her lifetime, according to results from the 2005 Ethiopia Demographic and Health Survey (EDHS). Most women want to either limit or space their childbearing at some point during their lives. Yet, only 15 percent of currently married women were using any method of family planning. The unmet need for family planning remains high at 34 percent of married women.

Pregnant women in Ethiopia face many challenges during pregnancy, delivery, and post-partum. Women's limited independent decision making, Gender-Based Violence (GBV), and limited male involvement restricts their access to Family Planning (FP) and Maternal, Newborn and Child Health (MNCH) services, which in turn negatively impact women's Reproductive Health (RH).

Findings of a Baseline Survey done by EGLDAM indicate that there are a number of harmful traditional practices (HTP) that are specifically directed at women, such as female genital mutilation, early marriage, marriage by abduction, shaking a woman after delivery, food discrimination, bleeding after expulsion of the placenta, massaging the abdomen in labor and drastic measures to enhance expulsion of the placenta.

Ante-Natal Care (ANC) and Post-Partum Care (PPC) use is low. Only 28% of pregnant women attend one ANC visit and only 7% of women deliver with the assistance of a skilled birth attendant. (2005, EDHS). Ethiopia also faces a shortage of emergency obstetric and newborn care services, including post-abortion care. The National Reproductive Health Strategy lists poor access, weak referral systems, limited human resources, and shortages of supplies and equipment as major problems contributing to low uptake of ANC services.

High fertility rates and early and late childbearing also contribute to Ethiopia's high levels of maternal mortality (673/100,000 live births), neonatal mortality (39/1,000), infant mortality (77/1,000), and under-five mortality (123/1,000). Mortality levels have however been steadily decreasing. The MMR for the period 1994 – 2000 was 871/100,000 live births, neonatal mortality was 49/1,000 and under five mortality was 166 per 1,000 live births. Despite this positive trend, there are still a number of health-related issues such as malaria, malnutrition, and HIV that are putting a serious strain on Ethiopia's weak health care system. Current estimates of the medical workforce include: 1,963 physicians, 2,307 health officers (clinical and public health), 18,146 nurses, 1,012 midwives, and 24,200 Health Extension Workers.

Despite the concerted efforts by the Government of Ethiopia (GOE) and development partners to increase access to Antenatal Care (ANC), delivery and Postnatal Care (PNC) services, utilization still remains low. There are an estimated 2,753,434 births annually according to the 2007 Health and Health Related Indicators. Out of this number an estimated 28% of mothers received antenatal care from health professionals and 6% of women delivered at a health facility.

The first two cases of HIV infection were reported in 1986, after which the disease spread at an alarming rate. The prevalence rate was 7.3 percent in 2000, then declined to 3.5% percent by 2005 after concerted prevention efforts. A national HIV/AIDS policy was approved in 1998 aimed at providing an enabling environment for prevention of HIV and to mitigate the impact of AIDS. The National HIV/AIDS Council was established in 2000 under the aegis of the President's Office and in 2001 they declared HIV a national emergency and launched the Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2001 - 2005.

In 2002 the Government identified HIV and AIDS as a crosscutting issue in the 2002 Sustainable Development and Poverty Reduction Program (SDPRP). This landmark decision widened the scope of HIV interventions within the broad elements of the development framework and gave rise to the need to establish a body that would coordinate all sectors HIV and AIDS responses, as well as the activities of all development partners. The federal HIV and AIDS Prevention and Control Office (HAPCO) was set up in 2002, coinciding with the endorsement of the national strategic framework. Following HAPCO's establishment, major activities included the formation of the donor forum, the endorsement of the Ethiopian Strategic Plan for intensifying the Multi- sectoral HIV/AIDS Response for the period 2004 – 2008 and the coordination and scale-up of antiretroviral therapy (ART) from 2003 onwards.

According to calibrated single point estimates (2007), the national adult HIV prevalence is reported to be 2.3% (7.7% in urban and 0.9% in rural areas). 977,394 Ethiopians are living with HIV/AIDS (41% males, 59% females): an estimated 79,183 HIV positive pregnant women delivered a child in 2008 in Ethiopia (GOE Single Point Estimate). In the same year, there were an estimated 14,093 new infant HIV infections. The GOE reported that only 1,885 infants received prophylaxis between July 2007 and March 2008. In addition, there is poor follow-up of mother/baby pairs for the mothers that test HIV positive.

HIV continues to spread in Ethiopia and the highest prevalence occurs in the 15 – 24 age group and prevalence is higher among females than males in both urban and rural areas. Prevalence appears to have leveled off in urban areas but continues to rise in rural areas where 85% of the population lives. According to the 2005 ANC Surveillance data, 3.5% of pregnant women were HIV positive. The estimated national adult prevalence for 2009 is 2.3% (Single Point Estimate). For the pregnant women who do learn their HIV status during pregnancy or labor, many never return to the health facility for postpartum care and follow-up. Those that do return often encounter a shortage of trained staff, shortage of basic opportunistic (OI) drugs, poor infrastructure, lack of other reproductive health services, no referrals to community support services, and poor infant diagnosis capabilities. Other constraints include stigma, discrimination, low levels of knowledge about PMTCT services, and low male involvement. There is much to be done in Ethiopia to help improve pregnant women's access to ANC, Family Planning, HIV Counseling & Testing, and ART services for themselves and their families.

In Ethiopian communities, households and families play the most significant role in caring for a sick family or extended family member. Although families most often assume the ultimate responsibility of caring for PLWHA, they face considerable difficulties in providing care given the poverty level throughout the country and the limited ability of most households to withstand such shocks. Families are the primary source of all health-related behaviors, including HIV prevention, though to date most prevention and care activities do not utilize intergenerational social networks.

Family involvement is most likely to occur when interventions are targeted at the family unit and key messages are reinforced through a variety of means: social and cultural networks, religious and other leaders, and personal relationships, including parents, grandparents, and peers. Acknowledgement of power dynamics and social influence in society can strengthen results by involving respected and influential individuals such as village elders, religious leaders, traditional healers and birth attendants. Their engagement is critical to making HIV/AIDS a topic for community discussion.

The main causes of stigma towards HIV/AIDS in Ethiopia relate to insufficient and inaccurate HIV/AIDS knowledge; fear of death and diseases; sexual norms that discourage discussions about sex and sexuality; attitudes that associate HIV infection to loose morality, shame and blame, sin and punishment; and a lack of recognition of stigma. It is widely believed that responses to prevention would improve significantly if leaders of society spoke out publicly about the behavior changes required for prevention and demonstrated their commitments through actions, such as being tested for HIV at public events and caring for HIV/AIDS patients. Throughout all segments of society, dialogue on prevention, VCT uptake and care would be enhanced with the reduction of stigma. Higher education, wealth, and urban residence are related to more accepting attitudes towards those who are HIV positive. The Ethiopia DHS 2005 shows that among men, for example, the percentage expressing accepting attitudes towards those living with AIDS is high (exceeds 40 percent) among urban residents, those with a secondary or higher education, and those living in Addis Ababa, Dire Dawa or Harari. Among women, the percentage expressing accepting attitudes exceeds 40 percent among those with a secondary or higher education and those living in Addis Ababa and Harari.

Numerous studies have documented that for many Ethiopians the social isolation after disclosing a positive HIV sero status is considered more painful than the disease itself. The concept of "living positively" is at a nascent stage. A reduction in stigma must occur for increased testing uptake, adoption of the Preventive Care Package, and OI symptom and treatment, particularly TB.

The high level of stigma produces an insurmountable obstacle for most PLWHA to disclose their sero status. Families commonly expel HIV positive family members due to the fear of being infected themselves and the fear of being shunned by their neighbors and community. Gender relations in Ethiopia present particular challenges. The consequences for most HIV positive women, AIDS widows and their children are severe; women -- and frequently their children -- are "branded" by society, demeaned and cast out. They correctly fear rejection, including violence and abandonment, if they are perceived as bringing the virus into the household. Property and inheritance rights for widows and children are frequently disregarded.

Throughout Ethiopia, the burden of care disproportionately falls on females, regardless of age. Women are expected to care for sick members of the household, and young girls are much more likely than their brothers to be withdrawn from school for care giving and/or should household assets diminish, requiring a choice to be made between which siblings continue his/her education.

Furthermore, there are other practices that are degrading to women such as those related to 'woman and blood'. A woman who is bleeding either as a result of her menstrual period or after child birth is considered unclean or polluted and is not allowed to join in religious or social services such as entering the church (Orthodox Church) or carrying out the 'Solat' for Muslim women. Anyone entering a house where there is a woman who has given birth, and the woman herself, must undergo some cleansing ceremonies before they are accepted as clean. These practices ultimately affect women's self esteem and position them as inferior to men.

Ethiopian Health Care System

Health service delivery in Ethiopia is based on a four-tier health care system constituting four levels of health facilities with the assumption of functional networks between them. The primary health care unit, a network of one health center with five satellite health posts, is expected to provide clinical services for 25,000 and 1,000,000 people respectively. Specialized service will be availed at referral hospitals in all of the regions in the country. Following decentralization of health service in the country, even though the emphasis was on increasing coverage, quality of health care was also an issue addressed in Health Sector Development Program (HSDP). Health service delivery and quality of service is one of the components of HSDP. The private sector plays a significant role in health care delivery in Ethiopia. For instance, in 2002, the private for-profit sector employed 55% of the general practitioners, 65% of specialist and 79% of the laboratory technicians available in the country (FMOH 2006, PPM Implementation Guidelines). Despite the level of manpower available in the private sector, the cost of care remains a deterrent and as such, the government is still the main health care provider and financier particularly in the rural parts of the nation.

The organization and financing of health services in Ethiopia face serious challenges. Basic medical care is available only to 50 % of the population (within a 10 km walk) and existing services are often of poor quality. Per capita expenditure is very low at \$7.10 compared to the average \$12 per person in other sub Saharan African countries. Much of the health expenditure is believed to be out of pocket payment, which is estimated to constitute 31 % of total health expenditure. In terms of human resources and infrastructure the health sector faces equally daunting challenges. There are roughly a little less than 2000 doctors which gives the doctor to population ratio of 1:48,000. There are only limited tertiary public hospitals which are largely concentrated in bigger urban centers. The more affordable and cost effective public health care services at district and town levels are often underfunded and poorly managed. However, the GOE is committed to improving this status quo and has embarked on strategies to reverse the health situation including massive training of HEWs, building of new Health Posts in rural areas etc.

GOE Response to MCH/PMTCT and HIV/AIDS

The Ministry of Health is in the midst of a massive expansion of health facilities, aimed at increasing access to health services for the Ethiopian population. Plans are in motion for an increase from the current 700 health centers to a total of 3,153 by the end of 2010. This expansion will support Ethiopia in reaching its goal of universal access to primary health care services, including HIV/AIDS services.

The Accelerating Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map for 2007 – 2008/10 shapes the national response to HIV/AIDS and outlines the national priorities, targets, and strategies. The Road Map set a target of starting 397,539 individuals on ART by the end of 2010. Ethiopia also set a target of reaching 80% of HIV positive women by 2010. The Road Map can be found on the following website <http://www.etharc.org/>.

In the quest to attain these goals, the government, in collaboration with development partners, adopted a number of strategies to scale up PMTCT services in the country. National efforts to coordinate and scale up PMTCT services began in Ethiopia in 2000 following a PMTCT needs assessment. The first national PMTCT Guidelines were issued in 2001 and revised in 2007. Key strategies include increasing access to quality Maternal and Child Health (ANC, delivery, family planning, and PNC) services and increasing the number of PMTCT sites. As of March 2009, there were an estimated 944+ PMTCT sites in Ethiopia, a significant increase from the four original PMTCT pilot sites started in 2002.

The GOE through the BPR has transitioned the national PMTCT program from Federal HAPCO to the Family Health Department (FHD) of the Federal MOH. There is a national PMTCT TWG which supports the integration of PMTCT with MCH services. This group helped update the revised 2007 National PMTCT Guidelines which call for the provision of comprehensive PMTCT services, the integration of

PMTCT with MCH services, opt-out counseling and testing, and the use of more effective PMTCT prophylaxis and treatment regimens. The guidelines also emphasize that all eligible HIV-positive pregnant women should receive ART for their own health and those not eligible should receive combination prophylaxis beginning in the 3rd trimester. Single dose-Nevirapine should be used only where combination ARV drugs are not available, such as in remote villages.

The GOE recognizes that a comprehensive and effective response to HIV/AIDS requires multi-sectoral and multi-programmatic coordination across a range of programs that rely on a diverse portfolio of commodities and is committed to strengthening national logistics systems. Securing commodities for PMTCT programs necessitates strong supply chain management, resources, coordination and harmonization. The logistics system for drugs and other health commodities have been weak and ineffective in Ethiopia. It was characterized by multiple procurement systems, parallel uncoordinated distribution, frequent stock-outs, over supplies and expiries at times and a weak logistics management information system which critically impacted public health program outcomes. It was to solve these problems in the public pharmaceuticals supply system, that the Pharmaceuticals Fund and Supply Agency (PFSA) was established in September 2007. PFSA's core process encompasses four basic sub processes i.e. Forecasting & Capacity Building, Procurement, Storage & Inventory Management and Distribution. Recently FHAPCO led a national forecasting exercise, covering all HIV/AIDS programs (including PMTCT) and funding sources. All these efforts, is expected to result in a functional PMTCT logistics system that is integrated into the general HIV/AIDS system.

PEPFAR's Response to HIV/AIDS

In 2003, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) was launched to combat global HIV/AIDS - the largest commitment by any nation to combat a single disease in history. On July 30, 2008, the [PEPFAR Initiative](#) was reauthorized at \$48 billion over the next 5 years to combat global HIV/AIDS, tuberculosis, and malaria. With reauthorization, PEPFAR plans to strengthen progress to date and to expand its work, particularly in PMTCT and the integration of services. Through 2013, the PEPFAR Ethiopia team will contribute to plans to work in partnership with host nations to support treatment for at least 3 million people; prevention of 12 million new infections; and care for 12 million people, including 5 million orphans and vulnerable children. To meet these goals and build sustainable local capacity, PEPFAR agencies will support training of at least 140,000 new health care workers worldwide in HIV/AIDS prevention, treatment and care. For further information about the Emergency Plan, Applicants can consult the following websites: <http://www.state.gov/s/gac/> ; http://www.usaid.gov/pop_health/aids/ ; and <http://www.pepfar.gov> .

The PEPFAR Ethiopia program's PMTCT activities focus on improving service delivery through pre-service and in-service training, supportive supervision, provision of drugs and test kits, Mothers Support Groups (MSGs), and community outreach. Over a dozen PEPFAR implementing partners currently support PMTCT efforts in country.

As a result, PEPFAR Ethiopia achieved notable increases in the number of pregnant women who were counseled and tested and received antiretroviral prophylaxis for PMTCT. Nevertheless, Ethiopia remains one of the lowest performing PEPFAR countries in the area of PMTCT due to weak systems. As of March 31, 2009, PEPFAR supported PMTCT services in 944 health facilities. In FY08, the program trained 2,259 health workers in the provision of PMTCT which assisted the country in testing 214,160 pregnant women. That is a 92% increase from the FY07 achievement of 111,513 women tested. Of those pregnant women testing HIV positive, 5,290 received antiretroviral prophylaxis, up from 3,089 women the year before. These accomplishments can be attributed to a massive roll out of the revised national PMTCT Guidelines (July 2007) through improved in-service and pre-service training; an increase in community promotion and outreach; and a greater focus on monitoring and evaluation of activities.

PEPFAR PMTCT Indicators	FY07 Achievement	FY08 Achievement	Semi-Annual FY09 Achievement
Number of service outlets providing the minimum package of PMTCT services according to national and international standards	353	429	944
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	111,513	214,160	218,158
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	3,089	5,290	4,207
Number of health workers trained in the provision of PMTCT services according to national and international standards	3,097	2,259	2,926

To improve performance and to assist the Government of Ethiopia with its goal of achieving universal access by 2010, PEPFAR Ethiopia with its partners is building on select best practices to improve PMTCT services in Ethiopia. The best practices include the consolidation of opt-out rapid HIV testing at all ANC and delivery sites; optimizing ARV prophylaxis regimens and ART for eligible women; integration of PMTCT into routine ANC and delivery services; timely postnatal follow-up of infants; expansion of collaboration with the private sector; expansion of Mothers' Support Groups (MSG); enhanced family centered approaches to care and treatment; as well as primary prevention. PEPFAR is expanding wraparound activities in the areas of family planning (FP), TB and nutrition, leveraging non-PEPFAR funded resources and skills. There is an increased focus on linking facilities with the community level to improve access and support to PMTCT/MCH services.

PEPFAR is providing support to the GOE in the design and implementation of an integrated pharmaceuticals and health commodities supply and logistics system in country. The system envisages a full supply of safe, effective essential drugs and health commodities for PMTCT/MCH/FP, to all public facilities in Ethiopia. Currently there are three USAID funded projects supporting these efforts; SCMS, USAID/Deliver and SPS.

Highlighted below are a number of current PEPFAR-funded activities related to PMTCT:

Regional Centre for Quality of Health Care/African Network for Care of Children Affected by HIV/AIDS (ANECCA)

ANECCA works with the HIV/AIDS Care and Support Program and its partners to provide comprehensive HIV/AIDS services at GOE health centers to strengthen the capacity for rolling out pediatric HIV care and treatment services. Activities include: 1.) Refresher trainings and clinical mentoring in pediatric HIV care, treatment and psychosocial care and counseling, 2.) Review, strengthen, produce and improve utilization of relevant HIV job aides; 3.) Promote functional referral linkages between Civil Society Organizations, OVC programs, Community Based Organizations (CBOs) and pediatric HIV care facilities.

Capacity Project

The Capacity Project currently provides technical assistance, training, and supportive supervision at the health center level in Oromia, SNNP, Tigray and Amhara regions. The project aims to expand access to comprehensive MCH services including PMTCT services in health centers and scale up access to MSG. The project works with HEWs to strengthen PMTCT outreach, referral, and pediatric case detection. The program has also worked in a number of private sector health facilities to introduce PMTCT services in urban areas with higher HIV prevalence.

C-Change

In 2008, the C-Change Project began providing support to the FMOH by bringing a mix of skills, experience, and creativity to the design and implementation of high impact health communication strategies. The goal is to integrate mass media, interpersonal communication, and community engagement to empower Ethiopian families to take malaria-related and ANC/MCH actions that will improve their health status. C-Change will streamline formative research and pre-testing methods, and create easy-to-use, front-line teaching tools and short skills-based training that can be managed by woreda and kebele level teams.

HIV/AIDS Care and Support Program

The HIV Care and Support Program's (HCSP) covers predominantly urban & peri-urban settings reaching out from health centers to health posts through outreach volunteers in coordination with Health Extension Workers, Peace Corps and other community agents for social mobilization activities. The program works to develop stronger linkages between PMTCT, ART, IMAI, and palliative care programs as well as improve the functionality of referrals and the continuum of care for HIV+ individuals at all levels. HCSP provides technical assistance and related monitoring and evaluation support to RHBs, case managers, Kebele-Oriented Outreach Workers (KOOWs), and Woreda and health center teams.

Integrated Family Health Program

The Integrated Family Health Project (IFHP) is a USAID Ethiopia five year bilateral program that began in June 2008. IFHP focuses on family planning; reproductive health; maternal, newborn, and child health, including malaria and PMTCT. The project aims to support the Government of Ethiopia's Health Extension Program in 284 rural woredas in Amhara, Oromia, Tigray, SNNPR, and some woredas in Addis Ababa and Benshangul.

UNIVERSITY PARTNERS –

- University of Washington (I-TECH)
- Columbia University (ICAP -CU)
- Johns Hopkins University (JHU -TSEHAI)
- University of California at San Diego (UCSD)
- Johns Hopkins University, Center for Communication Programs (JHPIEGO)

Through these partners, PEPFAR supports several hospital networks and the military to provide PMTCT services in Dire Dawa, Harari, Oromia, Somalia, Benshangul-Gumuz, Afar, Gambella, Tigray, SNNPR and Amhara regions. These programs support regional health bureaus to build PMTCT program management capacity at regional level and ensure sustainability. Activities engaged in range from supporting PMTCT advisors in the Regional Health Bureaus to assisting in the scale-up, integration, coordination, quality assurance and oversight of PMTCT program. The program also supports Mothers' Support Groups and Prevention with Positives activities for HIV+ pregnant mothers.

Last 10 Kilometers (L10K)

PEPFAR strengthened its support for the GOE's new Urban Health Extension Program (UHEP), which will place over 5,200 newly trained nurses in urban, high HIV prevalence areas to provide HIV prevention

and care services as well as education and referrals to other health services. USAID leveraged a \$7.3 million Bill and Melinda Gates Foundation grant for the L10K Program to support the GOE's program to scale-up the UHEP. PEPFAR support focuses on preventing new HIV infections through outreach into homes, referrals for voluntary couples' counseling and testing (CHCT), diagnosis and treatment of sexually transmitted infection, addressing TB/HIV co-infection and engaging communities to improve health seeking behavior.

Positive Change: Children, Communities and Care (PC3) Program

This Orphans & Vulnerable Children program provides nutritional support through a community based therapeutic care (CTC) approach to HIV-affected OVC and pregnant and lactating women. Currently the program works with 55 health facilities which have treated over 5,600 severe acute malnourished children. This activity represents a partnership with the MOH, World Food Programme, UNICEF and the Clinton Foundation.

President's Malaria Initiative (PMI)

Ethiopia is also one of the 15 focus countries benefiting from the PMI. The goal of this initiative is to reduce malaria-related mortality by 50% in each of the focus countries. In Ethiopia, the initiative will focus on Oromiya region and will include support for the implementation of proven preventive and therapeutic interventions, including artemisinin-based combination therapies; insecticide-treated bed nets (ITNs) and indoor residual spraying. In regards to FP/MNCH, activities under the PMI will support the improvement of facility and community-based antenatal, safe motherhood and adolescent health activities as they relate to malaria, e.g. antenatal care services (ANC) will be an avenue for educating mothers and their families on early disease recognition, appropriate malaria treatment and use of ITNs.

Reproductive Health and Family Planning (RH/FP)

USAID is supporting RH/FP programs through the RH/FP Project and other partners to expand access to and use of quality RH and FP services in the Amhara, Oromia, SNNPR and Tigray regions. USAID supports national level advocacy and policy in RH and contraceptive security and the expansion of services to urban and remote, hard-to-reach rural populations. Major areas of support include:

- Expanding RH/FP services, including the types of contraceptive methods offered, to over 237 urban and rural districts through 48 implementing partner organizations, focusing on community-based counseling and distribution of family planning methods through 10,000 community-based RH agents;
- Upgrading clinical services of public- and private sector providers for long-term and permanent methods and post-abortion care;
- Linking FP and HIV/AIDS services at voluntary counseling and testing centers as well as service sites for the prevention of maternal to child transmission of HIV;
- Providing RH/FP services in the workplace and in the market place;
- Training youth peer-educators to provide RH services and HIV/AIDS prevention counseling;
- Identification and referral for obstetric fistula treatment;
- Helping to improve the contraceptive logistics system of the country; and,
- Promoting the reduction of harmful traditional practices such as female genital cutting, rape, abduction, early marriage and wife inheritance.
- Male involvement on PMTCT and FP/RH
- Linking FP for positives
- Strong emphasis on PNC and FP for positives

Other Donor's Efforts in PMTCT

Clinton Foundation

The Clinton Foundation is changing the economics of HIV/AIDS care and treatment by applying business principles to lower the cost of lifesaving tests and medicines and by helping governments scale up

programs, to ensure that high-quality care and treatment reaches underserved populations. In Ethiopia, the foundation works in the areas of Hospital Management, Pediatrics, Laboratory Services and Procurement and Supply Chain Management.

The Global Fund for HIV, TB and Malaria

The GOE has secured \$1.7 billion in approved funding from GFATM to address HIV/AIDS, Malaria, and TB, the largest GFATM recipient in the world. Seventy five percent of this funding is for HIV/AIDS. The USG participates on the GFATM Country Coordinating Mechanism, has signed a Memorandum of Understanding to guide joint action and has developed a joint action plan to coordinate PEPFAR and GFATM-funded activities.

UNICEF

UNICEF played a leading role in launching and rolling out PMTCT in Ethiopia. In 2003, UNICEF supported the first implementation of PMTCT services outside Addis Ababa within four initial hospital sites and their satellite health centers. UNICEF supported the GOE's development of a national guideline on PMTCT and on clinical management of HIV infection in children and adults. UNICEF, in collaboration with the MOH and HAPCO, supported pre-training assessments; the procurement of drugs, equipment, and supplies; and PMTCT orientations for health facility staff. With the technical support of UNICEF, communities initiated community mobilization and advocacy projects to help increase HIV/AIDS awareness and partner testing. UNICEF integrated their Safe Motherhood and PMTCT programs, to offer a comprehensive PMTCT/MNCH/SRH program in Ethiopia.

UNHCR

Through support from PEPFAR, UNHCR works to provide HIV services, including PMTCT, for refugee populations and communities surrounding the camps. In 2007 UNHCR initiated PMTCT services through its existing VCT program by delivering single-dose Nevirapine to pregnant mothers in the camps and providing referrals for treatment in regional hospitals. UNHCR expanded services to include the training of midwives and traditional birth attendants (TBA) on safe delivery and infant feeding; training of counseling and testing staff in testing of all pregnant women presenting at antenatal sites; training of health clinic staff in provision of PMTCT treatment; and provision of psychosocial services for mothers testing positive for HIV.

WHO

The World Health Organization's (WHO) Ethiopia Country Office provides technical assistance to FHAPCO/FMOH and RHBs in the area of PMTCT. The areas of focus include, but are not limited to, the development of: 1) Evidence-based national policy directions, normative case-management guidelines and strategic planning frameworks; 2) Implementation guides, training curricula/materials/tools: e.g. in collaboration with other international partners (including USAID, CDC, UNICEF). WHO led the development of the current draft national PMTCT Implementation Guide as a member of the National PMTCT TWG; 3) Operations research, M&E and surveillance. WHO led the National PMTCT Situation Analysis exercise in response to the request by FMOH for a definitive assessment to address PMTCT scale-up challenges; 4) Health system and human resource capacity on all the above; including strengthening federal and sub-national health authorities (RHBs, zonal & woredas health offices) capacity to implement, assess and address the above. WHO assigns staff and experts to work with national and regional authorities in implementing and rolling-out the above technical assistance, including conducting trainings, regional analysis, and supportive supervision.

There have been several country wide PMTCT and Pediatrics evaluations conducted in the last year in Ethiopia. These include:

- PMTCT/MNCH Situational Analysis Focusing on Integration of Services, Family Health Department, Technical Assistance by WHO Ethiopia, February 2009;

- USG PEPFAR Ethiopia PMTCT Portfolio Review and Recommendations Report, July 21 – August 1, 2008;
- ANECA Ethiopia Pediatric HIV Assessment Report, September 1 - 6, 2008

These reports provide additional background information and can be found in the Annex to this solicitation.

III. COMMUNITY PMTCT PROGRAM

Overview

It is against the above background that USAID/Ethiopia proposes to initiate this project to increase MCH/PMTCT uptake and mother and child case follow-up at the community level. This will involve increasing community-based MCH/PMTCT services; creating awareness about MCH/PMTCT services among the community; strengthening community mechanisms to support MCH/PMTCT; and enhancing MCH/PMTCT service linkages.

The main program goal is to increase MCH/PMTCT service uptake and case follow-up through the provision of PMTCT services at the community level.

There are four primary program objectives below with the expected level of effort (LOE) indicated in parenthesis.

Objective 1: To build the capacity of regional health bureaus, zonal and woreda health offices and Community Based Organizations (CBO), to support and manage community-based PMTCT services (15% LOE)

Objective 2: To increase access to MCH/PMTCT services through providing facility and community services; and improving bi-directional linkages/referrals between PMTCT/MCH services at the community, health post, health center and hospital level. (35% LOE)

Objective 3: To increase demand for MCH/PMTCT services through community outreach (30% LOE)

Objective 4: To improve the quality of community and facility -based MCH/PMTCT services (20% LOE)

The guiding principles of this project are to build a program that:

1. Integrates and strengthens MCH, FP, and PMTCT services at public sector sites;
2. Complements and supports overall government and other donor programs;
3. Enhances PEPFAR and USAID investments in MCH and other health systems;
4. Strengthens the capacity of local institutions; and
5. Improves the coordination and planning of stakeholders at the regional, zonal and woreda levels for increased service coverage and support for community based HEWs and volunteers.

Thus far, PEPFAR programs have strengthened health systems at the community, clinic, regional and national levels. PEPFAR partners have worked in the communities, forming health committees and training local health workers to promote HIV prevention, Home-based care and ART adherence. At treatment sites, PEPFAR partners have renovated clinics, stocked pharmacies, equipped laboratories, and recruited and trained case managers, pharmacists, outreach workers and lab technicians. Whilst building on these successes, the Community PMTCT program should pilot innovative and promising practices.

In keeping with the recent GOE efforts to integrate PMTCT into mainstream Maternal and Child Health, prospective applicants should propose to focus primarily on PMTCT but as part of a bigger MCH component. The successful applicant is expected to work with the Regional Health Bureaus and federal Government, primarily at the Health Post level and with Urban Health Extension Workers. In addition to urban HEW, the program may work with other cadres of health providers, such as Community Based Reproductive Health Agents (CBRHAs), Community Health Agents (CHAs), Trained traditional birth attendants (TTBAs), Community Based Distributors (CBDs), Home Based Care Givers (HBCGs), KOOWS, Iddirs (Social support mechanism for bereavement) and other community health workers.

Geographic Scope and Implementation Levels

The successful applicant will work primarily at the health post and surrounding community levels in higher HIV prevalence areas. The program will also work at selected health centers, especially as the new Urban Health Extension Program (UHEP) will be coordinated at the health center level. The Community PMTCT program will work in Tigray, Amhara, Oromia, SNNPR and Addis Ababa. These five regions have a total of 654 health centers and 4,735 health posts, broken out respectively - Tigray (40/650), Amhara (171/1398), Oromia (242/1412), SNNPR (177/1275), and Addis Ababa (24; 0). Currently USAID/Ethiopia supports PMTCT services in 944 public and private health centers in these five regions, of which 644 provide HCT and 300 ART. These regions are considered high yield as they accounted for 2,683,553 out of 2,951,021 nationally expected pregnancies in 2008. These regions also have a low percentage of deliveries attended by a Skilled Birth Attendant - Tigray (11.7%), Amhara (16.7%), Oromia (16.7%), SNNPR (48.5%), and Addis Ababa (43.6%) against a national average of 23.2%.

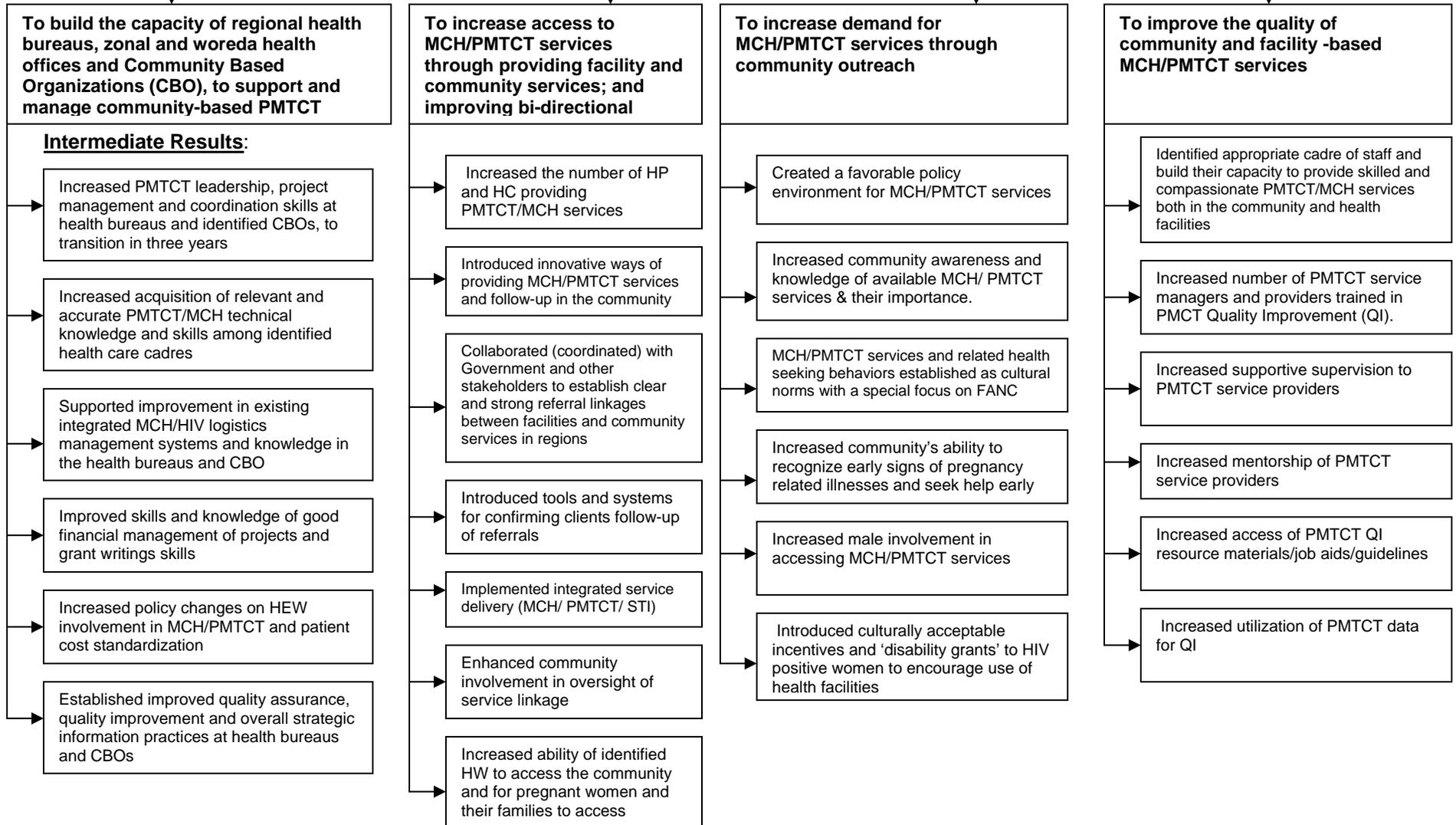
Note that no private sector facilities should be proposed for this RFA.

Project Framework

Goal:

To increase MCH/PMTCT service uptake and case follow-up through the provision of PMTCT services at the community level.

Objectives:



Below is a description of the different implementation levels in which the Community PMTCT Program would be expected to work.

Health Post

The MOH plans to increase the number of health posts to 15,000 by 2010. The GOE launched a new program for 'Accelerated Expansion of Primary Health Care Coverage' with the health extension program (HEP) as its centerpiece. Each health post is run by two Health Extension Workers (HEWs) and serves approximately 5,000 people. Health extension workers (HEW) have been posted both in functional and non-functional HPs. In kebeles without a HP building, they often work from the kebele administration office. The structure and size of HPs vary; some are built with standard cement block with corrugated iron roof and cement floors. Others are made of wood and mud and may have up to 4 rooms. The HPs should have water and hand washing facilities, but unfortunately not all do. HPs are also suppose to be equipped with birthing kits, anti-malaria drugs, Oral Rehydration Salt, and anti-parasitic drugs, but are often limited in their supplies of equipment and drugs.

Health Extension Program

The GOE created the cadre of HEWs in 2003 and by the end of 2007 had trained more than 17,600 HEW. Currently, there are an estimated 30,000 HEWs in Ethiopia. According to the HEW job description, the position should spend 25% of the time in the health posts and the other 75% in the community. The HEWs provide antenatal care, delivery, immunization, growth monitoring, nutritional advice, and family planning and referral services to the general population. In terms of HIV/AIDS, HEWs are expected to provide HIV education; psychological support; HIV counseling; PMTCT; patient care during home visits; ART adherence counseling; individual or group treatment support; referrals of complicated patients; and defaulter tracing. HEWs play a vital roll in supporting the national goal of having a health care system that gives comprehensive, integrated primary health care at the community level emphasizing on disease preventive care to reach the MDG.

The FMOH and RHBs are in the process of scaling up the new Urban Health Extension Program (UHEP). PEPFAR fully supports these task sharing efforts. Currently, the GOE plans a national review of the existing HEW Implementation Guideline, Training Manual and Urban HEP Package. Subsequently, the GOE plans to conduct a national three-week Training of Trainers (TOT) for Health Workers and Environmental Health Professionals. Each region will recruit and train nurses for a three-month period to expand the number of HEW by 5,200. These new HEWs will be deployed in urban areas with Addis Ababa receiving 1,200 HEWs. Tigray has already deployed HEWs in 14 towns and plans to expand to 40 or more towns this year.

The successful applicant is expected to work closely with each region to facilitate the deployment of these HEWs to work on their integrated agenda but with a key focus on PMTCT services. The work in each region may vary depending on where the regional Health Bureau is at present and their willingness to be innovative within existing policy guidelines. The Community PMTCT program will support the spectrum of MCH activities to be done by HEWs.

Health Centers

PEPFAR currently supports PMTCT services in 550 Health Centers. That still leaves approximately 100 Health Centers (HCs) that may need support in PMTCT in those regions. However, these remaining HCs are located in more rural areas where the HIV prevalence level is low. USAID has prioritized site selection for the successful applicant to 30 viable facilities across the identified five regions based on prevalence and HCT load and in coordination with the GOE and USG. The support provided at health center level might include in-service and refresher training; logistics support and procurement as needed; facilitating HMIS availability; follow-up in the community and linking with community services where available. Along with supporting quality services, the Community PMTCT program will help establish clear referral linkages between hospitals, health centers, and health posts/community services; refer clients to hospital as deemed appropriate; refer

clients to health posts and community services as deemed appropriate; and accept and manage clients referred from hospitals, health posts and the community.

Implementation Modalities

Below are PMTCT/MNCH Technical Components that the Community PMTCT Program should address:

Four PMTCT Prongs

Ethiopia has adopted the WHO/UNICEF/UNAIDS four – pronged PMTCT strategy as a key entry point to HIV care for women, men and families. Technical interventions, including antiretroviral medications, essential obstetric care, health system management and resource allocation, with gender balance, are part of the national comprehensive PMTCT program. The Community PMTCT program will address all Four Prongs in order to interrupt the cycle that leads to MTCT at several points. Mother-to-child transmission of HIV occurs during pregnancy, labor and delivery, or breastfeeding, so all areas should be addressed. The first prong promotes the delivery of primary prevention interventions within services related to reproductive health such as antenatal care, postpartum/natal care and other health and HIV service delivery points, including working with community structures. The second prong underscores the importance of providing appropriate counseling and support to women living with HIV to enable them make an informed decision about their future reproductive life, with special attention to preventing unintended pregnancies. The third prong of the strategy targets pregnant women already infected and demands that HIV testing be integrated in maternal child health units where ARVs are provided to prevent infection being passed on to their babies and also for the woman's own health; and adequate counseling is provided on the best feeding option for the baby. Finally, the fourth prong calls for better integration of HIV care, treatment and support for women found to be positive and their families. The Community PMTCT program will promote Primary Prevention as well as a prevention package for People Living with HIV/AIDS that should include (1) counseling on disclosure of HIV sero-status to sex partners, (2) partner and child testing, (3) risk reduction counseling on abstinence, fidelity, and consistent and correct condom use, (4) family planning for HIV-infected women, and (5) management and treatment of sexually transmitted infections.

Male Involvement and Gender

Community mobilization efforts should include behavior change messages to increase awareness of HIV prevention methods including PMTCT and promoting men's involvement in their family's health. Other messaging might address gender-based violence, harmful tradition practices and the link with HIV. Under the Male Norms Initiative, Ethiopia produced a number of radio spots and print materials addressing gender and PMTCT which could be utilized by the Community PMTCT Program.

HIV-related Palliative Care for Women and Children

This program will work to ensure that HIV positive pregnant women and their children are enrolled in longitudinal care. Efforts need to focus on the introduction of a systematic way of enrolling infants/younger children into care. HIV-related care should include the provision of ITN, maternal CTX, and provision of CTX to HIV-exposed infants as well as the provision of a basic preventive care package for HIV-exposed children (clean water, Vitamin A, immunizations, etc). The Community PMTCT program will link HIV positive women to clinical care as well as other services provided through PMI or an OVC program.

Infant Feeding and Nutritional Support

HIV positive women should receive infant feeding counseling during ante and post partum using the AFASS criteria, but mainly promoting exclusive breastfeeding according to the national guidelines. The Program should provide links to nutritional support for pregnant women and infected children,

including clinical referral for severely malnourished individuals and referrals to the WFP and Urban Gardens Program.

System Strengthening, Integration & Referrals

The Program should support the full integration of PMTCT and MCH service provision and ensure linkages to HIV care and treatment services, especially between pediatrics and PMTCT services. Also priority should be given to following up the mother and infant in the community and linking to health and social services.

PMTCT Program Monitoring, Evaluation and Quality Assurance Evaluation and Quality Assurance

The successful Applicant will work with the GOE to strengthen quality assurance and monitoring efforts at the community and health facility level, including the national integrated MCH registers, mother and child health cards, mapping of services, and referral systems. An evaluation component with clear criteria for Quality Assurance of programming should be included.

Training

The program will use the national in-service PMTCT & Pediatrics training curriculum and other standardized curriculum (such as the MSG materials) for basic and refresher training. The program may support efforts to develop pre-service curriculum in institutions. For instance pre-service for community midwives or similar groups would be a welcome innovation.

Testing and Counseling

In facilities where the Program will be implemented, routine “opt-out” testing at ANC and labor & delivery/post delivery should be instituted. Tests should be rapid HIV testing (in keeping with the National Algorithm) with same-day results. Use of lay counselors is encouraged as needed. Partner and Couple testing should be instituted and improved. There needs to be a systematic way of identifying HIV-exposed children including EID and antibody testing. PICT for children should also be introduced at facilities.

ARV Prophylaxis Regimen & Treatment

In health facilities and communities where the Program will be implemented, combination ARV beyond sdNVP should be instituted as well as the use of sdNVP for women who are found positive during labor & delivery and HAART for those eligible. Positive women should be prioritized for CD4 testing and fast tracked to HAART if eligible, especially in our setting where exclusive breast feeding is recommended and the risk of the mother transmitting HIV to the child (if the mother is eligible for HAART, but not on it) is very high. The Community PMTCT program can assist in ensuring that babies born to HIV+ women receive sdNVP within 72 hours and are followed-up to determine their HIV status.

Safe ANC and Delivery

The Community PMTCT program will promote improved MCH services, including infection prevention, focused ANC, safe and clean delivery, provision of misoprostol after birth, and essential newborn care. The 28% of women who access ANC provides a window of opportunity for provision of a package of high-impact interventions: Tetanus Toxoid (TT) and Insecticide Treated Nets (ITNs) for malaria prevention, iron supplementation and nutritional counseling, syphilis screening, counseling on exclusive breast feeding, LAM, and transition to other FP methods. These antenatal visits also should be used to counsel mothers and provide reminder materials on danger signs of pregnancy, delivery, and post-partum and newborn period, on planning for use of referral facilities in case of these complications, and on basic newborn care. They should also be used to identify other MCH needs, such as routine immunizations or counseling on the use of ORT for diarrhea. The use of a systematic screening tool such as that developed by the Population Council at the antenatal visit could assist in identification of unmet needs for maternal, infant and child health interventions, and filling these gaps.

Recognition of Complicated Pregnancy and EmOC This RFA intends to improve availability of skilled attendance for birth at home, the health post and health centers and to actually have increased utilization of these skilled birth attendants at facilities for delivery. The program will strengthen the capacity of communities, health posts and health centers to effectively refer these complications to appropriate referral facilities.

Financing & Procurement

The Program will work with RHB and Woreda Health Offices to secure and leverage other donor, public and private resources to ensure optimal financing for PMTCT and MCH services.

Other issues

This program will need to introduce a mechanism for effectively linking health facilities and community services, including confidential community registers for HIV+ mothers and exposed babies with regular updating of both registers to capture every mother baby pair. Innovative outreach sessions can also positively impact community PMTCT coverage and should be considered a strategy for addressing the current demand challenge.

Project Results

In order to increase MCH/PMTCT uptake and case follow-up, there is need to increase access to quality community/health-facility based MCH/PMTCT services; increase demand for PMTCT services through community engagement; strengthen referral linkages between PMTCT service points; and build capacity of MCH/PMTCT community-based organizations. Below are the four objectives with Intermediate Results (IR) and illustrative activities described below each objective.

Objective 1: To build the capacity of regional health bureaus, zonal and woreda health offices and Community Based Organizations (CBO), to support and manage community-based PMTCT services

- IR 1 – Increased PMTCT leadership, project management and coordination skills at health bureaus and identified CBOs, to transition in three years.
- IR 2 – Increased acquisition of relevant and accurate PMTCT/MCH technical knowledge and skills among identified health care cadres.
- IR 3 – Supported improvement in existing integrated MCH/HIV logistics management systems and knowledge in the health bureaus and CBO
- IR 4 – Improved skills and knowledge of good financial management of projects and grant writings skills
- IR 5 – Increased policy changes on HEW involvement in MCH/PMTCT and patient cost standardization
- IR 6 – Established improved quality assurance, quality improvement and overall strategic information practices at health bureaus and CBOs.

Intent Statement

This sub-result encourages the successful applicant to build the capacity of local CBOs to implement PMTCT programs. Recent assessments done show project management and coordination skills as areas of need in country. Other areas like logistics management, financial management and strategic information also need increased support. The successful Applicant will work with CBOs (including Community Health Departments in Universities, if feasible) as well as the regional health bureaus and equip them with skills to better manage PMTCT activities. Technical knowledge is also a very fast paced area that would require in-service trainings (basic and refresher) on a regular basis and relevant pre-service training as well. Applicants are encouraged to suggest relevant pre-service trainings e.g. a plan to train midwives would be viewed positively.

The Community PMTCT program will also enhance the work of the Regional Health Bureau system by capacity building of staff as needed, improving information and quality management; referral and supply chain systems; and laboratory networks. At the national level the program will support health

systems improvement directly and indirectly by helping to write national guidelines, enhance the personnel, training, laboratory, supply chain and informatics systems throughout the country to provide PMTCT in accordance with the guidelines.

The Community PMTCT program will be expected to address the remuneration of identified cadre working in PMTCT through advocacy. To retain good health workers, the successful applicant should partner with the GOE to agree on what would constitute fair remuneration (financial or non-financial) for staff. In resource limited communities, where the volunteer health worker actually depends on the income from the volunteerism as sole income, and spends equivalent of regular work hours at such jobs preventing them from getting other jobs, a fair remuneration package is needed to avoid high turn over of staff. Similarly patient cost issues have to be standardized across the various tiers of Government and operationalized at service points, so that women can be given accurate information during community activities.

Inclusion of HIV-exposure status and related interventions on both the mother's health card (ANC/MCH card) and the child's well-child card (Road to health/ EPI card) is important to facilitate linkages and referrals between MCH services, such as immunizations, and longitudinal HIV care services. The successful applicant will therefore be expected to advocate to and actively support the Government, on including the mother's HIV status on the infant card and modifying the roles of the HEW to include activities that promote MCH/PMTCT access.

Illustrative Activities

This may include but not be limited to:

- Institutional capacity assessment and planning
- Technical assistance and training in financial systems development and institutional quality control such as personnel policies and supervision, administrative systems and controls, program monitoring and evaluation.
- Mentoring on the job and formal training sessions, as required for individual organizations.
- Organizational development for CBO organizations undertaking PMTCT/MCH services
- Technical assistance to regional bureaus on coordination of PMTCT/MCH activities in the region
- Training in development of institutional sustainability strategies including assessment of alternative sources of funding. Where appropriate, assist CBOs in making necessary linkages with new funding sources
- Organize symposiums or technical forums to share findings of pilots on HEW involvement in HIV/AIDS Counseling and testing in Ethiopia.
- Facilitate consultative forums to review and revise policies on including mother's HIV status on the infant card; remuneration for health volunteers; HEW involvement in PMTCT and operationalizing standard MCH/PMTCT costs at facilities nationwide.

Illustrative Indicators

- *Number of CBOs provided with technical assistance for community PMTCT program management*
- *Number of RHB provided with TA for community PMTCT program management*
- *Number of Woreda health offices provided with TA for community PMTCT program management*
- *Number of CBOs provided with TA in financial management*
- *Number of individuals trained in financial management*
- *Number of MCH/PMTCT related health policies changed due to advocacy activities*
- *Number of national technical forums and symposiums held on relevant MCH/PMTCT best or promising practices*

Objective 2 – To increase access to MCH/PMTCT services through providing facility and community services; and improving bi-directional linkages/referrals between PMTCT/MCH services at the community, health post, health center and hospital level.

Expected – Results

- IR 1 – Increased the number of health posts and health centers providing PMTCT/MCH services
- IR 2 – Introduced innovative ways of providing MCH/PMTCT services and follow-up in the community
- IR 3 – Collaborated (coordinated) with Government and other stakeholders to establish clear and strong referral linkages between facilities and community services in regions
- IR 4 – Introduced internationally acceptable tools and systems for confirming clients follow-up of referrals
- IR 5 – Implemented integrated service delivery (MCH & PMTCT & STI)
- IR 6 – Enhanced community involvement in oversight of service linkage
- IR 7 – Increased the ability of identified health workers to access the community and for pregnant women and their families to access facilities.

Intent Statement

While building on PEPFAR and USAID investments in MCH/PMTCT and other health systems, the Community PMTCT program will be focused on providing services at the health post level and the community. It will adopt the four pronged strategy to PMTCT programming for a more holistic service delivery for women. Innovation is encouraged in delivering MCH/PMTCT services in the community. Applicants are encouraged to think ‘outside the box’ and suggest new cadres, avenues and locations to offer culturally acceptable services. Possible locations for service provision could include health posts as well as places of worship (if culturally acceptable) among others. We expect that Urban HEWs will be key partners in implementing Community PMTCT activities through mobile outreaches to various communities and health posts; having health workers rotate at health posts on varying days of the week; logging blood samples for CD4 testing, etc.

The health workers based in the community are also expected to offer care and support activities including psychosocial support, nutritional counseling/products; provision of Insecticide Treated Nets (ITN), Cotrimoxazole (CTX) and safe water products to families. Positive pregnant women and their families should be supported on their infant feeding choice according to the national guidelines. The affected mothers, babies and their families should also be linked to other services in the community including food by prescription, OVC services, malaria services etc. The clients and their families should also be referred to appropriate health facilities for follow up in longitudinal care and HAART when eligible.

Depending on the health cadre identified, (for instance if nurses (UHEW) undertake mobile outreaches or HEWs in regions where they are eligible) services like ‘opt out’, rapid, counseling and testing can be offered to the women in communities. A pilot offering rapid HIV testing and CD4 count testing for HIV positive clients at the point of service is also encouraged, so that women can be prioritized for HAART. Otherwise appropriate ARV prophylaxis and CTX can also be given to women immediately or at a later date. As much as possible, partners of these women should also be tested and referred as needed.

Postpartum women with unknown HIV status should also be targeted for testing within 72 hours of delivery, so that ARV prophylaxis can be offered to their infants (including CTX from six weeks) and the infants referred for EID, while the mother is linked to longitudinal care. Infants should be referred to other basic preventive care packages like vitamin A and immunizations etc. As much as possible partners are encouraged to avoid duplication and waste, by identifying and leveraging resources from other donor or private sources and link clients to such.

In order to carry out these services the successful applicant is expected to support and partner with existing GOE and USG partners in procurement, to ensure a flawless supply system. As much as possible the PMTCT supplies should be part of an integrated HIV/AIDS/MCH logistics system.

A major hindrance to services reaching the community is lack of transportation for health workers who very often walk long distances in trying to provide services to the community. Applicants are encouraged to suggest a strategy to overcome this, such as purchasing and maintaining motorcycles or bicycles for community health workers. Given the number of HEWs in each region (both rural and urban) it is difficult for them to cover upward of 500 families effectively with accurate messaging and training. Model families have been shown to have a great influence on varying health indicators, and can serve as a mechanism for reaching communities with targeted behavior change messaging and with the right intensity. HEWs identify and train model families that have been involved in other development work, and/or that have acceptance and credibility by the community, as early adopters of desirable health practices to become role models in line with health extension packages. Model families help diffuse health messages leading to the adoption of the desired practices and behaviors by the community.

Meeting the needs of pregnant positive women and their families requires a lot of collaboration between various levels of health facilities and the community. Strengthening effective referrals among these institutions needs clear communication channels and formalized network linkages. A greater challenge even exists where the referrals are inter partners i.e. services are provided by different partners, often with different funding streams. This community PMTCT project in appreciating that families need different services from varying groups desires to see detailed and clear plans for making intra and inter partner referrals work. Referrals should also include some degree of follow-up and facilitation of clients to ensure they access those services. The successful applicant is expected to play a key role in facilitating catchment area meetings where confirmation of referrals should be a key agenda item. As much as possible feedback on satisfaction with services provided should be included in referral planning.

Illustrative Activities

This may include but not be limited to:

- Counseling and testing of clients using the opt out strategy and rapid testing with same day results at the point of service
- Counsel HIV positive women on FP and refer as needed
- Effective referral of clients found to be HIV positive to a health facility for longitudinal care
- Link clients to community services like ITN, water guard and cotrimoxazole.
- Opt out counseling and testing alongside CD4 testing at point of service with ARV prophylaxis if HAART is not indicated
- Transportation coupons provided to women to enable them to reach health posts.
- Technical assistance on mapping available services in the identified region.
- Technical assistance on formalizing referral linkages through MOU's or other acceptable mechanisms
- Instituting two way referrals – not just from the higher to lower level facility but also the reverse
- Follow up with client in the community to confirm adherence to referral and outcome of visit
- Monitor or track referrals between facilities and the community
- Facilitate catchment area meetings
- Introduce organizational referral tools including registers that respects patients confidentiality
- Facilitate patient's transportation to services by suggesting innovative schemes like providing vehicles to Woreda's or subsidizing transportation cost in semi-urban regions
- Support regional bureau to coordinate monthly network meetings to facilitate stakeholders confirmation of referrals
- Conduct quality assurance of referrals reported

PEPFAR Indicator

- *Number of service outlets providing the minimum package of PMTCT services according to national and international standards*
- *Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results*

- *Number of HIV- Infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting*
- *Number of HIV-positive pregnant or lactating women receiving food and nutritional supplementation in a PMTCT setting*
- *Number of health workers trained in the provision of PMTCT services according to national and international standards*

Illustrative Indicators

- *Number of clients with unmet need for FP referred to the FP clinic*
- *Number of pregnant FP clients referred to ANC/PMTCT clinic*
- *Number of HIV positive pregnant women referred to a higher level health facility and received the intended service*
- *Number of HIV+ mothers who received post partum family planning methods*
- *Number of infants born to HIV positive mothers that are on opportunistic infection (OI) prophylaxis*
- *Number of children born to HIV positive mothers and are tested at 18 months*
- *Number of male partners of pregnant women who are counseled and tested for HIV, and received their results*
- *Number of health posts providing PMTCT/MCH services*
- *Number of HIV+ pregnant women counseled in infant feeding choices*
- *Proportion of HIV+ mothers linked to care and treatment*
- *Proportion of newborns to HIV+ mothers who received ARV prophylaxis*
- *Number of women provided with transportation coupons to reach a PMTCT service delivery site*
- *Number of HIV positive pregnant women trained for an IGA*
- *Number of HIV positive pregnant women who have established their own IGA and started to have their own income*
- *Number of MOUs produced with different service delivery sites on referral linkages*
- *Number of referral sites (social service, psychosocial service, food supplementation, etc) identified in a service mapping process in the nearby community*
- *Number of PMTCT service providers trained in effective referral / follow up of mother- baby pairs*

Objective 3: To increase demand for MCH/PMTCT services through community outreach

- IR 1 – Created a favorable policy environment for MCH/PMTCT services
- IR 2 – Increased community awareness and knowledge of available MCH/PMTCT services and their importance.
- IR 3 - MCH/PMTCT services and related health seeking behaviors established as cultural norms with a special focus on FANC.
- IR 4 - Increased community's ability to recognize early signs of pregnancy related illnesses and seek help early
- IR 5 – Increased male involvement in accessing MCH/PMTCT services
- IR 6 – Introduced culturally acceptable incentives and 'disability grants' to HIV positive women to encourage use of health facilities

Intent Statement

USAID's experience in supporting MCH/PMTCT programs in Ethiopia has produced substantial, promising and best practices on mobilizing communities towards good health practices. The Community PMTCT project will build on these experiences, with the aim of strengthening community engagement and household practices across the identified regions.

Community mobilization will be a key activity with a focus on behavior change using consistent and appropriate IEC messaging to increase awareness of HIV prevention including PMTCT. Male circumcision will be promoted where culturally acceptable as well as awareness creation on the prevention, early diagnosis and treatment of STI's. Innovation in community based male

involvement activities is encouraged as well as instituting community mothers support groups or PLWHA networks.

To achieve this, the project would need to support policy dialogues on diversifying services to lower levels of the health care system and health cadres at the federal, regional/zonal and woreda levels. Advisors may need to be identified for these regions to strengthen these dialogues and ensure policies are put in place, which would create an enabling environment for MCH/PMTCT services. When these policies are made the project will also ensure that the policies are applied in the zones and Woreda's as intended. This project will also produce prospective documentation and credible evidence as the project is implemented to strategically be applied to service delivery and program planning.

In partnership with health bureaus, the project is expected to introduce innovative approaches towards increasing demand for health services which may include introduction of 'disability grants', newborn baby packs, MAMMA Packs etc. The challenge of transportation costs can be addressed by supplementing such with pre-paid coupons or other mechanisms.

Illustrative Activities

This may include but not be limited to:

- Increase IEC/BCC and social mobilization in the community on HIV/AIDS, focusing primarily on PMTCT.
- Promote use of condom for dual protection.
- IEC activities to promote HIV prevention among women of child bearing age (15 – 49 years) focusing on PMTCT, Counseling and testing and Universal Precautions.
- Identify and address key obstacles to appropriate practices and care seeking behavior
- Train and engage community groups like women's group, (market women) and youth groups (in school or out of school) to recognize early signs of pregnancy related illnesses and appropriate health care seeking behaviors.
- Introduce innovative incentives to increase demand for ANC services like providing 'MAMMA PACKS' and other social support to attract women to health delivery points
- Participate in/conduct analyses of policy, resource and program constraints on improving MCH/PMTCT outcomes at the federal, regional/zonal and woreda's health bureaus like including the mother's HIV status on the child's health.
- Advocate for and influence policies to favor PMTCT service delivery at the health post & community level and by other cadres like HEWs, family members and TBAs as appropriate
- Support regions to adapt and apply important policy and strategy decisions at national or regional levels (e.g. free MCH services) at lower levels of the health system as appropriate.
- Increase the use of demonstrated health facility and community based information tools (e.g. ANC card) and communication materials

Illustrative Indicators

- *Number of individuals reached through community outreach that promote MCH/PMTCT services*
- *Number of IEC/BCC materials produced or adapted which primarily are focusing on PMTCT*
- *Number of community sensitization posters developed and displayed*
- *Number of community sensitization workshops conducted*
- *Number of "MAMMA PACKS" distributed*
- *Number of lay persons trained to recognize early warning signs of pregnancy*

Objective 4: To improve the quality of community and facility-based MCH/PMTCT services

IR 1 – Identified appropriate cadre of staff and build their capacity to provide skilled and compassionate PMTCT/MCH services both in the community and health facilities

IR 2 – Increased number of PMTCT service managers and providers trained in PMCT Quality Improvement (QI)

- IR 3 – Increased supportive supervision to PMTCT service providers
- IR 4 – Increased mentorship of PMTCT service providers
- IR 5 – Increased access of PMTCT Quality Improvement resource materials/job aids/guidelines
- IR 6 – Increased utilization of PMTCT data for Quality Improvement

Intent Statement

Integral to the delivery of health services is ensuring improved quality of care. In PMTCT like other program areas, monitoring, reporting, target setting and mapping have been challenging. This is due, to it being a national, population - based program, having a complex nature, the fact that services are provided in relatively weak general MCH settings (rather than special clinics), and the large number of women and potentially large number of program indicators involved.

There are many quality and performance improvement models available in the international development community that can be considered for this work and it will be critical that applicants select or modify an existing package that is appropriate to the Ethiopian context. At the same time, it is imperative that the package provides a sustainable solution to the gaps in quality care in Ethiopia and that MOH counterparts at the regional, zonal and most particularly, woreda levels as well as the service delivery sites, understand the value of quality improvement approaches and can apply the selected approach without heavy oversight or long-term external engagement.

Quality in PMTCT cuts across all earlier stated three objectives, particularly service provision. Issues to focus on include provider knowledge/training, counseling, PMTCT ARV adherence, infant feeding adherence and barriers, basic MCH care and context of PMTCT programming and linkage to care. Linking both mothers who received PMTCT services and their child to care for instance, remains a key challenge for implementing partners and is an area, we expect the applicants to seriously address. Also regular multi disciplinary facility or community meetings that address QI issues at sites should be built into proposed activities and sites should be mentored and monitored to implement this.

MCH/PMTCT services provided either at health post/centers or in the communities through outreach activities should be integrated and of a high quality. Appropriate health cadre should be trained using the standardized national in-service PMTCT/MCH and Pediatrics curriculums for basic and refresher trainings. Basic ANC, delivery and PNC services should be strengthened to provide a good platform for PMTCT services, as such, training of staff should be conducted using an integrated curriculum.

Considering the fact that HEWs are overburdened by the sheer number of tasks they are expected to carry out, applicants are encouraged to consider other cadres along with this group, such as Mother's Support Group mentors, Community Health Agents (CHA), TBA's, iddir's (Social support for bereavement), KOOWs, retired health workers, trained nurses and midwives. The identified cadres would have their skills accessed, so that competency based training can be undertaken, to equip them for the tasks they will perform.

Supervision is widely acknowledged in the literature as crucial for the continued quality of service provision by Health Workers. Only good supervision, refresher trainings when due, and adequate material support will enable health care workers to function well. The Community PMTCT program should prioritize supervision either through the Woredas or RHBs or through a different cadre. The proposed supervisors should be appropriate for the cadre being supervised. As much as possible the cadre to supervise should be chosen objectively for efficiency, based on skill sets needed by those to be supervised.

Adopting best and promising practices in PMTCT should also be viewed as strategies to improving quality of programs. CD4 testing for instance, should receive close attention, so women who are eligible for HAART are fast tracked. A pilot study on point of service CD4 testing at the Health

Center level is encouraged. Other practices like instituting strong community based MSGs is key to successfully increasing community demand and uptake for services. As the MSG program continues to evolve daily, applicants are encouraged to propose other support groups that could improve PMTCT uptake and quality like 'Father's or male support groups' and 'networks of PLWHA Associations' (comprising both males and females).

When services will be provided at health posts or centers, quality services are expected at the appropriate levels of care for the facility identified. All services provided should be recorded using the national integrated MCH/PMTCT registers and other HMIS tools to capture the unique nature of these programs, as certain indicators may not be adopted yet by PEPFAR and even the national government, but would help to capture the work being done by the Community PMTCT Program.

Illustrative Activities

This may include but not be limited to:

- Holistic capacity building of health cadres at health facilities and communities to include competency based pediatrics services, basic ANC issues, early recognition of emergency obstetric complications, family planning referral etc
- Facilitate production of a National Integrated MCH/PMTCT training manual
- Develop and distribute IEC materials, job aides and integration tools
- Training and mentoring on logistics management at health facilities and of community groups
- Mothers Support Group mentors provide support to pregnant women and their families on infant feeding options, mother's nutrition, and adherence to ART for mother and baby & facility follow up.
- Training and mentoring for skilled attendance at births with strict observance of universal precautions by various cadres like TBAs.
- Opt out counseling and testing alongside CD4 testing at point of service with ARV prophylaxis if HAART is not indicated
- Training and mentorship to institute national HMIS registers and tools for effective data collection and use of data to inform programming
- Transportation coupons provided to women to enable them to reach health posts.

PEPFAR Indicator

- *Number of health workers trained in the provision of PMTCT services according to national and international standards*

Illustrative Indicators

- *Number and percent of HIV positive pregnant women enrolled into HIV care and assessed for ART eligibility*
- *Number and percent of children born to HIV infected women who are enrolled into HIV care and treatment*
- *Number of PMTCT providers trained to address the FP needs of PMTCT clients by appropriate referral*
- *Number of FP providers trained to address the needs of PMTCT clients*
- *Number of IEC materials, job aides and integration tools developed and distributed*
- *Number of Mothers' Support Groups, PLWHA networks or Fathers Support Groups established*
- *Number of MSGs supported*
- *Number of Mother Mentors trained*
- *Number of HIV+ women who disclose their status to their partner*
- *Number of health care cadres trained in integrated ANC and community PMTCT*
- *Number of HEWs trained in integrated ANC and community PMTCT*
- *Number of individuals / community members trained in community PMTCT*
- *Number of supportive supervisory visits conducted by the successful applicant, RHB and Woreda's*

- *Number of facilities who have nationally accepted reporting formats and registers and are using them*
- *Number of clients satisfied with the service that the health cadres are providing*
- *Number of health facilities who have an optimal level quality standard measure*

IV. Expected Reporting Deliverables

Reporting

In the process of implementation, the successful applicant is expected to also keep track of and regularly report on the following PEPFAR indicators and key illustrative indicators which are considered necessary for future programming. The successful applicant can also report on other relevant indicators either from the list of illustrative indicators or new ones based on strategies and activities implemented.

PEPFAR Indicators

- *Number of service outlets providing the minimum package of PMTCT services according to national and international standards*
- *Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results*
- *Number of HIV- Infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting*
- *Number of HIV-positive pregnant or lactating women receiving food and nutritional supplementation in a PMTCT setting*
- *Number of health workers trained in the provision of PMTCT services according to national and international standards*

Key Program Indicators

- *Number of pregnant women who received HIV counseling and testing for PMTCT and tested HIV positive*
- *Number of HIV- Infected pregnant women enrolled in care*
- *Number of HIV- Infected pregnant women receive HAART and initiate ART*
- *Number of HIV-Infected women who benefitted from adult prevention activities*
- *Number of HIV- Infected pregnant women provided with syphilis screening*
- *Number of HIV- Infected pregnant women counseled and referred to Family Planning services screening*
- *Number of HIV-infected pregnant women who received anti-retroviral to reduce risk of mother-to-child-transmission, by regimen type*
- *Number of HIV-infected pregnant women assessed for ART eligibility*
- *Number of regional, zonal, woreda offices and CBOs provided with technical assistance in managing MCH/PMTCT services*
- *Number and percent of HIV positive pregnant women enrolled into HIV care and assessed for ART eligibility*
- *Number and percent of children born to HIV infected women who are enrolled into HIV care and treatment*
- *Number of MDT meetings addressing QI issues held at facilities*
- *Number of catchment area meetings held with a key focus on referrals and referral confirmations*

Other activities

- *The successful applicant in conjunction with the National PMTCT TWG and the MOH should assess and develop a clear 5-year strategy to support PMTCT monitoring*
- *In conjunction with the National PMTCT TWG and the MOH, set new national targets in PMTCT*
- *Support the national program to adapt and implement new international PMTCT M&E indicators and guidelines (expected summer 2009).*

V. Monitoring and Evaluation

This is a performance-based Cooperative Agreement. Implementing partners will establish a rigorous monitoring and evaluation system for the program as a whole, including adequate staffing, technical support and systems for routine data collection. Illustrative and required indicators relevant to this project are provided in this document. Applicants may propose additional or alternative indicators to the illustrative indicators to measure program success. Applicants must propose and outline a framework for a final evaluation before the end of program implementation. During the first sixty days after the award is made, the successful Applicant will work closely with USAID to refine indicators, performance targets for each indicator based on the most recent results, and finalize a project monitoring and evaluation plan that monitors progress towards achieving program objectives and results according to USAID guidelines. USAID and the successful Applicant will conduct six-monthly performance reviews with the MOH to monitor the progress of work and the achievement of results based on the targets specified in the project M&E plan.

The Community PMTCT/MCH Activity, through collaborative efforts and appropriate partnerships, must achieve regional level impact that ultimately contributes to national level impact. The most recent data available from the DHS 2005 survey, and other existing surveys and studies will form the baseline for this project. Applicants will propose an evaluation plan to measure the outcome and impact of the program. The plan must also describe collaboration with the MOH's information systems (e.g. HMIS/LMIS) so as to work within the government framework wherever possible. Success will be measured not only through improved coverage and quality of health services and impact on health status but also through measures of improved GFDRE/MOH management. The successful Applicant will be responsible for data collection and analysis required by USAID for performance reporting.

The successful Applicant will be responsible for sharing information in a timely manner with USAID, donor partners, and MOH entities. Information sharing will create opportunities to discuss progress, identify constraints and find solutions with all stakeholders.

Performance Monitoring

The USAID AOTR, in conjunction with the USAID Agreement Officer, will monitor and evaluate the Recipient's overall performance in accordance with progress toward deliverables and expected performance against COP and other progress indicators. The Recipient will utilize standard COP indicators and will propose additional indicators for assessing performance of activities or outcomes accomplished.

Criteria for judging the performance of the Recipient will include the ability to foster good working relationships with the USG Ethiopia Team and other implementing partners. Semi-annual performance reviews will be conducted through the life of the project after submission of Quarter Two and Quarter Four reports. USAID may contract an external contractor to conduct a midterm evaluation of the Agreement approximately 24 months after the award and toward the end of the project to produce a final report synthesizing the work, deliverables and results of the project over the entire duration. USAID may also conduct management reviews of work progress during the life of implementation.

Monitoring, Evaluation and Reporting

All applications must include plans to document, monitor and evaluate program performance. The USG in Ethiopia will evaluate progress by monitoring selected indicators and assessing these in relation to the targets and overall objectives set by program staff. Applications for funding under this RFA should clearly state how proposed activities relate to these program objectives and how data will be collected, verified, and reported to document progress toward these objectives, including a staffing plan. Data quality is a critical component of this program and all applicants must develop

systems to ensure data quality and must be prepared for data quality audits. Applicants should be prepared for revisions in required program indicators and reporting requirements during the lifetime of the award.

a. Work plan, Exit Strategy and Performance Monitoring Plan (PMP)

Within 45 days of award, the Recipient shall submit one electronic and one hard copy of a first-year work plan to implement the Agreement. Subsequent work plans will be submitted for each year cycle that currently runs dependent on the award date. The initial work plan will include a proposed Exit Strategy documenting steps the Recipient will take to strengthen host country ability to sustain the deliverables of the Agreement. The initial work plan will include a proposed PMP for the entire period of performance including the process for collecting baseline data. The Work plan, Exit Strategy, and the PMP will be subject to the written approval of the AOTR.

b. Quarterly and Annual Progress Reports

The Recipient shall submit quarterly narrative performance reports and one annual narrative report . These reports will indicate progress achieved towards benchmarks, highlight tangible results, identify any problems encountered in implementation, and propose remedial actions as appropriate. Annual reports will be submitted within 45 days of the close of the Agreement Year. Each report will cover activities completed during the preceding 12 months and will be submitted to the AOTR. Quarterly progress reports that highlight accomplishments, constraints and progress against COP indicators will be submitted within two weeks of the end of USG fiscal year quarters.

c. Financial Reports

The Recipient shall submit a quarterly financial report that will include a summary of finances and a pipeline analysis of funds obligated, funds expended, expenses accrued, and funds remaining by program area.

d. Demobilization Plan

Six months prior to the completion date, the Recipient shall submit a Demobilization Plan for AOTR approval. The plan will include, at a minimum, an illustrative Property Disposition Plan; a plan for the phase-out of in-country operations; a delivery schedule for all reports or other deliverables required under the Cooperative Agreement; and a timetable for completing all required actions, including the submission date of the final Property Disposition Plan to the Agreement Officer. A final project report will be due 30 days after project completion.

e. Outreach Materials

At a minimum, the Recipient shall submit two, one-page success stories covering prevention, care or treatment activities on a semi-annual basis in accordance with USAID guidance on "success stories" available at <http://www.usaid.gov/stories/>.

f. Performance Indicators

The Recipient shall utilize standard and agreed indicators in quarterly and annual progress reports.

REFERENCES

1. Report PMTCT/MNCH Situational analysis; Focusing on integration of services Ethiopia, Prevention of Mother to Child HIV Transmission (PMTCT) Portfolio Review and Recommendations, 21 July – 01 August, 2008 -Final Report
2. Report First ANECCA Ethiopia TDY Pediatric HIV Case Finding Utilizing Community And Health Centre Facility Approaches
3. Federal Ministry of Health E: Health extension workers and health officers programs in Ethiopia. International Conference on Task Shifting, Addis Ababa. Federal Ministry of Health; 2008.
4. Federal HIV/AIDS Prevention and Control Office MoH: Guidelines for prevention of mother to child transmission of HIV in Ethiopia. Addis Ababa: Ministry of Health; 2007.
5. Community health workers for ART in sub-Saharan Africa: Learning from experience - Capitalizing on new opportunities. *Human Resources for Health* 2009, **7**:31 doi:10.1186/1478-4491-7-31
6. *Federal Ministry of Health; HSDP – 111 Woreda Based Annual Core Plan EFY 2001(2008/9)*
7. *HIV/AIDS in Ethiopia – An Epidemiological Synthesis, April 2008 – HAPCO and GAMET*

- END OF SECTION C -

**SECTION D - CERTIFICATIONS, ASSURANCES, OTHER STATEMENTS OF RECIPIENT
REQUIRED FOR COOPERATIVE AGREEMENT AWARD**

Note: When these Certification, Assurances, and Other Statements of Recipient are used for cooperative agreements, the term "Grant" means "Cooperative Agreement".

PART I - CERTIFICATIONS AND ASSURANCES

1. ASSURANCE OF COMPLIANCE WITH LAWS AND REGULATIONS GOVERNING NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

- (a) The recipient hereby assures that no person in the United States shall, on the bases set forth below, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under, any program or activity receiving financial assistance from USAID, and that with respect to the grant for which application is being made, it will comply with the requirements of:
- (1). Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352, 42 U.S.C. 2000-d), which prohibits discrimination on the basis of race, color or national origin, in programs and activities receiving Federal financial assistance;
 - (2). Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance;
 - (3). The Age Discrimination Act of 1975, as amended (Pub. L. 95-478), which prohibits discrimination based on age in the delivery of services and benefits supported with Federal funds;
 - (4). Title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), which prohibits discrimination on the basis of sex in education programs and activities receiving Federal financial assistance (whether or not the programs or activities are offered or sponsored by an educational institution); and
 - (5). USAID regulations implementing the above nondiscrimination laws set forth in Chapter II of Title 22 of the Code of Federal Regulations.
- (b) If the recipient is an institution of higher education, the Assurances given herein extend to admission practices and to all other practices relating to the treatment of students or clients of the institution, or relating to the opportunity to participate in the provision of services or other benefits to such individuals, and shall be applicable to the entire institution unless the recipient establishes to the satisfaction of the USAID Administrator that the institution's practices in designated parts or programs of the institution will in no way affect its practices in the program of the institution for which financial assistance is sought, or the beneficiaries of, or participants in, such programs.
- (c) This assurance is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the recipient by the Agency, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The recipient recognizes and agrees that such Federal financial assistance will be extended in reliance on the representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial

enforcement of this Assurance. This Assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the recipient.

2. CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Statement for Loan Guarantees and Loan Insurance

The undersigned states, to the best of his or her knowledge and belief, that: If any funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this commitment providing for the United States to insure or guarantee a loan, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Submission of this statement is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required statement shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

3. PROHIBITION ON ASSISTANCE TO DRUG TRAFFICKERS FOR COVERED COUNTRIES AND INDIVIDUALS (ADS 206)

USAID reserves the right to terminate this Agreement, to demand a refund or take other appropriate measures if the Grantee is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140. The undersigned shall review USAID ADS 206 to determine if any certifications are required for Key Individuals or Covered Participants.

If there are COVERED PARTICIPANTS: USAID reserves the right to terminate assistance to, or take or take other appropriate measures with respect to, any participant approved by USAID who is found to have been convicted of a narcotics offense or to have been engaged in drug trafficking as defined in 22 CFR Part 140.

4. CERTIFICATION REGARDING TERRORIST FINANCING IMPLEMENTING E.O. 13224

Certification

By signing and submitting this application, the prospective recipient provides the certification set out below:

1. The Recipient, to the best of its current knowledge, did not provide, within the previous ten years, and will take all reasonable steps to ensure that it does not and will not knowingly provide, material support or resources to any individual or entity that commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated, or participated in terrorist acts, as that term is defined in paragraph 3.
2. The following steps may enable the Recipient to comply with its obligations under paragraph 1:
 - a. Before providing any material support or resources to an individual or entity, the Recipient will verify that the individual or entity does not (i) appear on the master list of Specially Designated Nationals and Blocked Persons, which list is maintained by the U.S. Treasury's Office of Foreign Assets Control (OFAC) and is available online at OFAC's website : <http://www.treas.gov/offices/eotffc/ofac/sdn/t11sdn.pdf>, or (ii) is not included in any supplementary information concerning prohibited individuals or entities that may be provided by USAID to the Recipient.
 - b. Before providing any material support or resources to an individual or entity, the Recipient also will verify that the individual or entity has not been designated by the United Nations Security (UNSC) sanctions committee established under UNSC Resolution 1267 (1999) (the "1267 Committee") [individuals and entities linked to the Taliban, Osama bin Laden, or the Al Qaeda Organization]. To determine whether there has been a published designation of an individual or entity by the 1267 Committee, the Recipient should refer to the consolidated list available online at the Committee's website: <http://www.un.org/Docs/sc/committees/1267/1267ListEng.htm>
 - c. Before providing any material support or resources to an individual or entity, the Recipient will consider all information about that individual or entity of which it is aware and all public information that is reasonably available to it or of which it should be aware.
 - d. The Recipient also will implement reasonable monitoring and oversight procedures to safeguard against assistance being diverted to support terrorist activity.
3. For purposes of this Certification-
 - a. "Material support and resources" means currency or monetary instruments or financial securities, financial services, lodging, training, expert advice or assistance, safehouses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials."
 - b. "Terrorist act" means-

- (i) An act prohibited pursuant to one of the 12 United Nations Conventions and Protocols related to terrorism (see UN terrorism conventions Internet site: <http://untreaty.un.org/English/Terrorism.asp>); or
 - (ii) An act of premeditated, politically motivated violence perpetrated against noncombatant targets by subnational groups or clandestine agents; or
 - (iii) any other act intended to cause death or serious bodily injury to a civilian, or to any other person not taking an active part in hostilities in a situation of armed conflict, when the purpose of such act, by its nature or context, is to intimidate a population, or to compel a government or an international organization to do or to abstain from doing any act.
- c. "Entity" means a partnership, association, corporation, or other organization, group or subgroup.
 - d. References in this Certification to the provision of material support and resources shall not be deemed to include the furnishing of USAID funds or USAID-financed commodities to the ultimate beneficiaries of USAID assistance, such as recipients of food, medical care, micro-enterprise loans, shelter, etc., unless the Recipient has reason to believe that one or more of these beneficiaries commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated or participated in terrorist acts.
 - e. The Recipient's obligations under paragraph 1 are not applicable to the procurement of goods and/or services by the Recipient that are acquired in the ordinary course of business through contract or purchase, e.g., utilities, rents, office supplies, gasoline, etc., unless the Recipient has reason to believe that a vendor or supplier of such goods and services commits, attempts to commit, advocates, facilitates, or participates in terrorist acts, or has committed, attempted to commit, facilitated or participated in terrorist acts.

This Certification is an express term and condition of any agreement issued as a result of this application, and any violation of it shall be grounds for unilateral termination of the agreement by USAID prior to the end of its term.

5. CERTIFICATION OF RECIPIENT

By signing below the recipient provides certifications and assurances for (1) the Assurance of Compliance with Laws and Regulations Governing Non-Discrimination in Federally Assisted Programs, (2) the Certification Regarding Lobbying, (3) the Prohibition on Assistance to Drug Traffickers for Covered Countries and Individuals (ADS 206) and (4) the Certification Regarding Terrorist Financing Implementing Executive Order 13224 above.

RFA/APS No. _____

Application No. _____

Date of Application _____

Name of Recipient _____

Typed Name and Title _____

Signature _____

Date _____

6. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

(a) Instructions for Certification

(1) By signing and/or submitting this application or grant, the recipient is providing the certification set out below.

(2) The certification set out below is a material representation of fact upon which reliance was placed when the agency determined to award the Cooperative Agreement. If it is later determined that the recipient knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

(3) For recipients other than individuals, Alternate I applies.

(4) For recipients who are individuals, Alternate II applies.

(b) Certification Regarding Drug-Free Workplace Requirements

Alternate I

(1) The recipient certifies that it will provide a drug-free workplace by:

(A) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the applicant's/grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(B) Establishing a drug-free awareness program to inform employees about--

1. The dangers of drug abuse in the workplace;

2. The recipient's policy of maintaining a drug-free workplace;

3. Any available drug counseling, rehabilitation, and employee assistance programs; and

4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(C) Making it a requirement that each employee to be engaged in the performance of the Cooperative Agreement be given a copy of the statement required by paragraph (b)(1)(A);

(D) Notifying the employee in the statement required by paragraph (b)(1)(A) that, as a condition of employment under the Cooperative Agreement, the employee will--

1. Abide by the terms of the statement; and

2. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(E) Notifying the agency within ten days after receiving notice under subparagraph (b)(1)(D)1. from an employee or otherwise receiving actual notice of such conviction;

(F) Taking one of the following actions, within 30 days of receiving notice under subparagraph (b)(1)(D)2., with respect to any employee who is so convicted--

1. Taking appropriate personnel action against such an employee, up to and including termination; or

2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(G) Making a good faith effort to continue to maintain a drug- free workplace through implementation of paragraphs (b)(1)(A), (b)(1)(B), (b)(1)(C), (b)(1)(D), (b)(1)(E) and (b)(1)(F).

(2) The recipient shall insert in the space provided below the site(s) for the performance of work done in connection with the specific Cooperative Agreement:

Place of Performance (Street address, city, county, state, zip code)

Alternate II

The recipient certifies that, as a condition of the Cooperative Agreement, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the Cooperative Agreement.

7. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS [3]

(a) Instructions for Certification

1. By signing and submitting this application, the prospective primary participant is providing the certification set out below.

2. The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3. The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

4. The prospective primary participant shall provide immediate written notice to the department or agency to whom this application is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

5. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "application," and "voluntarily excluded," as used in this clause, have the meaning set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549. [4] You may contact the department or agency to which this application is being submitted for assistance in obtaining a copy of those regulations.

6. The prospective primary participant agrees by submitting this application that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.

7. The prospective primary participant further agrees by submitting this application that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," [5] provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the methods and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non-procurement List.

9. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealing.

10. Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

(b) Certification Regarding Debarment, Suspension, and Other Responsibility Matters--Primary Covered Transactions

(1) The prospective primary participant certifies to the best of its knowledge and belief, that it and its principals:

(A) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(B) Have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(C) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(B) of this certification;

(D) Have not within a three-year period preceding this application/application had one or more public transactions (Federal, State or local) terminated for cause or default.

(2) Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this application.

PART II - KEY INDIVIDUAL CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

I hereby certify that within the last ten years:

1. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.
2. I am not and have not been an illicit trafficker in any such drug or controlled substance.
3. I am not and have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

Signature: _____

Date: _____ (MM/DD/YYYY)

Name: _____

Title/Position: _____

Organization: _____

Address: _____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140, Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain key individuals of organizations must sign this Certification.
2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

PART III - PARTICIPANT CERTIFICATION NARCOTICS OFFENSES AND DRUG TRAFFICKING

1. I hereby certify that within the last ten years:

- a. I have not been convicted of a violation of, or a conspiracy to violate, any law or regulation of the United States or any other country concerning narcotic or psychotropic drugs or other controlled substances.
- b. I am not and have not been an illicit trafficker in any such drug or controlled substance.
- c. I am not or have not been a knowing assistor, abettor, conspirator, or colluder with others in the illicit trafficking in any such drug or substance.

2. I understand that USAID may terminate my training if it is determined that I engaged in the above conduct during the last ten years or during my USAID training.

Signature: _____

Name: _____

Date: _____

Address: _____

Date of Birth: _____

NOTICE:

1. You are required to sign this Certification under the provisions of 22 CFR Part 140, Prohibition on Assistance to Drug Traffickers. These regulations were issued by the Department of State and require that certain participants must sign this Certification.
2. If you make a false Certification you are subject to U.S. criminal prosecution under 18 U.S.C. 1001.

PART IV - CERTIFICATION OF COMPLIANCE WITH THE STANDARD PROVISIONS ENTITLED "CONDOMS" AND "PROHIBITION ON THE PROMOTION OR ADVOCACY OF THE LEGALIZATION OR PRACTICE OF PROSTITUTION OR SEX TRAFFICKING."

This certification requirement only applies to the prime recipient. Before a U.S. or non-U.S. non-governmental organization receives FY04-FY08 HIV/AIDS funds under a grant or cooperative agreement, such recipient must provide to the Agreement Officer a certification substantially as follows:

"[Recipient's name] certifies compliance as applicable with the standard provisions entitled "Condoms" and "Prohibition on the Promotion or Advocacy of the Legalization or Practice of Prostitution or Sex Trafficking" included in the referenced agreement."

RFA/APS No. _____

Application No. _____

Date of Application _____

Name of Applicant/Subgrantee _____

Typed Name and Title _____

Signature _____

PART V: SUPPORTING USAID'S DISABILITY POLICY IN COOPERATIVE AGREEMENTS

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

(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 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.”

PART VI - SURVEY ON ENSURING EQUAL OPPORTUNITY FOR APPLICANTS

Applicability: All RFA's must include the attached Survey on Ensuring Equal Opportunity for Applicants as an attachment to the RFA package. Applicants under unsolicited applications are also to be provided the survey. (While inclusion of the survey by Agreement Officers in RFA packages is required, the applicant's completion of the survey is voluntary, and must not be a requirement of the RFA. The absence of a completed survey in an application may not be a basis upon which the application is determined incomplete or non-responsive. Applicants who volunteer to complete and submit the survey under a competitive or non-competitive action are instructed within the text of the survey to submit it as part of the application process.)

PART VII - OTHER STATEMENTS OF RECIPIENT

1. AUTHORIZED INDIVIDUALS

The recipient represents that the following persons are authorized to negotiate on its behalf with the Government and to bind the recipient in connection with this application or grant:

Name	Title	Telephone No.	Email Address

2. TAXPAYER IDENTIFICATION NUMBER (TIN)

If the recipient is a U.S. organization, or a foreign organization which has income effectively connected with the conduct of activities in the U.S. or has an office or a place of business or a fiscal paying agent in the U.S., please indicate the recipient's TIN:

TIN: _____

3. CONTRACTOR IDENTIFICATION NUMBER - DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER

(a) In the space provided at the end of this provision, the recipient should supply the Data Universal Numbering System (DUNS) number applicable to that name and address. Recipients should take care to report the number that identifies the recipient's name and address exactly as stated in the application.

- (b) The DUNS is a 9-digit number assigned by Dun and Bradstreet Information Services. If the recipient does not have a DUNS number, the recipient should call Dun and Bradstreet directly at 1-800-333-0505. A DUNS number will be provided immediately by telephone at no charge to the recipient. The recipient should be prepared to provide the following information:
- (1) Recipient's name.
 - (2) Recipient's address.
 - (3) Recipient's telephone number.
 - (4) Line of business.
 - (5) Chief executive officer/key manager.
 - (6) Date the organization was started.
 - (7) Number of people employed by the recipient.
 - (8) Company affiliation.
- (c) Recipients located outside the United States may obtain the location and phone number of the local Dun and Bradstreet Information Services office from the Internet Home Page at <http://www.dbisna.com/dbis/customer/custlist.htm>. If an offeror is unable to locate a local service center, it may send an e-mail to Dun and Bradstreet at globalinfo@dbisma.com.

The DUNS system is distinct from the Federal Taxpayer Identification Number (TIN) system.

DUNS: _____

4. LETTER OF CREDIT (LOC) NUMBER

If the recipient has an existing Letter of Credit (LOC) with USAID, please indicate the LOC number:

LOC: _____

5. PROCUREMENT INFORMATION

- (a) Applicability. This applies to the procurement of goods and services planned by the recipient (i.e., contracts, purchase orders, etc.) from a supplier of goods or services for the direct use or benefit of the recipient in conducting the program supported by the grant, and not to assistance provided by the recipient (i.e., a subgrant or subagreement) to a subgrantee or sub recipient in support of the sub grantee's or sub recipient's program. Provision by the recipient of the requested information does not, in and of itself, constitute USAID approval.
- (b) Amount of Procurement. Please indicate the total estimated dollar amount of goods and services which the recipient plans to purchase under the grant:
- \$ _____
- (c) Nonexpendable Property. If the recipient plans to purchase nonexpendable equipment which would require the approval of the Agreement Officer, please indicate below (using a continuation page, as necessary) the types, quantities of each, and estimated unit costs. Nonexpendable equipment for which the Agreement Officer's approval to purchase is required is any article of nonexpendable tangible personal property charged directly to the grant, having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit.

TYPE/DESCRIPTION (Generic)	QUANTITY	ESTIMATED UNIT COST
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- (d) Source, Origin, and Componentry of Goods. If the recipient plans to purchase any goods/commodities which are not of U.S. source and/or U.S. origin, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, and probable source and/or origin. "Source" means the country from which a commodity is shipped to the cooperating country or the cooperating country itself if the commodity is located therein at the time of purchase. However, where a commodity is shipped from a free port or bonded warehouse in the form in which received therein, "source" means the country from which the commodity was shipped to the free port or bonded warehouse. Any commodity whose source is a non-Free World country is ineligible for USAID financing. The "origin" of a commodity is the country or area in which a commodity is mined, grown, or produced. A commodity is produced when: through manufacturing, processing, or substantial and major assembling of components, a commercially recognized new commodity results, which is substantially different in basic characteristics or in purpose or utility from its components. Merely packaging various items together for a particular procurement or relabeling items does not constitute production of a commodity. Any commodity whose origin is a non-Free World country is ineligible for USAID financing. "Components" are the goods which go directly into the production of a produced commodity. Any component from a non-Free World country makes the commodity ineligible for USAID financing.

TYPE/ PROBABLE DESCRIPTION COMPONENTS (Generic)	QUANTITY	EST. GOODS UNIT Cost	PROBABLE SOURCE	GOODS
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- (e) Restricted Goods. If the recipient plans to purchase any restricted goods, please indicate below (using a continuation page, as necessary) the types and quantities of each, estimated unit costs of each, intended use, and probable source and/or origin. Restricted goods are Agricultural Commodities, Motor Vehicles, Pharmaceuticals, Pesticides, Rubber Compounding Chemicals and Plasticizers, Used Equipment, U.S. Government-Owned Excess Property, and Fertilizer.

TYPE/ DESCRIPTION (Generic)	QUANTITY	ESTIMATED UNIT COST	PROBABLE SOURCE	PROBABLE ORIGIN	INTENDED USE
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- (f) Supplier Nationality. If the recipient plans to purchase any goods or services from suppliers of goods and services whose nationality is not in the U.S., please indicate below (using a continuation page, as necessary) the types and quantities of each good or service, estimated costs of each, probable nationality of each non-U.S. supplier of each good or service, and the rationale for purchasing from a non-U.S. supplier. Any supplier whose nationality is a non-Free World country is ineligible for USAID financing.

TYPE/ RATIONALE DESCRIPTION (Generic)	QUANTITY	ESTIMATED UNIT COST	PROBABLE SUPPLIER (Non-US Only)	NATIONALITY for Non-US
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- (g) Proposed Disposition. If the recipient plans to purchase any nonexpendable equipment with a unit acquisition cost of \$5,000 or more, please indicate below (using a continuation page, as necessary) the proposed disposition of each such item. Generally, the recipient may either retain the property for other uses and make compensation to USAID (computed by applying the percentage of federal participation in the cost of the original program to the current fair market value of the property), or sell the property and reimburse USAID an amount computed by applying to the sales proceeds the percentage of federal participation in the cost of the

original program (except that the recipient may deduct from the federal share \$500 or 10% of the proceeds, whichever is greater, for selling and handling expenses), or donate the property to a host country institution, or otherwise dispose of the property as instructed by USAID.

TYPE/DESCRIPTION (Generic)	QUANTITY	ESTIMATED UNIT COST	PROPOSED	DISPOSITION
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6. PAST PERFORMANCE REFERENCES

On a continuation page, please provide a list of the most recent and/or current U.S. Government and/or privately-funded contracts, grants, cooperative agreements, etc., and the name, address, and telephone number of the Contract/Agreement Officer or other contact person.

7. TYPE OF ORGANIZATION

The recipient, by checking the applicable box, represents that -

If the recipient is a U.S. entity, it operates as a corporation incorporated under the laws of the State of _____, an individual, a partnership, a nongovernmental nonprofit organization, a state or local governmental organization, a private college or university, a public college or university, an international organization, or a joint venture; or

(a) If the recipient is a non-U.S. entity, it operates as a corporation organized under the laws of _____ (country), an individual, a partnership, a nongovernmental nonprofit organization, a nongovernmental educational institution, a governmental organization, an international organization, or a joint venture.

8. ESTIMATED COSTS OF COMMUNICATIONS PRODUCTS

The following are the estimate(s) of the cost of each separate communications product (i.e., any printed material [other than non-color photocopy material], photographic services, or video production services) which is anticipated under the grant. Each estimate must include all the costs associated with preparation and execution of the product. Use a continuation page as necessary.

FORMATS\GRNTCERT: Rev. 06/16/97 (ADS 303.6, E303.5.6a) When these Certifications, Assurances, and Other Statements of Recipient are used for cooperative agreements, the term "Grant" means "Cooperative Agreement". The recipient must obtain from each identified subgrantee and sub-contractor, and submit with its application/proposal, the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Transactions, set forth in Attachment A hereto. The recipient should reproduce additional copies as necessary. See ADS Chapter E303.5.6a, 22 CFR 208, Annex1, App A. For USAID, this clause is entitled "Debarment, Suspension, Ineligibility, and Voluntary Exclusion (March 1989)" and is set forth in the grant standard provision entitled "Debarment, Suspension, and Related Matters" if the recipient is a U.S. nongovernmental organization, or in the grant standard provision entitled "Debarment, Suspension, and Other Responsibility Matters" if the recipient is a non-U.S. nongovernmental organization.

- END OF SECTION D -