Technical Assistance Contract 4 Africa (TASC4 Africa) IDIQ SECTION A –REQUEST FOR TASK ORDER PROPOSAL (RFTOP)		
Tuberculosis South Africa Project (TBSAP)		
1	RFTOP Number	SOL-674-15-000036
2	Date RFTOP Issued	06/30/2015
3	Issuing Office	USAID/South Africa
4	Contracting Officer	Michael Ashkouri Office:+27-12-452-2171 E-mail: mashkouri@usaid.gov
5	Proposals to be Submitted to	Jaime Dominguez Office: +27-12-452-2170; Email: proposals@usaid.gov **Please cite RFTOP # in subject line.**
6	Questions on RFTOP Due: Proposals Due:	07/07/2014 07/30/2015
7	Payment Office	See Section G.2 Invoices
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12	Address of Firm	XXXX
13	RFTOP Point of Contact	Name: Same as 5 above Phone: Fax: Email:
14	Person Authorized to Sign RFTOP	Sonja Stroud-Gooden, Contracting Officer
15	Signature	Sonja Stroud-Gooden
16	Date	06-30-15

PART I – THE SCHEDULE

SECTION B – SUPPLIES OR SERVICES AND PRICE

B.1 PURPOSE

The purpose of this task order (TO) is to provide technical assistance to the Government of South Africa (GoSA) in order to reduce the burden of tuberculosis (TB) in the country. The United States Agency for International Development's Mission in Southern Africa (USAID/Southern Africa or USAID/SA) seeks to provide capacity-building to strengthen implementation of government policies and guidelines.

B.2 CONTRACT TYPE

Contract type is Cost-Plus-Fixed-Fee (CPFF) term. The Contractor shall provide the level of effort described in Section F.6 to accomplish the objectives set forth under Section C of this solicitation.

B.3 ESTIMATED COST, FIXED FEE, AND OBLIGATED AMOUNT

[note that the tables and information below will be incorporated based on the successful offeror's submission]

(a) The Total Estimated Cost Plus Fixed Fee for the performance of the work required is as follows:

Total Estimated Cost:	$ xx
Fixed Fee:	$ xx
Total Estimated Cost plus Fixed Fee:	$ xx

(b) The total estimated cost for the performance of the work required hereunder, exclusive of fixed fee, is $xx. The total fixed fee is $xx. The total estimated cost plus fixed fee is $xx.

B.4 INDIRECT COSTS

Pending establishment of revised provisional or final indirect cost rates, allowable indirect costs shall be reimbursed on the basis of the appropriate rates and bases:

Description	Rate	Base	Type	Period
	xx.xx% xx.xx%	1/	Provisional	xx/xx/xx until amended
G&A	xx.xx%	4/	Provisional	xx/xx/xx until amended

B.5 COST REIMBURSABLE

The U.S. dollar costs allowable shall be limited to reasonable, allocable, and allowable costs determined in accordance with FAR 52.216-7, "Allowable Cost and Payment," FAR 52.216-8, Fixed Fee, if applicable, and AIDAR 752.7003, "Documentation for Payment." The application of the following clauses (incorporated by reference in Section I) is as follows:

FAR 52.232-20 Limitation of Cost (applies while the contract is fully funded).
FAR 52.232-22 Limitation of Funds (applies while the contract is funded in an amount less than the total cost plus fixed fee).

[END OF SECTION B]

SECTION C –STATEMENT OF WORK (SOW)

C.1 OBJECTIVES

The main goal of the National TB Program (NTP), as outlined in the National Strategic Plan (NSP), is to support South Africa's vision of zero infections, death, stigma and discrimination from TB and HIV/AIDS by:

- Increasing the proportion of bacteriologically-confirmed drug-susceptible TB patients initiated on treatment;
- Strengthening the system for tracing and referral of patients during treatment in order to reduce loss to follow up;
- Increasing the proportion of Lab diagnosed Rifampicin resistant TB patients initiated on treatment;
- Increasing awareness and TB screening across general population and high-risk groups;
- Increasing the proportion of co-infected TB/HIV patients initiated on anti-retroviral drugs (ARVs); and
- Strengthening monitoring, reporting, and surveillance systems for TB and drug-resistant TB to improve the quality of data.

C.2 BACKGROUND

The South African National Department of Health (NDOH) is on course to meeting its main NSP 2012-2016 targets. Policies and guidelines that support and promote international standards are in place and the country has been a world leader in the early adoption and scale up of innovative technologies such as GeneXpert and multi-drug resistant (MDR) TB treatments such as Bedaquiline. There has been a rapid scale-up of anti-retroviral therapy (ART) services, resulting in a four-fold increase in the number of people receiving ART between 2009 and 2012. The national HIV counseling and testing (HCT) campaign resulted in about 15-20 million tests for HIV and over 3 million people screened for TB. There is universal coverage for prevention of mother-to-child transmission (PMTCT) services. TB case detection has increased and the number of sites initiating MDR-TB treatment has increased from 11 to 45. Among the critical outcomes, the TB treatment success rate has been improving over the years, from 54% in 2000 to 79% in 2011. However, this is still below the global target of 85%.

Despite these improvements, challenges remain in bridging the gaps in case detection and successful treatment of cases in order to reach global TB control targets. Also, South Africa lags behind in some areas including TB coverage among children and adolescents, and other key populations. The TB epidemic is further compounded by drug-resistant tuberculosis, with almost 15,419 laboratory confirmed MDR-TB cases and over 900 extensive drug resistant (XDR)-TB cases in 2012. TB screening among people living with HIV (PLHIV) is around 80%. Of those who are screened negative for TB disease, only 38% were initiated on Isoniazid Preventive Therapy (IPT). TB screening for PLHIV has been scaled up and collaborative TB/HIV activities strengthened, especially through the expansion of HIV testing and decentralization of

ART through Nurse-Initiated Management of ART (NIMART) for adults. However, staff nurses, who serve as primary TB focal points, have been excluded from NIMART trainings and qualifications, and consistent gaps exist in integrating TB prevention (through IPT) and TB screening and diagnosis in pre-ART care. Late initiation of ART in TB patients has contributed to high levels of mortality.

In an effort to systematically and thoroughly document the state of TB in South Africa, the NDOH commissioned a Joint Review of the TB/HIV and PMTCT programs in 2013. The main purpose of this independent review, carried out by a multi-disciplinary team of South Africans and international reviewers, was to assess performance of the program and provide options for improvements. The focus of the Joint Review was on issues critical to effective delivery and impact of HIV, TB and PMTCT services – to assess progress made, identify challenges, and highlight best practices. The review also recommended strategic and operational approaches for further scale-up, improvement of quality and increasing value for money of key HIV, TB and PMTCT services. The Final Report published in April 2014 had 12 overall recommendations of which the following nine focused on TB:

1. Promote the routine use of cascade analysis at all levels to identify intervention points to reduce losses and enforce long term retention in care of both PLHIV and TB.
2. Further strengthen capacity for the delivery of integrated services at primary health care (PHC) and community level with particular focus on improving access to HIV and TB services for children, adolescents and key populations.
3. Introduce, strengthen and routinize systematic screening and diagnosis of TB including in maternal, neonatal and child health, community based outreach services and among health works.
4. Optimize the full use of GeneXpert (GXP) for the diagnosis of drug susceptibility and drug resistant TB at PHC.
5. Ensure correct recording of GXP Mycobacterium TB (MTB)/Rifampicin (RIF) results at PHC levels.
6. Integrate program management (supervision, training, planning, and resource mobilization) particularly at district and sub-district levels across TB, HIV and MCH programs using context specific mechanisms.
7. Introduce a unique patient identifier that will assist the inter-operability and linkage of existing systems.
8. Establish and strengthen the standardized documentation and reporting of community-based activities in TB, HIV and maternal child health (MCH)/PMTCT services.
9. Integrate and improve existing patient records, registers and information systems with particular emphasis of the following key items: introduce electronic TB register "ETR.net" to all facilities already implementing Tier.net and integrate IPT initiation.

The Project Design Team (PDT) envisions that the overarching goal of the five-year Tuberculosis South Africa Project (TBSAP) will be to reduce the burden of TB, X/MDR-TB, and TB/HIV in South Africa. This will contribute to achieving the Mission's Development Objective 1, *Health outcomes for South Africans improved,* expressed in the Country Development Cooperation Strategy (CDCS). The goal will be achieved through a number of inputs in support of three key objectives aiming to ensure

that TB diagnosis and treatment in South Africa is more effective, and more accessible to all, including vulnerable populations.

The TBSAP will support and build upon the progress made under USAID's current and prior TB interventions, achievements and activities, as well as the results from the formal evaluation of these activities. The project is in alignment with the South Africa NSP 2012-2016 and in accordance with World Health Organization's (WHO) new Stop TB Strategy and the new USG Global TB strategy. In addition, Grants under Contract (GUCs) will be made available over the life of the contract to strengthen local capacity, encourage innovation, and improve the overall capacity and implementation of TB programs by South African local organizations.

C.3 KEY COMPONENTS, TASKS, AND OUTCOMES

The National Department of Health (NDOH) provides policy guidance and technical leadership for the National TB program, which is primarily funded by the Government of South Africa. These resources support a public health program for HIV/AIDS and TB that is managed through a network of provincial, district, sub-district and local health facilities and hospitals, responsible for the implementation of effective TB programs in accordance with policy set by the national TB program. The national program also funds all drug procurement and laboratory services. Recent NDOH policy has mandated increased decentralization of TB treatment, under the PHC Re-engineering Framework, specifically for all TB patients receiving medication, including ART, and patients with MDR-TB referred down to PHC facilities.

The development problem addressed by USAID is the issue of fast, consistent and sustainable implementation of the national TB policy. The TB program is managed and monitored through provincial, district, and sub-district programs that include a data recording and reporting system from the PHC level up. Community organizations are also involved in services at the PHC level. But the quality of service delivery is uneven. A recent review by the national TB Program analyzing district level data to identify low-performing areas, confirmed that implementation of national standards for the TB program was inconsistent. Problem areas include major gaps in recording and reporting service delivery and TB incidence, delays in turn-around time after MDR-TB testing, issues around cross-testing and referrals of co-infected TB/HIV patients, consistent infection control (IC), and public awareness of the TB epidemic. The policy and guidelines for the management of TB have been well articulated by the national TB program: the problem is ensuring consistent, high quality implementation of the policies. Two conditions are required to be met in addressing this problem: (1) long-term commitment to detailed, regular assessments of progress; and (2) supportive input to expand improved implementation of government policy from an independent trusted organization or organizations.

The development hypothesis for this project is that a sustainable response to the TB epidemic requires minimizing the transmission of TB, expanding access to TB services, improving the quality of TB services at provincial, district and local levels, and working with both health practitioners and community members to ensure their understanding of, commitment to, and participation in an expanded high-quality TB program. The

hypothesis is based on USAID's past experience in South Africa that evidence-based capacity-building to support the Government of South Africa's (GoSA) TB Program has contributed to the adoption of new methodologies and strengthened systems by the National TB Program.

Project Purpose, Sub-Purposes and Logical Framework

The activities proposed will take place within the framework of, and in partnership with, the National TB Program. USAID will continue to strengthen the TB response in South Africa by providing capacity-building to strengthen implementation of government policies and guidelines. Furthermore, to improve continuity and sustainability after the activity ends, USAID seeks to strengthen the utilization of the highly qualified and suitable local resources (including personnel, policies, procedures, and systems) available in South Africa.

The purpose of the TBSAP is to *reduce the burden of TB in South Africa.* This will contribute to achieving the Mission's Development Objective 1, *Health outcomes for South Africans improved*, expressed in the Country Development Cooperation Strategy (CDCS), and to the overall goal of the CDCS: *South Africa's continued transformation into an equitable, effective and exemplary nation strengthened.* The project sub-purposes are aligned with the Intermediate Results of Development Objective 1 in the CDCS.

Intermediate Result 1: *TB Infections Reduced*
IR 1.1: Increased public awareness of the TB epidemic
IR 1.2: Effective implementation of Infection Control
IR 1.3: Improved TB screening, including key populations

Intermediate Result 2: *Sustainability of Effective TB Response Systems Increased*
IR 2.1: Strengthened management capacity at all levels
IR 2.2: Strengthened service delivery capacity at all levels
IR 2.3: Improved data reporting and recording systems at all levels

Intermediate Result 3: *Care and Treatment of Vulnerable Populations Improved*
IR 3.1: Increased contact tracing of key populations
IR 3.2: Improved TB case management in key populations
IR 3.3: Strengthened comprehensive systems and partnerships for care

The project will be aligned with government priorities. It will work in conjunction with other donor programs and will keep the government and other donors informed of the project's progress. It will also collaborate with USAID/South Africa's Implementation Science Research Agenda to provide information on project results and barriers that may inform research needs. Primarily, the project will coordinate closely with USG South Africa's PEPFAR program, which addresses the needs of the approximately 60% of TB patients who are co-infected with HIV. (See Annex B. for Logical Framework table)

Planned Accomplishments and Activity Highlights

Purpose level accomplishments will reduce the burden of TB in South Africa. They will

include progress towards universal access to TB services through increasing the number of identified TB cases and expanding outreach, care and treatment to vulnerable populations, many of whom do not currently have access to TB services. The project will improve the systems, process and time needed for TB case identification, including MDR-TB, contact tracing, starting treatment and ensuring treatment completion, and will support an improved and harmonized data recording, reporting and feedback system. The project will focus on improvements in areas identified as needing strengthening in the *WHO Joint Review.*

Project activities will contribute, through support for the development of TB management systems and human capacity, to the following indicators of success in the NSP:

- Increase the Treatment Success Rate to 85% for drug-susceptible cases and MDR-TB to at least 70%;
- Successfully initiate all bacteriologically confirmed DR-TB cases on appropriate treatment;
- Increase ART coverage to 90% for all registered TB cases who are co-infected with HIV.

Intended outputs/results include:

- Strengthened human and institutional capacity of health system to manage TB, X/MDR-TB, TB/HIV services;
- More equitable access to comprehensive and quality TB preventive, diagnostic and treatment services for vulnerable populations, including women;
- Early detection of TB amongst HIV-positive clients through regular TB testing;
- Integrated, and community-based systems for TB and MDR-TB implemented across districts;
- Enhanced enabling environment promoting TB, X/MDR-TB, TB/HIV services;
- Improved coordination and linkage of TB with other health services (HIV, PMTCT), private sector, community and civil society organizations (CSOs) ;
- Use by TB service providers and managers of harmonized electronic TB management information systems (MIS) and of quality data for evidence-based decision making at all levels.

Intermediate Result 1: *TB Infections Reduced*

Prevention is one of the pillars of the Global post-2015 strategy that was recently endorsed by the World Health Assembly in May 2014. The main areas for interventions to reduce TB infections include strategies such as screening for TB, improved follow-up for those dropping out of treatment, stronger infection control in health facilities and congregate settings, effective treatment, and advocacy to increase public awareness of the risk of contracting TB and of prevention measures. The risk of TB transmission is affected by many other factors, including the prevalence of active infectious pulmonary disease in the community; the severity of TB disease; the frequency, intensity, and duration of exposure; and the presence of risk factors such as HIV, diabetes mellitus, silicosis, overcrowding in congregate settings.

IR 1.1: Increased public awareness of the TB epidemic

While prevention of transmission requires accelerated action to minimize TB infection and accelerate cure, it is also hastened through programs to increase public awareness of risk. Despite the high prevalence of TB infections in South Africa, including the high level of HIV/AIDS and TB co-infection, the extent of the TB epidemic and the risk of TB infection have a low public profile. South Africa has high implementation capacity for TB treatment, with over 8000 public health facilities in the country, but there is little public awareness of the disease.

The Contractor will develop a strategy to promote and provide capacity-building to Advocacy, Communication and Social Mobilization (ACSM) activities, working in collaboration and support of the National TB Program's planned activities, and with the Management Teams at provincial, district and local levels. The TBSAP will intensify ACSM to bring the extent of the epidemic and its impact on national productivity and individual lives to the forefront of public attention. Additional issues that can be highlighted include support for adherence to treatment and for the role of individuals as enablers for completing treatment. The strategy will also explore collaboration with commercial and community enterprises to catalyze their involvement in local events to increase public awareness, and will develop mechanisms to measure links between exposure to events or campaigns and attendance and screening for TB.

Activities could include the development of timed campaigns and messages aimed at increased knowledge of TB among the general public, including schools, outreach to clubs and organizations outside health facilities and collaboration with the NTP to ensure local events reflect national campaigns.

IR 1.2: Effective Implementation of Infection Control

The foundation of infection control and transmission prevention is early and rapid diagnosis of infectious cases and proper management of TB patients rendering them non-infectious. However, key activities usually associated with infection prevention and control (IPC) are those related to health settings, such as implementation of administrative and environmental controls, including use of personal protective equipment, adequate ventilation, and minimizing close contact between infected and non-infected persons in congregate settings. Preventing the spread of TB and MDR-TB in congregate setting and communities is a major concern to USAID/SA, and a fundamental core requirement of this SoW. The prevention and reduction of the number of infections in high risk populations and settings is critical to achieving a reduction in TB infections.

Reduction of TB infection is also dependent on reducing initial defaulter rates, and this in turn is linked to the capacity of facilities, particularly at the PHC level, and communities to support patients who are on treatment. The project will build the capacity of health providers and NGO and community partners to foster adherence, track and re-enroll defaulters, and thus reduce the risk of infection.

The high infection rate among health providers is also evidence of the need to strengthen

IC in health settings[1]. There have been limited efforts to support IC implementation in congregate settings, such as prisons, shelters, congested urban environments and other community settings. However, the most cost-effective and efficient manner to implement IPC requires additional study. The project will focus on improved implementation of IPC recommendations at national, facility, community, congregate and household settings. The Contractor should incorporate a plan to measure, assess, and prioritize the most effective evidence-based interventions to support sustainable improved IPC.

Illustrative inputs could include facility-level assessments, the development of IPC tools and job aids, support for ACSM strategies targeting communities and key populations, strengthened partnerships with relevant government entities, and operations and implementation research.

IR 1.3: Improved TB screening, including key populations

The primary strategy of screening is to improve the early detection of active TB which leads to early treatment, reduced risk of poor treatment outcomes, and reduced prevalence and death rates. In addition, it reduces transmission by shortening the infectiousness period and reduced incidence of TB. The Project will therefore support the NDOH through strategies to increase access to improved TB testing, particularly for individuals and groups at high risk. The approaches include:

(a) Expanding strategies to reach, screen and evaluate individuals in groups at higher risk for latent TB infection and TB disease. Many from these groups do not present to health care facilities or benefit from intensified case finding in care facilities, congregate settings and other high risk locations. This approach will be strengthened by increased partnerships with community-based organizations (CBOs) and other social organizations, particularly at the community level.

(b) Improved application of diagnostic tests and clinical assessment with high combined specificity. This particularly applies to the introduction of testing with GXP machines to track MDR-TB and provide a faster, more specific diagnosis. Despite laboratory confirmed diagnosis of the total number of MDR-TB cases, less than half of those were started on treatment in 2012. The Project will continue to support GXP implementation and further study of the cause of the unexpected decline in treatment initiation.

(c) Minimizing the risk of progression from latent TB infection (LTBI) to disease. There is a large population of individuals with latent TB, who will continue to generate TB cases unless their risk of progression to disease is diminished through a post-exposure vaccine, improved LTBI detection, treatment implementation and adherence, and/or addressing the underlying clinical and population risk factors for progression. These strategies may also need to be targeted to key populations and settings within South Africa. Screening for LTBI is beneficial if LTBI diagnosis can be made with reasonable accuracy, while excluding active TB. Currently, there is no reliable standard for LTBI diagnosis, and the decision to treat LTBI is largely based

[1] A 2009 study of 133 PHC facilities indicated an incidence rate of more than double that of the general population (Classens et.al, TB in Healthcare Workers, PLOS 1, October 2013).

on imprecise tests in combination with the identification of risk markers for progression to active disease. The coverage and adherence to LTBI treatment are poor and its effectiveness, based on current treatment regimens, is not fully proven.

Illustrative activities and input to support this output include: support for Implementation research to collect and assess data on screening processes; strengthening the development and dissemination of guidelines, standard operating procedures (SOPs) and policies on screening and follow-up; ongoing support for health and mobile facilities at district and community level, particularly for vulnerable groups, and developing activities to reduce access barriers to vulnerable and underserved groups, for example linkages with PHC/MCH services.

***Intermediate Result 2**: Increased Sustainability of Effective TB Response Systems*

TB services are implemented and delivered by existing health systems, which provide the platform on which key TB prevention, diagnosis and treatment activities are introduced, expanded and strengthened. The quality of the larger health system, including the capability and attitudes of its staff, therefore has a critical role in the provision of quality TB services. Underlying the ability of the Project to provide sustainable capacity-building to support the effective implementation of health policy, is therefore the need to strengthen the capability of Health Management Teams at all levels to identify gaps and shortfalls in procedures; guide the recording, reporting, analysis and feedback of relevant data; and propose and get consensus on future action (e.g. training required). It is critical to improve the quality and availability of TB-related health systems including those for drug and laboratory policy and management, human resources for health, and monitoring and evaluation (M&E).

IR 2.1: Strengthened management capacity at all levels

It is expected that specific activities to strengthen management capacity will be developed following a baseline Quality Assurance (QA) assessment of current procedures in low-performing health facilities to identify current strengths and weaknesses. A particular area of interest is the extent of effective implementation of the recent NDOH policy of decentralization and re-engineering the responsibilities of the management of identified chronic diseases at the PHC level. This includes TB patients receiving medication, and MDR-TB patients who have been referred down. It also includes PLHIV on pre-ART treatment or on ART, including mothers and children on the PMTCT program. Decentralization has been accompanied by new responsibilities, such as the creation of a Ward-based Outreach Team (WBOT) that includes both nurses and Community Health Workers. Monitoring and providing training to this expanded community outreach will be part of the scope of the TBSAP project.

Issues to be addressed by the TBSAP include assisting the Management Teams to plan for, assess and supervise the technical capability of staff in health facilities; the scope and frequency of outreach to the community; the linkages with and involvement of stakeholders; and the system of cross-referrals and exchange of information between health facilities and the PHC system. The assumption underlying this activity is that strengthened management capacity will contribute to and be reflected in institutionalized and improved systems.

Illustrative input activities to support this output include: assessing the efficacy of existing QA systems; introduction and scale-up of Comprehensive Case Management and Treatment approaches; capacity-building to support the Integrated Clinical Services Model; strengthening the training and post-training assessment procedures for health staff; and working with PEPFAR to harmonize and strengthen links between the HIV/AIDS and TB programs at all levels.

IR 2.2: Strengthened service delivery capacity at all levels

This outcome will focus on two major areas: first, the Project will provide guidance and training to health care personnel, with particular attention to institutionalizing sustainable quality improvement through work with nursing colleges, expanding access to training programs, and focusing on strengthening a Training of Trainers approach. Second, the Project will strengthen supportive systems for patient treatment. The Project will explore innovative strategies for reducing the turnaround time (TAT) for test results, especially for infection control, and initiating treatment early.

(a) Training health providers on TB remains a challenge. Training programs, materials and follow-up of staff performance will be developed as required, based on an assessment of needs in each Project district. An ongoing problem for strengthening staff capacity has been a disconnection between staff training and frequent staff transfers. The Project will also assess the need to establish a training program focusing on Palliative Care for TB patients who are non-responsive to drugs, and work with the NTP to establish standards and practices to scale up effective approaches to service delivery, at both the facility and community level.

Activities could include ensuring regular quality assurance reviews and follow up of TOT courses for both pre- and in-service training, supporting the establishment of Provincial Expert Committees and support for new systems, such as the WBOTs at the PHC level. Curriculum reviews are another approach to ensuring that new methodologies and research findings are fully represented and that scale-up of current best practices is supported through training.

(b) A functional comprehensive laboratory network is a priority for a successful TB program. The network should be able to address the management, organizational, bio-safety, and work quality aspects of the laboratory at all levels. It is critical that future approaches to laboratory and diagnostic strengthening are comprehensive and strategic in nature to fully address the gaps and delays in the national TB program. This is one of the priority areas for the DOH.

Specifically, the capacity of the laboratories in South Africa to detect drug resistant TB strains can be further improved. While the use of GXPfor diagnosis has been scaled up rapidly, the experience so far has not shown a decrease in the TAT for initiation of treatment compared to conventional smear microscopy. Delays in treatment initiation mean an increased likelihood of transmission of TB, including DR-TB, particularly if the patients have already been referred down to the PHC level. The development, introduction, and expansion of laboratories to conduct quality culture and drug susceptibility testing (DST), and introduce new and more

effective diagnostic tools for MDR-TB detection is an urgent and critical issue to be addressed. There needs to be a comprehensive and rapid approach to supporting the national TB Program in strengthening this capacity. This technical area will therefore focus on the policy, management, supervisory and quality assurance systems for smear microscopy, culture, drug susceptibility testing, Global Exchange Program (GXP) methodology and all other new diagnostics.

The immediate goal of this activity is a reduction in the TAT for testing, resulting from strengthened TB diagnosis network capability and stronger linkages with treatment sites, supported by an effective system for collecting and transporting specimens to laboratories for TB diagnosis.

The Contractor will provide input for the development and implementation of TB and DR-TB diagnostic algorithms to guide the best combination and utilization of all available TB diagnostic tools (bacteriological, molecular and radiological) and for an effective system for monitoring and maintaining the quality of laboratory diagnostic services.

Training and performance reviews are essential to maintain high quality of all areas related to TB control, for example, to ensuring an effective drug supply and management system. The TB recording and reporting system is designed to provide the information needed to plan, procure, distribute and maintain adequate stocks of drugs, while pharmaceutical services need to be well managed and able to issue and track the issue of TB drugs to individual patients. Implementation of the regulatory framework for quality and rational use of medicines is essential to achieving successful treatment outcomes: the Project can work with health system management to strengthen drug procurement and management capacities to forecast TB program needs, and to ensure that this subject is part of pre-service and in-service training.

IR 2.3: Improved data recording and reporting systems at all levels

A key component of this Project is to support the DOH in its move to harmonize and standardize the recording and reporting system for TB. Target setting and monitoring of progress in implementing each component of the strategic plans are critical. Monitoring should be done routinely using standardized methods based on data with documented quality. However, the existence of complete and reliable data is weakened by the lack of harmonization and synchronization of different data systems, and gaps in data entry at service delivery level. Specifically, there are gaps in follow-up and tracking individuals which limit the DOH's ability to identify major problem areas in the Cascade of Services.

Currently, four data reporting systems are in use: the Electronic TB Register (ETR), the Electronic Drug Resistance Register (EDR), the District Health Information System (DHIS) and the new electronic Tier system. TB data is generally reported through Version 2 of the ETR (though adoption of ETR Version 2 lags in some district), while many HIV/AIDS programs funded through USAID are moving to the Tier system. Harmonization through creating functional interoperability of the current systems for TB, MDR-TB and TB/HIV and standardization of the reporting to ETR, EDR, DHIS and Tier data will improve validity and reliability, and consequently strengthen the evidence base for decision-making. The TBSAP will also track the progress and support the

introduction of the Unique Patient Identifier into data recording and reporting, which has been approved as policy by the DOH.

The Contractor will identify specific weakness in data recording, and reporting and work with the DOH, provincial and district officials to design a system for data review and analysis that can provide regular feedback on trends, successes and needs to all levels of the health system. Working with DOH Management teams will be important to strengthen data verification activities, address gaps in case notification and registration (for example, recording case entry, results and referrals in registers unconnected to the overall electronic system and so lost to analysis), and introduce and support scale-up of innovative technologies such as tablets, and cellphones for surveillance.

***Intermediate Result 3**: Care and Treatment of Vulnerable Populations Improved*

Marginalized, vulnerable populations as well as those most at-risk are a special focus for the DOH. Unless TB services are extended to serve these populations, the achievement of country goals will not be possible. Although TB, DR-TB, and TB/HIV treatment is mandated by South African national policies and provided free of charge within the public health care system, quality treatment is still not accessible to many groups of people. These include persons in congregate or disadvantaged settings, such as prisoners, miners, external and internal migrants, and other socially disadvantaged groups.

Access to treatment also needs to be expanded to ensure women are appropriately reached and gender considerations are integrated into the TB program. The barriers to access services for girls and women are considerable in South Africa. While more men contract TB than women, TB is a leading cause of infectious disease deaths among women. Diagnosis for children and adolescents is a challenge. Strategies to diagnose and treat children need to be developed, especially for children with MDR-TB and TB-HIV. There is also a need to address the statistical basis and the cultural, social, economic and/or political barriers to access to services for all groups at high risk for TB, including those in overcrowded or informal settlements and those at high risk for TB because of other health factors, such as diabetics.

The Project will use several approaches to increase care and treatment services for vulnerable populations: (1) improved systems of reaching these populations through contact tracing and TB case monitoring; (2) expanding community involvement in and links with the PHC system for directly observed treatment short-course (DOTS) delivery; and (3) increasing formal and informal linkages with organizations and institutions that work with these populations. The improvement in systems and performance that are aimed at increasing this outreach will benefit all patients. The strategy will be developed in close collaboration with PEPFAR's program for co-infected patients.

IR 3.1: Increased contact tracing among communities, including key populations

The Joint Review of TB Programs in South Africa, April 2014 identified strengthened use of cascade analysis as a key instrument in order to reduce losses of patients and the

National TB Program has identified this process as an immediate priority. Cascade analysis can identify the key intervention points in the referral cascade that need to be addressed to reduce losses and ensure retention in care for TB patients. Proposed actions include screening for TB of all persons attending health facilities, testing of identified suspects, tracing and screening of contacts of confirmed patients; initiation of treatment and loss to follow up. In collaboration with the Ministry of Health, the Global Fund is instituting a "Tracing System" that supports 52 linkage officers and Health to support the recovery of these patients.

The project will collaborate with the Global Fund to increase contact tracing and support strengthened case monitoring systems, focusing particularly on working with key populations in the project areas. Ideally, this activity could be framed as an operational research project, in collaboration with USAID's Implementation Science Research agenda. The *Joint Review of TB Programs in South Africa* identifies several problem areas that contribute to losses at each stage of the cascade: unsystematic application of the outreach TB detection services (including mobile health teams and health visits by community health workers (CHWs) and non-governmental organizations (NGOs), unstandardized and systematic TB screening practices and documentation; inconsistent data reporting and insufficient analysis of data, limited contact tracing and flexible definitions of index cases and no standardized monitoring system.

The Contractor will develop an overall plan for a pilot intervention in selected areas and set up a review board (to include DOH, PEPFAR, the Global Fund and community representation. Capacity-building will be provided to strengthen processes for working on the outreach, ACSM, and data reporting and analytic aspects of this activity; and for regular feedback on practical recommendations for change. The outcome will be verified by cascade data and supported by guidelines, job aids, and training.

IR 3.2: Improved TB case management in communities, including key populations

Expanding access to reliable, linked TB services for key populations requires tailoring program elements to the specific conditions and different issues of each population. These programs will be developed in conjunction with the DOH and with the staff at each institution. Case management systems for these populations need to be responsive to the shifting situation of many of these populations, for example, systems for sputum collection and testing in such settings.

Programs for prisoners will be developed with the Department of Correctional Services, in order to reduce the current lack of continuity in the case management of transferred and released prisoners. Screening and testing systems need to be established at initial incarceration, and rescreening at six-monthly intervals; while referral systems to ensure treatment continuation, including use of the unique patient identifier (UPI), must be established with other health facilities to minimize defaulters and adherence to treatment.

The mining industry has similar problems with a shifting population, as the workforce migrates across internal and inter-regional borders, and will require the Project to work closely with management to identify the costs, insurance implications, and mechanisms for establishing a system for TB case management that can track migrant workers

through links with their home public health facilities. The effectiveness of comprehensive TB treatment that links different health providers will depend greatly on the adoption of the UPI, strengthening a unified data system, and strengthened data reporting, recording and analysis.

Underserved populations include children, adolescents and those suffering from pre-existing health conditions, such as diabetes. Ensuring that there is universal screening at all health facilities at registration, especially at the PHC level, would strengthen pre-identification for TB testing. For children and adolescents, there is need to strengthen referrals, testing (particularly difficult for under 5s) and case reporting, and to train teachers to recognize signs and symptoms of infection. The TBSAP project will explore working with the Department of Basic Education to develop guidelines and training materials.

The TBSAP will continue to make training a key element in building the capacity of health staff. It will focus on ensuring and strengthening a sustainable training system by working with DOH to institutionalize a Train the Trainer (TOT) approach. The project will work with pre-service and in-service personnel, and nursing colleges to institutionalize training on TB and quality assurance procedures. TB staff at all levels will also be trained in the management of an effective drug supply to ensure there are no drug stock-outs; and this will be monitored through Quality Assurance reviews. Policy issues can also affect the identification of TB infection, for example in restricting the staff eligible for training through NIMART, who can refer patients for TB testing. The TBSAP will work with the DOH to provide input into policy changes that facilitate expanded identification of TB patients.

Inputs could include support for training in quality management of TB cases; the development of guidelines, algorithms and job aids to disseminate and guide the implementation of policy, and interaction, pilot activities and assessments with new partners, to reach expanded populations at risk of TB infection.

IR 3.3: Strengthened comprehensive systems and partnerships for care.

To strengthen the outreach and access to high quality patient support and care for TB services in a wider range of settings, it is necessary to develop new or stronger partnerships with the health service, across government agencies and, where possible, with local organizations and health service providers in the private sector. In South Africa, as in many other countries, the private, quasi-governmental and non-DOH public sectors play an important role in providing health and TB services and in reaching out to particular communities at risk. Challenges, however, remain in developing the capacity of local health care organizations; and in working with the private sector, which does not report data to the government's national TB register, and therefore is not included in the calculation of targets for case detection and successful TB treatment. The quality and monitoring of services of all care providers and links to the DOH system must be improved to facilitate meeting these targets. Private providers, general practitioners for example, have engaged in some pilot Private-Public Partnerships (PPPs), but scaling up these initiatives is difficult. The project will explore the opportunities for developing locally-generated models of best practices in TB, MDR-TB TB/HIV care packages and services in the private sector (for example, for physicians, pharmacists, private hospitals,

and workplaces).

The Contractor must also improve the continuity and sustainability of the project after the activity ends. Illustrative tasks include the use of grants under contract (GUCs) to improve systems, policies, and processes among local health organizations. Similarly, the selection and utilization of highly qualified and suitable local resources (including personnel, policies, procedures, and systems) available in South Africa is highly preferred.

Models of stronger partnerships across the health and social sectors and between the health sector and communities already exist. Civil society organizations and NGOs are already strongly engaged in supporting community-level health issues through funding from PEPFAR's District Support Project. Their competencies include reaching out to vulnerable populations, mobilizing populations, training their members to become leaders, channeling information, helping to create demand for care, and .framing effective delivery models. In addition, TB is a disease of poverty affecting the most marginalized and hard to reach populations. There have been efforts and small-scale models to systematically identify and address these groups in South Africa. However, there is a need to ensure the best practices are scaled-up. The project will take the lead in exploring and advocating for potential partnerships and entry points for TB services. Within government facilities, this includes advocating for inclusion of TB services and entry points for children, adolescents, youth and those at risk because of pre-existing health conditions. The Contractor will develop an overall strategy for expanding the number of entry points, the information available, and the ability for health staff to make cross-referrals; as well as an expanded system for recording this data within health facilities. The project will identify innovative cost effective means of expanding screening for TB to these populations.

In addition, TB disproportionately affects those dwelling in urban areas due to the overcrowding and links to poverty. By 2030, urban areas worldwide will house an additional 1.4 billion people, with the vast majority of this growth occurring in the developing and transitioning countries. Many TB patients in urban settings are from highly deprived communities that may contribute to a poorer outcome. In countries like South Africa with large, urban areas, the local challenges to accessing and retaining TB services are even more critical than other areas. Strategies for assessing the situation, developing and implementing local solutions, and evaluating the interventions for best practices and scale-up are needed. In addition, migrant populations and those in informal settlements are also at risk, and are often populations with minimal access to health facilities and services. The TBSAP will assess the scope of this problem in their selected districts and will collaborate with PEPFAR in identifying the best approaches to scaling up promising interventions.

The Contractor will actively pursue incipient new partnerships to reach vulnerable populations. These include working with the Department of Correctional Services, with the Department of Basic Education, and with the Department of Mining Resources. It will take a leading role in providing capacity-building to the national TB Program on developing policies and guidelines for these services; for example, in improving mechanisms for coordination between the correctional services and TB services for improved discharge planning and case management.

The project will also explore and provide input to strengthen mechanisms for referral and screening between USG agencies and major donors working with the national program. Key actions include linking and expanding activities in TB/HIV between the PEPFAR program and separately-funded USAID and Center for Disease Control (CDC) activities; and harmonizing planning with the Global Fund. .

Illustrative inputs that support this output include: identifying the health-seeking behaviors of key populations and evaluating the availability, use and quality of the TB diagnostic and treatment services available; tailoring services, including follow-up, to the needs of particular communities; improving mechanisms to link and coordinate TB services for mobile populations (prison inmates, miners, other migrant populations); strengthening the engagement of community members and organizations in follow-up for adherence and contact tracing; addressing the issues of stigma and self-stigma; and expanding discussions with industries and government departments who work with populations at risk.

C.5 KEY PERSONNEL

The Project's Key Personnel must include, at minimum, the following:

a. **Chief of Party (COP):** The COP must have the following qualities:

- A strong record of leading projects of similar size and complexity in South Africa;
- At least 10 years of experience, preferably in South Africa, in TB policy and technical skills;
- A full time, South African national COP is preferred;
- Demonstrated ability to establish productive relationships with senior government officials, the business community, civil society, and international donors; excellent written and oral communications skills;
- Excellent English language written and oral communications skills; and
- A degree in a relevant discipline such as Medicine or Public Health.

b. **Director, Technical Programs:** The Deputy COP (DCOP) must have the following qualities:

- A record of successful performance in TB technical area that, ideally, is complementary to, not duplicative of, the COP's area of expertise;
- At least 5 years health management experience;
- A full time, South African national DCOP is preferred;
- Excellent English language written and oral communications skills; and
- A degree in a relevant discipline such as Medicine or Public Health.

c. **Manager of Strategic Communications (MSC):** The MSC must have the following qualities:

- At least five years of work experience in a related field;
- Proven experience contributing to the design and/or implementation of a (local or national) government strategic communication strategy; and
- A full time, South African national is preferred;
- Excellent English language written and oral communications skills; and

- A degree in a relevant discipline such as public relations, mass communications, public policy, or journalism.

d. **Financial Management and Operations Manager:** The minimum qualifications for this position are:

- A degree in financial management, Business Administration Finance, Accounting or other relevant field, with over 10 years of experience;
- Over 10 years of accounting, operations, and financial management of large-scale, complex, international development assistance programs;
- A full time, South African national is preferred;
- Familiarity with USG financial reporting and compliance requirements will be an advantage;
- Excellent English language written and oral communications skills; and
- Demonstrated experience and skills in developing and managing large budgets.

e. **Manager of Monitoring, Evaluation and Learning:** The minimum qualifications for this position are:

- Minimum five years' work experience in implementing public health or other social sector programs is desired. PEPFAR/South Africa implementing partner experience preferred.
- Familiarity with the electronic TB register (ETR.Net);
- A full time, South African national is preferred.
- Proven experience contributing to the design and/or implementation of TB monitoring and evaluation programs to include indicator measurement, data quality assessments (DQAs), evaluations, etc.;
- Experience in briefing higher level managers;
- Excellent English language written and oral communications skills; and
- Possession of a university degree in public health, public policy, epidemiology, demography, social science or related field, and with demonstrated emphasis on database or other information management required.

C.6 PERFORMANCE MANAGEMENT AND EVALUATION PLAN (PMEP) AND INDICATORS

The Performance Management and Evaluation Plan (PMEP) is composed of the performance indicators for each level in the log frame, life of project targets, methods for data collection, including baseline data collection, plan for evaluations and special studies as well as the approach for sharing information and learning. These key performance indicators are based on those that are found in the National Strategic Plan (2012-2016), USAID Global Health Indicators for TB, and the WHO TB Indicators. The overall targets follow the "90-90-90" policy, including a 90% rate of MDR-TB diagnosed patients to start treatment, a 90% rate of treatment success, and a 90% rate for initiating TB/HIV co-infected patients on ARVs.

To achieve the overall targets, performance indicators will be defined by the Contractor to measure project performance and the impact of interventions at the goal, purpose and output levels to be recorded in the PMEP. These same indicators especially at the output level will also be adopted by the implementing partners to ensure that USAID/SA receives the required data and information to report projects and program performance as per requirements. (For further information, see Section F.7(b)) Initial targets will be revised once the baseline data is collected to define a realistic expectation of achievements. Annual targets in projects performance plans will also be reviewed based

on performance and changes in the operating environment and resource availability.

Data for the performance indicators will be collected through various sources as indicated in the Logframe (Annex B). The contractor will be the biggest source of performance data given their on the ground presence and technical expertise in the area providing routine project data on program inputs, outputs and outcomes. Other data will be collected from documents and reports produced by the South African Government (SAG) such as the electronic TB register (ETR.Net). The data collection design used for baseline data collection will be adopted for the mid-term and post ante evaluations to achieve objective judgment of the project performance. Other performance data will be collected through evaluations and special studies. It is expected that the COR, together with other technical officers, will conduct DQA for selected indicators annually.

A draft monitoring framework is provided in Annex A. where the indicators, baseline and targets, proposed data collection methods, data disaggregation requirements and the individuals who will be responsible must be provided. In addition, custom indicators and targets suggested by the selected contractor must be included in the PMEP. The implementing partner will be required to allocate sufficient resources for M&E in consultation with USAID/SA, as part of the PMEP. A list of required USAID indicators is included in the attached Logical Framework (Annex B.), and additional indicators and targets will be based on the proposed interventions.

To achieve project results, the Contractor must build upon the work completed and in-progress under the existing TB Project. All interventions must also comply with USAID Environmental Procedures in Title 11 of the Code of Federal Regulations, Chapter 216 (22 CFR 216), and in USAID's Automated Directives System (ADS) Parts 201.5.10g and 204 (*http://www.usaid.gov/policy/ads/200/*). USAID completed an Initial Environmental Examination (IEE), which is also included. (See Section H.7)

[END OF SECTION C]

SECTION D – PACKAGING AND MARKING

D.1 AIDAR 752.7009 MARKING (JAN 1993)

(a) It is USAID policy that USAID-financed commodities and activities, and project construction sites and other project locations be suitably marked with the USAID brand. As a general rule, marking is not required for raw materials shipped in bulk (such as coal, grain, etc.), or for semi-finished products which are not packaged.

(b) Authority to waive marking requirements is vested with the Regional Assistant Administrators, and with Mission Directors.

(c) A copy of any specific marking instructions or waivers from marking requirements is to be sent to the Contracting Officer; the original should be retained by the Contractor.

D.2 BRANDING STRATEGY AND MARKING PLAN

In accordance with ADS 320.3.2.1, Contractor must prepare a Branding Implementation Plan (BIP) and Marking Plan (MP) to address the Branding Strategy described below. This is to ensure that the successful Offeror's Branding Implementation Plan and Marking Plan under this contract are in compliance with the USAID Graphics Standard Manual available at http://www.usaid.gov/branding and any successor branding policy, as detailed in ADS Chapter 320. A helpful list of Frequently Asked Questions (FAQs) about branding and marking can also be found on the USAID website: http://www.usaid.gov/branding/marking.faq.html.

Program Name: Tuberculosis South Africa (TBSAP),

Branding: The branding shall incorporate the message that "This assistance is from the American People" sponsored by USAID.

Positioning on materials and communications: USAID policy requires exclusive branding and marking in USAID direct acquisitions. Contractor is required to use USAID identity on any program-related deliverables, commodities or communication to be produced and delivered under this contract. Contractor and subcontractor's corporate identities are prohibited on all program materials. Marking is not required on contractor vehicles, offices, and office supplies or other commodities used solely for administration of this contract.

Desired Level of Visibility: USAID identity must be prominently displayed on: commodities or equipment; printed, audio, visual or electronic public communications; studies, reports, publications, web sites, and promotional and informational products; events and grants under contracts financed by USAID. Visibility for the program is a very important segment of the project implementation and is essential for the success of the TBSAP program.

Exceptions: Exceptions and waivers to USAID marking requirements may be granted in accordance with ADS 320.3.2.5 Exceptions to Contract Marking Requirements and ADS 320.3.2.6 waivers to Contract Marking Requirements.

Other organizations to be acknowledged: Where appropriate and applicable, the branding may acknowledge the cooperation and participation of other organizations deemed as partners of an event or deliverable.

All branding must comply with the standardized USAID regulations on branding. All branding for USAID, its partners, and other USG and non-USG entities engaged in a specific activity implemented under this task order, must have equal representation on all public or internal documentation, publications, advertising, presentations, brochures, etc.

The MP shall enumerate all of the public communications, commodities, infrastructure projects, program materials, events, deliverables, and other items that shall be marked with the USAID identity or brand.

The contractor shall comply with, and all contract deliverables shall be marked with the USAID identity following the requirements of the USAID "Graphic Standards Manual" available at www.usaid.gov/branding or any successor branding policy.

D.3 BRANDING, IMPLEMENTATION AND MARKING PLAN

The Contractor will adhere to all USAID policy directives and required procedures on branding and marking of USAID-funded programs, projects, activities, public communications, and commodities with the USAID "Standard Graphic Identity" (or "USAID Identity") as specified in ADS 320 (effective 05/05/2009) and the Graphic Standards Manual (GSM).

(a) In accordance with ADS 320.3.2.1, the Branding Strategy (BS) is a part of the contract requirements. Contracting Officers must ensure that USAID contract solicitations include a Branding Strategy and therefore offerors are instructed to prepare a Branding Implementation Plan (BIP) and Marking Plan (MP) to implement the Branding Strategy for TBSAP (unless directed otherwise in a specific Task Order). Contractor shall submit Branding Implementation Plan with proposal. The standard forms for the BRANDING AND MARKING TEMPLATES are located at: http://www.usaid.gov/branding/.

(b) Contractors and subcontractors' corporate identities or logos must not be used on USAID-funded program materials. Marking is not permitted on any communications that are strictly administrative, rather than programmatic, in nature. USAID identity is also prohibited on Contractor and recipient communications related to award administration, such as hiring/firing of staff or renting office space and/or equipment.

(c) Each request for Task Order proposal under this IDIQ shall request a program-

specific BIP and MP. For each Task Order, the contractor shall develop a detailed BIP and MP. The MP may include requests for exceptions to marking requirements or programmatic reasons, to be approved by the Contracting Officer. Waivers, as defined by ADS 320, may be necessary for compelling political, safety or security concerns or if the marking shall have an adverse effect in the host country. Marking and attribution for physical structures may need to be visible as soon as work commences. As grants are authorized in the TO, the Contractor shall clearly and conspicuously state in the small grants documentation and all delivered procurement that resources for the grant have been donated by USAID and make clear that the Contractor is acting as USAID's agent.

[END OF SECTION D]

SECTION E - INSPECTION AND ACCEPTANCE

E.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

The following contract clauses pertinent to this section are hereby incorporated by reference (by Citation Number, Title, and Date) in accordance with the clause at FAR 52.252-2 CLAUSES INCORPORATED BY REFERENCE in Section I of this contract. See FAR 52.252-2 for an internet address (if specified) for electronic access to the full text of a clause.

NUMBER	TITLE	DATE
	FEDERAL ACQUISITION REGULATION (48 CFR Chapter 1)	
52.246-3	Inspection of Supplies – Cost-Reimbursement	MAY 2001
52.246-5	Inspection of Services – Cost-Reimbursement	APR 1984

E.2 INSPECTION AND ACCEPTANCE

USAID inspection and acceptance of services, reports and other required deliverables or outputs shall take place at USAID/South Africa, Pretoria, South Africa or at any other location where the services are performed and reports and deliverables or outputs are produced or submitted. The Contracting Officer's Representative (COR) identified in Section F has been delegated authority to inspect and accept all services, reports and required deliverables or outputs.

[END OF SECTION E]

SECTION F – DELIVERIES OR PERFORMANCE

F.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

The following contract clauses pertinent to this section are hereby incorporated by reference (by Citation Number, Title, and Date) in accordance with the clause at FAR 52.252-2 CLAUSES INCORPORATED BY REFERENCE in Section I of this contract. See FAR 52.252-2 for an internet address (if specified) for electronic access to the full text of a clause.

NUMBER	TITLE	DATE
	FEDERAL ACQUISITION REGULATION (48 CFR Chapter 1)	
52.242-15	Stop-Work Order	(AUG 1989)
	Alternate I	(APR 1984)

F2. PERIOD OF PERFORMANCE

The period of performance is from the effective date of signing to __[to be completed at signing]__.

F.3 PLACE OF PERFORMANCE

The Contractor shall perform the services described in Section C in South Africa.

F.4 PERFORMANCE EVALUATION

Evaluation of the Contractor's overall performance shall be conducted annually by the COR and the Contracting Officer (CO), in accordance with the performance standards set forth in FAR 42.15, Contractor Performance Information and corresponding Sections C and F. This annual report shall form the basis of the Contractor's permanent performance record with regard to this contract

F.5 KEY PERSONNEL

A. Key personnel are defined as those personnel directly responsible for management of the contract, or those personnel whose professional and technical skills are certified by the requiring office as being essential for the successful implementation of the contract activity.

As stated below, the Offeror must identify the positions which it considers to be key personnel for this activity, provide detailed position descriptions for each position, and propose individuals for these positions.

The key personnel whom the Contractor shall furnish for the performance of this contract shall include at a minimum the following: (See also Section C.5)

Chief of Party (COP) _____[TBD]_____
Director, Technical Programs _____[TBD]_____
Manager of Strategic Communications (MSC) _____[TBD]_____
Finance Management and Operations Manager _____[TBD]_____
Manager of Monitoring, Evaluation and Learning _____[TBD]_____

B. The key personnel specified above are considered to be essential to the work being performed hereunder. Prior to replacing any of the specified individuals, the Contractor shall immediately notify both the Contracting Officer (CO) and USAID COR reasonably in advance and shall submit written justification (including proposed substitutions) in sufficient detail to permit evaluation of the impact on the program. No replacement of key personnel shall be made by the Contractor without the written consent of the CO.

F.6 PROFESSIONAL LEVEL OF EFFORT

(a) The contractor shall devote 84,400 person-days level of effort of professional technical employee, consultant, and subcontractor labor for the period specified in the clause Period of Performance, above.

(b) The number of person-days for any labor category may be used in any other labor category, subject to the prior written approval or direction of the COR. Once the level of effort has been fully expended, this contract is complete.

(c) The level of effort by labor category is set forth in Attachment [_] [note that this table will be incorporated based on the successful offeror's submission].

F.7 DELIVERABLES, REPORTS, AND TIMETABLE

(a) Work Plans and Training Plans

Annual work plans, annual training plans, a Performance Management & Evaluation Plan (PMEP), and a five-year overall life-of-project (LOP) work plan and training plan are required. For the first year, the Contractor shall begin working on the PMEP, as well as the annual work plan (to include assessments at the district level for upcoming annual training plans) for Year 1 of the Contract, and the LOP work plan and preliminary training plan as soon as possible. These plans must be completed on the following schedule:

1. For the first year, draft PMEP, work plans (to include assessments at the district level for upcoming annual training plans), submitted by the Contractor no later than 70 days after the effective date of the Contract;
2. USAID provides comments on draft PMEP, work plans (to include assessments at the district level for upcoming annual training plans) no later than 80 days after the effective date of the Contract; and
3. Final PMEP, work plans (to include assessments at the district level for upcoming annual training plans), submitted for approval by USAID no later than 90 days after the effective date of the Contract.

4. Draft LOP work plan and training plan submitted by the Contractor no later than 160 days after the effective date of the Contract;
5. USAID provides comments on draft LOP work plan and training plan no later than 170 days after the effective date of the Contract;
6. Final LOP work plan and training plan submitted for approval by USAID no later than 180 days after the effective date of the Contract.

For the four subsequent years, the annual work plans, annual training plans, and any updates to the LOP work plan and training plan must be completed on the following schedule:

1. Draft work plans and training plans submitted by the Contractor no later than 35 days before the anniversary date of the Contract;
2. USAID provides comments on draft work plans and training plans no later than 25 days before the anniversary date of the Contract; and
3. Final work plans and training plans submitted for approval by USAID no later than 15 days before the anniversary date of the Contract.

The annual work plans and annual training plans should provide sufficient detail to provide a working guide to the activities, services and deliverables that will be provided by the Contractor during the year. It should describe the services and deliverables required, all activities planned, and their sequence and time frames. The work plans and training plans shall be reviewed semi-annually (or as mutually agreed between the Chief of Party and the COR, based upon program implementation needs), and any changes proposed by the Contractor must be approved by USAID.

The five-year, overall LOP work plan and training plan shall provide the same information for the entire five-year period of performance for the Contract. The overall LOP work plan and training plan shall be updated annually on the schedule above to describe any and all recommended changes and modifications to services, activities or deliverables.

The details and format of the annual work plans and annual training plans should be determined through consultations between the Contractor and Mission staff, led by the COR. The COR shall determine the final content and format for the work plans and training plans. In order for a work plan or training plan to be considered completed as required by this section, it must be approved by the COR in writing.

Any technical services required in the first 90 days before the initial work plans and training plans are approved shall be authorized **in writing** by the COR and incorporated into the first annual work plan and annual training plan. Because unforeseen changes will occur during the course of a year, a work plan or a training plan may be modified during the year with the approval of the COR. The COR shall approve any modifications to either the work or training plans **in writing**.

(b) Performance Management and Evaluation Plan (PMEP)

The Contractor must deliver a draft PMEP that establishes concrete measures, including rationale, monitoring and evaluation plan, data collection tools and methods, data

sources and plans for achieving and capturing results using, as appropriate, the USAID required/standard and agreed custom performance indicators. The overall targets follow the "90-90-90" policy, including a 90% rate of MDR-TB diagnosed patients to start treatment, a 90% rate of treatment success, and a 90% rate for initiating TB/HIV co-infected patients on ARVs.

A draft monitoring framework is provided in Annex A, to be incorporated into the PMEP, which should include mandatory USAID indicators found in the TBSAP Logical Framework, Annex B. The Contractor and the partners must include these as a minimum and must prepare M&E indicators as part of the PMEP, while recommending other custom indicators to help track performance towards the desired results. The details and the format of the annual PMEP, including M&E indicators, should be determined through consultations between the Contractor and Mission staff, led by the COR. The COR shall determine the final content and format of the overall PMEP. Thereafter, the Contractor will make adjustments to the PMEP as necessary and when needed, but at least annually in conjunction with the annual work plan and the annual training plan. The Contractor must obtain COR approval of the initial PMEP, and any adjustments made thereafter over the life of the contract. An updated plan submission is required when changes to the PMEP are proposed by the Contractor.

(c) Quarterly Progress Reports

Quarterly progress reports must be submitted no later than the tenth (10^{th}) day after the completion of each quarter. These reports will only be considered delivered when accepted by the COR as containing the information required.

Quarterly progress reports shall include a summary of current activities, presentation of problem areas and recommendations for resolving these problems and attendant schedules for their resolution and anticipated activities for the following quarter. These reports will also describe progress in implementing the program in accordance with the terms of the contract.

The quarterly progress report format will be determined by the COR after consultations with the Contractor. If the report is longer than 25 pages, the Contractor must include an executive summary, highlighting major successes and failures, with links to more detailed sections in the report. Specifically, the report will contain, at a minimum, the following information:

- Progress (achievements) since the last report.
- Problems described in previous report solved or still outstanding and intentions to address outstanding problems.
- New problems encountered since previous report.
- Proposed solutions to outstanding and new problems.
- Plan for following quarter.
- Current data for output and performance indicators.
- Compelling individual-level success stories.
- Project summaries (one page) on the impact of the interventions.
- Documentation of better practices that can be replicated or taken to scale.

- Annual Performance, Monitoring Reports (PMRs)
- Briefing: The contractor shall brief the mission and the cooperating country officials on the principal activities, accomplishments and funding during the implementation period.

(d) Quarterly Financial Reports and Accruals

These reports will only be considered delivered when accepted by the COR as containing the information required. The financial report will show, for the contract and each subcontract, cost to date, the budget estimate for the upcoming quarter, variations from previous estimates (should be highlighted on any spreadsheets and should be addressed in a narrative if significant) and the estimated cost to complete. Actual cost information will be submitted in the format of the budgets submitted in the Contractor's cost proposal. The Contractor will track the level of funding available and used for sub-grants and the level of funding available and used for administrative support and oversight.

The financial report format will be determined by the COR after consultations with the Contractor, except as specified above. Specifically, the report should contain at a minimum the following information:

- Total funds committed to date by USAID into the Contract.
- Total funds expended by the Offeror to date, including a breakdown to the budget categories provided in the Contractor's cost proposal, with additional detail to be provided upon request by the COR.
- Pipeline (committed funds minus expended funds).
- Funds and time remaining in the Award.

(e) Annual Performance Management Progress Reports

Based on the PMEP, and as part of USAID's Performance Review and Annual Report process, the Contractor must submit Annual Performance Reports 30 days after the end of the USAID Fiscal Year (by October 31), describing the progress towards achieving the program results, including expected results for the year, success stories, problems encountered, and plans for the next year and what success will look like after 5 years of implementation. In the reports, the Contractor must submit the monitoring and reporting on milestone events that demonstrate progress towards the descriptions of success, presented with narrative descriptions of success at the program end. Annual Performance Management Progress Reports are to be submitted to the COR with a copy to the CO and Activity Manager; a final copy will be required 15 days after receipt of comments from the COR. These Reports must include both narrative and quantitative sections (indicator tables). If the narrative report is longer than 25 pages, the Contractor must include an executive summary, highlighting major results, with links to more detailed sections in the report. The contractor must obtain COR approval on the template for the Annual Performance Management Progress Report prior to submitting the first year's report.

(f) Grants Manual

The Contractor must develop and submit for approval by the CO a sub-granting manual, detailing guidelines for submitting grant proposals, establishing specific eligibility criteria and developing procedures for the review and approval of grants. The procedures for monitoring the funded projects and reporting results must also be indicated in the manual. The manual must indicate compliance with 22 CFR 216 and USAID's ADS 201.5 and 204 regarding environmental safeguards.

(g) Final Report

In addition, a final report will be provided to USAID ninety days after the completion of the contract based on a format listed below in Section F.10, and in consultation with USAID according to the terms of the Contract and any applicable policies or guidance.

The Contractor must submit the draft final report which includes an assessment of the project's success in implementing activities. This report will substitute for the Annual Progress report for Year 5. The report must provide details on the following:

- Measurement and evaluation of project indicators, as laid out in the Performance Management and Evaluation Plan;
- Details on any impediments faced in implementing the strategies developed;
- An assessment of the sustainability of any activities supported through this project; and
- Estimated financial expenditures and projected remaining balance, if any, under the contract.

F.8 MEETINGS, BRIFINGS, AND TIMETABLE

The Offeror must coordinate briefings with USAID for each deliverable, with particular care to maintaining cohesiveness across the full number of years of project implementation, as well as coordination with the Government of South Africa and other stakeholders.

1. **Team planning meeting(s)**
   At least one team planning meeting will be conducted in advance of any project activities. This meeting will allow USAID to present the management team with the purpose, expectations, and agenda of the assignment, as well as provide any feedback on the evaluation design and methodology submitted as part of the proposal.

2. **Methodology plan & study protocol developed in coordination with the Government of South Africa**
   Written methodology plans (e.g., project design, key questions, methods, tools, data collection instruments, data analysis plan, and operational work plans) will be prepared by the Contractor and approved by USAID prior to implementation. The written design of the project will be shared with stakeholders before being finalized. After USAID approval, the project protocol **must be submitted to the National Department of Health**

(NDOH) and consensus must be reached on the approach, or if consensus cannot be reached on approval by USAID.

3. **Debriefings with quarterly progress reports**
   The COP and/or DCOP will provide quarterly progress reports in-person to USAID on work plan implementation. These interim briefings per quarter with USAID should review the progress and methodology of the evaluation with recommendations for achieving the following quarter results.

4. **Debriefings with other stakeholders**
   The team will present debriefings and next-year plans to the USAID partner (as appropriate, and as defined by USAID), and to the NDOH through PowerPoint presentations. The debriefings will include a discussion of achievements, activities, and recommendations. The senior team will consider partner comments and revise the draft reports accordingly, as appropriate.

5. **Data sets**
   Provide data, technical materials, and other information produced in the execution of USAID funded activities

The Awardee will provide USAID with data, technical materials, and other relevant materials produced in the execution of this Award. This includes pedagogical materials and other technical inputs developed to support early grade reading outcomes and other Award objectives, as well as data and information needed for reporting under the relevant foreign assistance objectives, areas and elements. The Awardee is also required to provide technical assistance (TA) materials and other technical inputs developed to support project outcomes and other Award objectives. Examples of TA technical inputs to be provided to USAID include assessment instruments, observation tools, training guides, workshop reports, assessment tools, sampling frames, photographs, videos, and other recordings. The Awardee will transmit technical materials to the COR (if applicable) and/or COR, and submit them to the USAID Development Experience Clearinghouse (see F.9 below).

F.9 AIDAR 752.7005 SUBMISSION REQUIREMENTS FOR DEVELOPMENT EXPERIENCE DOCUMENTS (SEP 2013)

(a) Contract Reports and information/Intellectual Products.

(1) Within thirty (30) calendar days of obtaining the COR's approval, the Contractor must submit to USAID's Development Experience Clearinghouse (DEC) one copy of each reports and information products which describe, communicate or organize program/project development assistance activities , methods, technologies, management, research, results and experience. These reports include: assessments, evaluations, studies, technical and periodic reports, annual and final reports, and development experience documents (defined as documents that (1) describe the planning, design, implementation, evaluation, and results of development assistance; and (2) are generated during the life cycle of development assistance programs or activities.) The Contractor must also submit copies of information products including training materials,

publications, databases, computer software programs, videos and other intellectual deliverable materials required under the Contract Schedule. The following information is not to be submitted:

(i) Time-sensitive materials such as newsletters, brochures, bulletins.

(ii) The Contractor's information that is incidental to award administration, such as financial, administrative, cost or pricing, or management information.

(2) Within thirty (30) days after completion of the contract, the contractor must submit to the DEC any reports that have not been previously submitted, and an index of all reports and information/intellectual products referenced in paragraph (a)(1) of this clause.

(b) Submission requirements. The Contractor must review the DEC web site for the most up-to-date submission instructions, including the DEC address for paper submissions, the document formatting and the types of documents to be submitted. The submission instructions can be found at: https://dec.usaid.gov/.

F.10 REPORTING FORMAT AND CRITERIA

Format

The format for all reports listed in Section F must be submitted with Microsoft Office products, using 12-point type font throughout the body of each narrative report, and 1 inch page margins top/bottom and left/right. As described above, quarterly progress reports and annual performance management reports should be approximately 25 pages, and the final report should not exceed 35 pages, excluding references and annexes.

- All pages should be numbered consecutively; items such as cover pages, dividers, table of contents, and attachments are not included in the any page limitations.
- Typed, single space on letter-sized paper (not legal-sized);
- All materials and supporting documentation required in English;
- Text must be in a recent Windows-compatible version of MS Word (version 2000 or later);
- Spreadsheets must be in MS Excel (version 2000 or later);

F.10. TECHNICAL DIRECTION AND DESIGNATION OF RESPONSIBLE USAID OFFICIALS

TASK ORDER CONTRACTING OFFICER:

TBD
U.S. Agency for International Development
100 Totius Street
Groenkloof
0027 Pretoria,
South Africa
Email: TBD

TASK ORDER CONTRACTING OFFICER'S REPRESENTATIVE (COR):

Nellie Gqwaru
U.S. Agency for International Development
100 Totius Street
Groenkloof
0027 Pretoria,
South Africa
Email: ngqwaru@usaid.gov

[END OF SECTION F]

SECTION G – TASK ORDER ADMINISTRATION DATA

G.1 CONTRACTING OFFICE

The Contracting Officer with authority to administer the order is:

TBD
USAID/Southern Africa
100 Totius Street
P. O. Box 43
Groenkloof
0027 Pretoria
South Africa

The Contracting Officer is the only person authorized to make or approve any changes in the requirements of this task order and notwithstanding any provisions contained elsewhere in this task order, the said authority remains solely in the Contracting Officer. In the event the Contractor makes any changes at the direction of any person other than the Contracting Officer, the change shall be considered to have been made without authority and no adjustment shall be made in the contract terms and conditions, including price.

G.2 INVOICES

One original of each invoice shall be submitted on an SF-1034 "Public Voucher for Purchases and Services Other Than Personal" to the Financial Management Office at USAID/Southern Africa. One copy of the voucher and the invoice shall also be submitted TOCOR.

Electronic submission of invoices is encouraged. The SF-1034 must be signed, and it must be submitted along with the invoice and any other documentation in Adobe PDF to the Regional Financial Management Office to this address: invoice@usaid.gov

Paper invoices may be sent to the following address:

USAID/Southern Africa,
Financial Management Office
P.O. Box 43,
Groenkloof,
Pretoria 0027

Or via courier to:

USAID/Southern Africa
Financial Management Office
100 Totius Street

Groenkloof,
Pretoria 0027

If submitting invoices electronically, please do not send a paper copy.

G.3 ACCOUNTING AND APPROPRIATION DATA

(To be completed with included with the final task order):

Budget Fiscal:
Operating Unit:
Strategic
Objective:
Team/Division:
Benefiting Geo
Area: Object
Class:
Amount Obligated: $

[END OF SECTION G]

SECTION H – SPECIAL TASK ORDER REQUIREMENTS

H.1 AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for the purchase of goods and services under this task order is 937.

H.2 LANGUAGE REQUIREMENTS

All deliverables shall be produced in English.

H.3 GOVERNMENT FURNISHED FACILITIES OR PROPERTY

The Contractor and any employee or consultant of the Contractor is prohibited from using U.S. Government facilities (such as office space or equipment) or U.S. Government clerical or technical personnel in the performance of the services specified in the Task Order unless the use of Government facilities or personnel is specifically authorized in the Task Order or is authorized in advance, in writing, by the COR.

H.4 GRANTS UNDER CONTRACT (GUC)

The Contractor must make grants pursuant to ADS 302.3.4.13 and 303 (Grants Under Contract). Use of the GUCs procedure is subject to specific approval by USAID and must meet certain conditions, not all of which are summarized herein. The Contractor is required USAID to develop a grants procedure manual, approved by the USAID Contracting Officer, for the administration of GUCs. USAID must be significantly involved in establishing selection criteria for GUCs and must approve the actual selection of grant recipients. In addition, USAID will retain the right to terminate grants unilaterally.

H.5 CONFIDENTIALITY AND OWNERSHIP OF INTELLECTUAL PROPERTY

All reports generated and data collected during this project shall be considered the property of USAID and shall not be reproduced, disseminated or discussed in open forum, other than for the purposes of completing the tasks described in this document, without the express written approval of a duly-authorized representative of USAID. All findings, conclusions and recommendations shall be considered confidential and proprietary.

H.6 CONTRACTOR'S STAFF SUPPORT, AND ADMINISTRATIVE AND LOGISTICS ARRANGEMENTS

The Contractor shall be responsible for all administrative support and logistics required to fulfill the requirements of this task order. These shall include all travel

arrangements, appointment scheduling, secretarial services, report preparations services, printing, and duplicating.

H.7 ENVIRONMENTAL COMPLIANCE

Environmental Analyses are developed in order to evaluate the potential risk of new projects that are being developed by USAID and to address those risks early in the development process by integrating measures that will prevent or mitigate environmental risks into the design of the project. This environmental analysis serves as assurance that the Project Appraisal (PAD) team considered environmental impacts in the design process per ADS 201.3.8.3(a) which states that pre-obligation, "must ensure that USAID funds do not lead to environmentally unsustainable impacts by the end of the CDCS, or promote a trajectory which could reasonably be expected to lead to serious environmental impacts, otherwise mitigated under 22 CFR 216 if such funds were directly obligated."

Currently there is an existing IEE which was developed at DO level for the Health Program (HEALTH IEE). This IEE was approved by the Bureau Environment Officer on 30th of September 2014. The IEE covers the period 2014-2018, with an expiration date of 31st of December 2018.

Activities covered by the IEE
The following intervention categories in the USAID/South Africa bilateral health portfolio are covered by the IEE:

1. Health Care Waste Management (HCWM).
2. Procurement, storage, management, distribution and disposal of public health commodities & equipment; strengthening public health commodity supply chain management.
3. Construction.
4. Water and Sanitation for Health (WASH).
5. Capacity Development/Training: a) prevention, care and treatment HIV/AIDS, TB and MDR-TB; b) MCC; c) PMTCT, MCC, OVC and GBV
6. Social marketing, Education and Behavioral Change Communication (BCC)
7. Policy & strategy development (including formulation of clinical norms).
8. Health Systems Strengthening (HSS): studies, surveys/public health surveillance and other data-gathering assessments, models, and capacity-building in support of all areas above. Dissemination of resulting information/lessons learned/best practices.

Activities to be undertaken
USAID has provided essential capacity building support for TB prevention and control in the country, and this support has been crucial in the progress being made on the TB control front. In collaboration with partners and stakeholders, USAID has been instrumental in providing critical and wide-spectrum TA at national, provincial and district levels. This has ranged from developing and updating guidelines to quality assurance of service delivery in the worst- performing clinics.

The TBSAP will support and build upon the progress made under the USAID's current and prior previously supported TB interventions, achievements and activities (2009-

2014), as well as the results from their formal evaluation. It is in alignment with the South Africa NSP 2012-2016 and in accordance with new WHO's Stop TB Strategy and the new USG Global TB strategy.

Environmental Analysis of Project Activities

The activities that are to be carried out under the TBSAP are covered by the existing HEALTH IEE. A negative determination with conditions was granted in the existing IEE. The conditions entail ensuring that training/curricula/supervision addresses appropriate management practices concerning the proper handling, use, and disposal of medical waste, including proper disposal of blood, sputum, swabs, masks and sharps associated with HIV/AIDS and TB and MDR-TB testing. They also entail ensuring that Healthcare waste management plans should be implemented at the relevant facilities supported by USAID per the USAID Sector's Environmental Guidelines for Healthcare Waste (http://www.usaidgems.org/Sectors/ healthcareWaste.htm) and WHO's "Safe Management of Wastes from Healthcare Activities." For Health Program-supported activities including blood testing, http://www.who.int/watersanitation_health /medicalwaste/wastemanag/en/.

For detailed explanations of the prescribed conditions refer to the IEE document.

Conclusion

This Environmental Analysis provides a preemptive evaluation of potential environmental concerns arising from implementation of activities under the TBSAP SoW. No new environmental compliance requirements need to be established at this time, and the HEALTH IEE does not need to be amended prior to approval of the SoW. However, bearing in mind that the IEE will expire on 31 December 2018, an extension of the IEE will be required later to cover activities through the end of the project.

The environmental compliance requirements established in the HEALTH IEE should be referenced in the PAD and carried forward as requirements of procurement and further programming. In addition, USAID, in implementation of all activities, should strive to promote messages of environmental sustainability and protection.

[END OF SECTION H]

SECTION I – CONTRACT CLAUSES

I.1 NOTICE LISTING CONTRACT CLAUSES INCORPORATED BY REFERENCE

The following Provisions and/or Contract clauses pertinent to this section are hereby incorporated by reference (by Citation Number, Title, and Date) in accordance with the clause at FAR "52.252-2 CLAUSES INCORPORATED BY REFERENCE" in Section I of this acquisition. See FAR 52.252-2 for an internet address (if specified) for electronic access to the full text of a clause.

NUMBER	TITLE	DATE
52.202-1	DEFINITIONS	NOV 2013
52.203-5	COVENANT AGAINST CONTINGENT FEES	MAY 2014
52.203-7	ANTI-KICKBACK PROCEDURES	MAY 2014
52.203-8	CANCELLATION, RESCISSION, AND RECOVERY OF FUNDS FOR ILLEGAL OR IMPROPER ACTIVITY	MAY 2014
52.203-10	PRICE OR FEE ADJUSTMENT FOR ILLEGAL OR IMPROPER ACTIVITY	MAY 2014
52.204-4	PRINTED OR COPIED DOUBLE-SIDED ON	MAY 2011
52.204-7	SYSTEM FOR AWARD MANAGEMENT	JUL 2013
52.204-10	REPORTING EXECUTIVE COMPENSATION FOR FIRST TIER SUBCONTRACT AWARDS	JUL 2013
52.209-6	PROTECTING THE GOVERNMENT'S INTEREST WHEN SUBCONTRACTING WITH CONTRACTORS DEBARRED, SUSPENDED, OR PROPOSED FOR DEBARMENT	AUG 2013
52.215-10	PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA	AUG 2011
52.215-11	PRICE REDUCTION FOR DEFECTIVE COST OR PRICING DATA – MODIFICATIONS	AUG 2011
52.216-7	ALLOWABLE COST AND PAYMENT	JUN 2013
52.216-8	FIXED FEE	JUN 2011
52.219-4	NOTICE OF PRICE EVALUATION PREFERENCE FOR HUBZONE SMALL BUSINESS CONCERNS	OCT 2014
52.219-8	UTILIZATION OF SMALL BUSINESS CONCERNS	OCT 2014
52.219-9	SMALL BUSINESS SUBCONTRACTING PLAN	OCT 2014
52.219-9	ALTERNATE III	OCT 2014
52.219-9	SMALL BUSINESS SUBCONTRACTING PLAN (DEVIATION 2013-O0014)	AUG 2013
52.219-14	LIMITATIONS ON SUBCONTRACTING	NOV 2011
52.219-28	POST-AWARD SMALL BUSINESS PROGRAM REPRESENTATION	JUL 2013
52.222-21	PROHIBITION OF SEGREGATED FACILITIES	APR 2015
52.222-26	EQUAL OPPORTUNITY	APR 2015

52.222-29	NOTIFICATION OF VISA DENIAL	APR 2015
52.222-35	EQUAL OPPORTUNITY FOR VETERANS	JUL 2014
52.222-36	EQUAL OPPORTUNITY FOR WORKERS WITH DISABILITIES	JUL 2014
52.222-37	EMPLOYMENT REPORTS ON VETERANS	JUL 2014
52.222-50	COMBATING TRAFFICKING IN PERSONS	MAR 2015
52.222-50	ALTERNATE I	MAR 2015
52.222-54	EMPLOYMENT ELIGIBILITY VERIFICATION	AUG 2013
52.223-14	ACQUISITION OF EPEAT ® - REGISTERED TELEVISIONS	JUN 2014
52.223-18	CONTRACTOR POLICY TO BAN TEXT MESSAGING WHILE DRIVING	AUG 2011
52.227-14	RIGHTS IN DATA---GENERAL	MAY 2014
52.228-3	WORKERS' COMPENSATION INSURANCE (DEFENSE BASE ACT)	JUL 2014
52.230-2	COST ACCOUNTING STANDARDS	MAY 2014
52.232-17	INTEREST	MAY 2014
52.232-23	ASSIGNMENT OF CLAIMS	MAY 2014
52.232-25	PROMPT PAYMENT	MAY 2014
52.232-33	PAYMENT BY ELECTRONIC FUNDS—SYSTEM FOR AWARD MANAGEMENT	JUL 2014
52.233-1	DISPUTES	MAY 2014
52.242-3	PENALTIES FOR UNALLOWABLE COSTS	MAY 2014
52.244-6	SUBCONTRACTS FOR COMMERCIAL ITEMS	JUL 2013
52.245-1	GOVERNMENT PROPERTY	APR 2012
52.245-1	ALTERNATE I	APR 2012
52.245-1	ALTERNATE II	APR 2012
52.245-9	USE AND CHARGES	APR 2012
52.251-1	GOVERNMENT SUPPLY SOURCES	APR 2012

AIDAR 48 CFR CHAPTER 7

I.2 ALTERNATE (52.222-50, COMBATTING TRAFFICKING IN PERSONS)

Alternate I (Aug 2007). As prescribed in 22.1705(b), substitute the following paragraph in place of paragraph (c)(1)(i) of the basic clause:

(i)(A) The United States Government's zero tolerance policy described in paragraph (b) of this clause; and

(B) The following directive(s) or notice(s) applicable to employees performing work at the contract place(s) of performance as indicated below:

Document Title in/at:	Document may be obtained from:	Applies performance to
_____	_____	_____
_____	_____	_____

[Contracting Officer shall insert title of directive/notice; indicate the document is attached or provide source (such as website link) for obtaining document; and, indicate the contract performance location outside the U.S. to which the document applies.]

[END OF CLAUSE]

I.3 52.233-2 SERVICE OF PROTEST (SEP 2006)

(a) Protests, as defined in section 33.101 of the Federal Acquisition Regulation, that are filed directly with an agency, and copies of any protests that are filed with the Government Accountability Office (GAO), shall be served on the Contracting Officer by obtaining written and dated acknowledgment of receipt from both:

Bruce Baltas, Contracting Officer, USAID Office of Acquisition and Assistance
M/OAA/GH, SA-44 Rm. 549 – J
1300 Pennsylvania Ave., NW Washington, DC 20523 and

William Buckhold, Asst. General Counsel USAID, GC/LE
Ronald Reagan Building (RRB) Rm. 6.06- 071 1300 Pennsylvania Ave., NW
Washington, DC 20523-6601
Fax for William Buckhold: 202-216-3058

(b) The copy of any protest shall be received in the office(s) designated above within one day of filing a protest with the GAO.

[END OF CLAUSE]

[END OF SECTION I]

SECTION J – LIST OF DOCUMENTS EXHIBITS AND OTHER ATTACHMENTS

Annex A: Monitoring Framework (table)

Annex B: Logical Framework – TBSAP Project

Annex C: Results Framework – TBSAP Project

[END OF SECTION J]

SECTION K – REPRESENTATIONS, CERTIFICATIONS, AND OTHER STATEMENTS

Not required.

[END OF SECTION K]

SECTION L - INSTRUCTIONS, CONDITIONS, AND NOTICES TO OFFERORS

L.1 GENERAL

The Government anticipates the award of one (1) task order as a result of this acquisition.

L.2 GENERAL INSTRUCTIONS TO OFFERORS

A. Instructions: If an Offeror does not follow the instructions set forth herein, the Offeror's proposal may be eliminated from further consideration, or the proposal may be downgraded and not receive full or partial credit under the applicable evaluation criteria.

B. Accurate and Complete Information: Offerors must set forth full, accurate and complete information as required by this acquisition. The penalty for making false statements to the Government is prescribed in 18 U.S.C. 1001.

C. Offer Acceptability: The Government may determine an offer to be unacceptable if the offer does not comply with all of the terms and conditions of the RFTOP.

D. Proposal Preparation Costs: The U.S. Government will not pay for any proposal preparation costs.

L.3 DELIVERY INSTRUCTIONS

A. Submission, Marking and Copies

The Offeror should submit the proposal electronically - Internet email with up to 6 attachments (2MB limit per attachment), compatible with recent Windows-compatible version of MS Word (version 2000 or later); spreadsheets must be in MS Excel (version 2000 or later); and Adobe Acrobat (.pdf) usable in a MS Windows environment.

All documents should be prepared in 12 font type, single spaced, with a maximum of 25 pages, numbered consecutively. Items such as cover pages, dividers, table of contents, and attachments are not included in the 25-page limitation. Technical and Cost Applications shall be submitted in separate documents, as described below, with all materials and supporting documentation required in English. The address for the receipt of electronic proposals is **proposals@usaid.gov**.

Zipped files attachments are not allowed. Any budget spreadsheets shall be sent in unlocked Excel format (formula shown). The subject line of the emails shall include following **"SOL-674-15-00000x – TB SOUTH AFRICA PROJECT."**

The Technical/Cost Proposals must be clearly marked on the email as follows:

Technical Proposal:
SOL-674-15-0000xx – TBSAP
[Name of Offeror] Technical Proposal [Email # of #]

Cost Proposal:
SOL-674-15-0000xx – TBSAP
[Name of Offeror] Cost Proposal [Email # of #]

These same requirements exist for the submission of subsequent revised technical and/or cost proposals and technical/financial clarification costs.

B. Closing Date and Time

All proposals in response to this acquisition shall be due at proposals@usaid.gov, no later than the Time and Date indicated on the cover letter.

L.4 INSTRUCTIONS FOR THE PREPARATION OF THE TECHNICAL PROPOSAL

In its technical proposal, the Offeror must address how it proposes to carry out the Statement of Work (SoW) contained in Section C. The proposal must reflect a clear understanding of the results to be achieved and the responsibilities of all parties. Proposals must follow the format specified below.

The technical proposal must be organized as follows:

1. Cover Letter (Maximum 1 page) (not included in page limit)
2. Executive Summary (Maximum 1 page)
3. Table of Contents (not included in page limit)
4. Acronym list (not included in page limit)
5. Technical Approach (Page Limit 15 pages)
6. Management and Staffing Plan (Page Limit: 4 pages)
7. Corporate Capabilities and Experience (Page Limit: 3 pages)
8. Contractor Performance Information (Page Limit: 2 pages)

The following must be presented as annexes and are **not** included in the page limit:

1. Annex A – Mobilization Plan (NTE 4 pages)
2. Annex B – Outline of Year 1 Work Plan, including district level assessments for upcoming annual training plans (NTE 4 pages)
3. Annex C – CVs of Key Personnel (NTE 5 CVs, Limit of 2 pages each)
4. Annex D – Organizational chart (NTE 1 organizational chart)
5. Annex E – Contractor Performance Information & References
6. Annex F – Branding Implementation Plan

7. Annex G – Summary Table of Professional Level of Effort

The sections, below, including Annexes where relevant, should include all information required to fairly evaluate the Offeror under the applicable evaluation factor. The Summary Table of Level of Effort must include the prime contractor and the subcontractor level of effort (person-days), broken down by professional and non-professional labor, expatriate, CCN and TCN status, and short- and long-term status; the number of days (if based on other than 220 workdays, explain); and total for each labor category.

Section 1: Executive Summary (Page Limit: 1 page)
In this section, the Offeror must introduce its proposal and summarize highlights of its approach.

Section 2: Technical Approach (Page Limit: 15 pages) [See Section M.3]
In this section, the Offeror must describe its proposed technical methodology, as well as an approach for achieving the results and meeting the requirements of the SoW and technical deliverables, given the locations listed in the Geographical Areas listed below. As USAID has required Offeror's input to complete the SoW (i.e., tailoring of USAID illustrative indicators, creating additional custom indicators, identification of targets, etc.), their proposal must address these items in this section. At a minimum, Offerors should demonstrate and describe the following within the technical approach of the proposal:

1. A 5-year vision and strategy for the contract, illustrating a thorough understanding of the development challenges facing the South African Government in managing the TB epidemic per Section C, while showing how project interventions will support cross-cutting goals related to gender and transparency;
2. The narratives for a Year-1 Work Plan (including district level assessments for upcoming annual training plans) that identifies critical activities, milestones, deliverables and timelines, and describes a logical and feasible path for project transition from the current award and delivery of results.
3. A life of project (LOP) Work Plan and LOP Training Plan for long-term sustainability via partnerships with local South African national organizations that leverage the efforts of other donors and other USAID projects in the country (both existing and prospective TBSAP grants under contract), while the relationship to key host country counterparts focuses on capacity building and sustainability;
4. A logical framework and illustrative project management and evaluation plan (PMEP) that demonstrates activities are feasible and sustainable; proves to be cost-effective; shows the causal linkages between objectives, outputs, and inputs; and has clear and measurable indicators that align with the Offeror's approach for achievement of results.

Geographic Areas

The TBSAP will support the National TB Program (NTP's) assessment and prioritization of 12 districts needing enhanced support on the basis of the following

criteria:

- Burden of disease, exceeding 5,000 TB cases per year
- Treatment success rate, below 80%
- Defaulter rate, exceeding 6.2%
- Death rate, exceeding 5.6%
- Transferred out rate, exceeding 2.4%
- DR TB burden, Rifampicin Resistance – proxy for MDR TB

The 12 districts that fall under the above criteria and their provinces include:

1. eThekwini (KwaZulu Natal)
2. Cape Town Metro (Western cape)
3. Johannesburg Metro (Gauteng)
4. OR Tambo (Eastern Cape)
5. Ehlanzeni (Mpumalnga)
6. Nelson Mandela Metro (Eastern Cape)
7. Bojanala Platinum (North West)
8. Buffalo City (Eastern Cape)
9. Dr. K Kaunda (North West)
10. Chris Hani (Eastern Cape)
11. Mangaung Metro (Free State)
12. Cacadu (Eastern Cape)

Nine of these districts overlap with the PEPFAR's realigned priority districts which focus on curbing the AIDS epidemic by targeting 80% of People Living with HIV/AIDS (PLHIV). The TBSAP will coordinate with PEPFAR to ensure that the TB entry point is integrated with HIV/AIDS care, treatment and prevention. In addition the HIV/AIDS entry point will improve TB screening and referrals.

Additional districts will be proposed for consultation with NDOH and provincial DOH teams. Additional criteria will include lagging implementation of TB/HIV collaborative activities, as shown by one or more of these indicators: ART uptake, TB and HIV integration, Intensified Case Finding (ICF), and Infection Control (IC) in program activities and key populations. Changes (additions or graduations) in the geographic area of the project will be based on the regular quarterly and annual reviews of performance by the DOH and on the TBSAP project results and reports.

Section 3: Management and Staffing Plan (Page Limit: 4 pages) [See Section M.4]

a. **Overall Management Plan (Page Limit: 2 pages) [See Section M.4(a)]**

An overall management plan which details the methods by which the Offeror will recruit and manage staff, provide adequate home office support, address procurement and logistical requirements, and establish field offices. This plan must include systems to control costs, develop clear lines of communication and authority, coordinate and manage activities of the Offeror and any subcontractors or other partners and the National Department of Health (NDOH), as well as anticipate and resolve implementation complexities.

b. **Utilization of South African National Institutions and Nationals (Page**

Limit: 2 pages) [See Section M.4(b)]

A staffing plan that enables achievement of results and demonstrates an appropriate mix of skillsets. The staffing plan's professional technical staff should maximize the use of South African resources (personnel, systems, policies, and procedures), and only be minimally supplemented by expatriate personnel or international consultants and firms that possess proven technical experience in South Africa. The staffing plan should reflect the minimum number of highly experienced technical staff sufficient to meet project needs.

Section 4: Corporate Capabilities and Experience (Page Limit: 3 pages) [See Section M.5]

The Offeror must describe its demonstrated capacity to manage a project of this nature, and must also identify South African national resources that support its ability to launch and support this project, and the Offeror's technical approach. The proposal must display the Offeror's breadth of experience in South Africa, given the specific technical areas identified in the SoW. The proposal must also reflect the Offeror's South African expertise in relation to implementing M&E in the country.

Section 5: Contractor Performance Information (Page Limit: 2 pages) [See Section M.6]

The Offeror (including all partners of a joint venture) must provide performance information for itself on TB awards of similar size, scope and complexity, as well as for each subcontractor and including the use of small business concerns in accordance with Annex E, below.

Section 6: Annexes

Annex A – Mobilization Plan (NTE 4 pages)

The Offeror must provide a detailed mobilization plan covering the first 90 days of the contract period. The plan must include details on how the contractor will ensure a rapid start and transition from the existing TB award, including logistical arrangements and having the appropriate staff and technical assistance recruited, in position and ready to start work; the plan must also include a list of key activities to be accomplished, responsible personnel, and a timeline for proposed activities in preparation for activities covered in the Year-1 work plan.

Annex B – Outline of Year-1 Work Plan, to include district level assessments for upcoming annual training plans (NTE 4 pages)

The Offeror must provide an outline of first year activities/milestones/deliverables by quarter, identifying responsible personnel. While the Offeror does not have to list all first year activities, it does have to include critical path items, including district level preparations for training implementation. Critical path means critical to the success of project launch and success over the life of the contract. The Outline of Year-1 Work Plans must logically support or show appropriate linkages to other sections of the proposal. Start date for activities described under the Year-1Work is immediately following the award (i.e., it picks up where the prior TB award leaves off).

Annex C – CVs of Key Personnel (NTE 8 CVs at a limit of 2 pages each)

The Offeror may use any format for CVs, provided it does not exceed 2 pages and

complies with text formatting requirements for the technical proposal. The Offeror should provide references on the CV. The contract proposed by this solicitation includes a key personnel clause, and the quality of key personnel proposed will be an evaluation factor. The Offeror must include as part of its proposal a statement signed by all individuals proposed as key personnel, confirming their present intention to serve in the stated position and their present availability to serve for the term of the proposed contract.

Annex D – Organizational chart (NTE 1 organizational chart at a limit of 2 pages)
The Offeror must provide a project-related organization chart that supports an integrated management approach, regardless of whether subcontractors are proposed or not.

Annex E –Contractor Performance Information and References
The Offeror must identify recent and relevant past performance of the organization, key personnel, and subcontractors (if proposed). USAID defines recent as the last three years. USAID defines relevant as TB projects of similar size, scope and complexity.

(a) The Offeror (including all partners of a joint venture) must provide performance information for itself and each subcontractor in accordance with the following:

1. List up to five of the most recent and relevant contracts for similar TB projects. The most relevant indicators of performance are contracts of similar contract type, type of work, scope of work, complexity/diversity of tasks, and mix of skills/expertise required, including how recently they were performed. Relevant past performance information should demonstrate the Offeror's capability to:
    - Provide technical assistance to South African institutions, local partners, and local governments to create an enabling environment, considering communications, sensitivity and coordination with local government and non-governmental institutions and civil society;
    - Engage local organizations and the private sector in TB and health service projects;
    - Build and strengthen human and institutional capacity and sustainability;
    - Manage key personnel, including the appropriateness of personnel and prompt and satisfactory changes in personnel when problems arise; and
    - Maintain the project schedule, including timeliness in completion of the contract, milestones, and delivery schedules; and meeting administrative requirements of cost control and accuracy in financial reporting.

2. Provide for each of the contracts listed above, a list of contact names, job titles, mailing addresses, phone numbers, e-mail addresses, and a description of the performance to include:
    - Scope of work or complexity/diversity of tasks,
    - Primary location(s) of work,
    - Term of performance,
    - Skills/expertise required,
    - Dollar value, and
    - Contract type, i.e., fixed-price, cost reimbursement, etc.

    (USAID recommends that Offerors alert the contacts that their names have been submitted and that they are authorized to provide performance information concerning the listed contracts if and when USAID requests it.)

(b) If extraordinary problems impacted any of the referenced contracts, provide a short explanation and the corrective action taken (FAR 15.305(a)(2)).

(c) Describe any quality awards or certifications that indicate exceptional ability to provide the service or product described in the SoW. This information is not included in the page limit.

(d) Performance in Using Small Business (SB) Concerns (as defined in FAR 19.001).

1. This section (d) is not applicable to offers from small business concerns.
2. As part of the evaluation of performance in M.6 of this solicitation, USAID will evaluate the extent to which the Offeror used and promoted the use of small business concerns under current and prior contracts. The evaluation will assess the extent small business concerns participated in these contracts relative to the size/value of the contracts, the complexity and variety of the work small business concerns performed, and compliance with the Offeror's SB subcontracting plan or other similar small business incentive programs set out in Offeror's contract(s).

(e) In order for USAID to fully and fairly evaluate performance in this area, all Offerors who are not small business concerns must do the following:

1. Provide a narrative summary of Offeror's use of small business concerns over the past three years. Describe how small businesses were employed--as subcontractors, as joint venture partners, through other teaming arrangements, etc. Explain the nature of the work small businesses performed--substantive technical professional services, administrative support, logistics support, etc. Describe the extent of Offeror's compliance with SB subcontracting plan(s) or other similar SB incentive programs in Offeror's contract(s) and explain any mitigating circumstances if goals were not achieved.

2. To supplement the narrative summary in (e)1., above, provide a list of five recent contracts for which Offeror submitted subcontract reports to electronic Subcontracting Reporting System (eSRS) (FAR 52.219-9(d)(10), and a copy of any similarly recent subcontracting reports if they were not submitted to eSRS.
3. Provide the names and addresses of five SB concerns for USAID to contact for their assessment of Offeror's performance in using SB concerns. Provide a brief summary of the type of work each SB concern provided to Offeror and the name of a contact person, his/her title, phone number, and e-mail address.

Annex F- Branding Implementation Plan and Marking Plan
(Note: Will not be scored)
In accordance with ADS 320.3.1.2, Pre-Award Procedures, Offeror(s) will prepare and submit a preliminary Branding Implementation Plan (BIP) and Marking Plan (MP), not to exceed 5 pages, as part of the Technical Proposal Annex. Although not weighted as an evaluation factor for award, the preliminary BIP and MP will be negotiated prior to award and included in and made a part of the resultant contract. Failure to submit and negotiate a BIP and/or MP will make the Offeror ineligible for award of the contract. Offerors shall include all estimated costs associated with monitoring and enforcement of branding and marking requirements in their cost proposals. (NOTE: Will not be scored)

Annex G – Summary Table of Professional Level of Effort
Include prime contractor and the subcontractor level of effort (person-days), broken down by professional expatriate, CCN and TCN status, and short- and long-term status; the number of days (if based on other than 220 workdays, explain); and total for each labor category.

L.5 INSTRUCTIONS FOR THE PREPARATION OF THE COST PROPOSAL

This task order will be cost plus fixed fee (term). Offerors shall submit a detailed budget in order for USAID to evaluate the Offeror's proposed price for completeness, reasonableness, and realism. Budget shall be submitted in unlocked Microsoft Excel format.

a. Part 1 - Standard Form (SF) 33

The Offeror must submit the cover page (Section A) of this Solicitation [Standard Form (SF) 33, "Solicitation, Offer, and Award"], with blocks 12 through 18 completed, with an original signature of a person authorized on behalf of the Offeror to sign the offer.

b. Part 2 - Proposed Costs/Prices

This part of the Cost Proposal should include the following information: detailed budgets in spreadsheet format, budget notes and supporting documents (e.g. documents that support the calculation of costs included in the spreadsheets, such as Negotiated Indirect Cost Rate Agreements, Bio Data Sheets, and Cost Agreements

with subcontractors, etc.).

1. Detailed Budget Preparation Guidance

The detailed budget must be provided in one large spreadsheet, with multiple worksheets by year that link to the overall summary budget, with unprotected and unlocked formulas. The budgets should be organized based on types of costs as set forth in the section immediately below. In summary, the following detailed budgets should be provided:

- Overall Summary Budget covering all five years; and
- Detailed Budget Worksheets by year supporting the summary data.

2. Budget Line Item Headings

In order to undertake a meaningful comparison of cost, Offerors shall use the following standard cost elements organized as specified below.

A. Direct Costs
    1. Labor Costs
        a. Salary and Wages
        b. Fringe Benefits
        c. Consultants
    2. Travel
        a. Air Fares
        b. Per Diem
        c. Local Transportation (car rental, taxis etc.)
        d. Miscellaneous (Visas, Inoculations, etc.),
    3. Other Direct Costs
        a. Equipment
        b. Miscellaneous Direct Costs (including, but not limited to, software, insurance, communications, facilities, vehicle and equipment maintenance and operation, banking and legal costs, and miscellaneous subcontracts [other than for training, assessments, analyses, and other direct program implementation costs])
        c. Training, Assessments, Analyses, and other Direct Program Implementation Costs (not including internal labor costs or internal travel costs)
B. Indirect Costs
    1. Material Handling
    2. Overhead
    3. G&A
C. Total Estimated Cost (Direct Cost plus Indirect Cost)
D. Fixed Fee
E. Total Estimated Cost Plus Fixed Fee

3. Budget Line Item Definitions

Salary and Wages: FAR 31.205-6, AIDAR 731.205-46, and AIDAR 752.7007 provides for compensation for personal services. Direct salary and wages should be proposed in accordance with the Offeror's personnel policies and meet the regulatory

requirements. For example, costs of long-term and short-term personnel should be broken down by person years, months, days, or hours. Bio Data Sheets are required for any individual specifically identified in the cost or technical proposal.

Fringe Benefits: FAR 31.205-6 provides for allowances and services provided by the Contractor to its employees as compensation in addition to regular wages and salaries. If fringe benefits are provided for as part of a firm's indirect cost rate structure, see FAR 42.700. If not part of an indirect cost rate, a detailed cost breakdown by benefit type should be provided.

Consultants: FAR 31.205-33 provides for services rendered by persons who are members of a particular profession or possess a special skill and who are not officers or employees of the Contractor. For example, costs of consultants should be broken down by person years, months, days, or hours.

Travel, Transportation, and Per Diem: FAR 31.205-46, AIDAR 731.205-46 and AIDAR 752-7032 provide for costs for transportation, lodging, meals and incidental expenses. For example, costs should be broken down by the number of trips, domestic and international, cost per trip, per diem, and other related travel costs.

Equipment and Supplies: FAR 2.101 provides for supplies as all property except land or interest in land; FAR 31.205-26 provides for material costs; and FAR 45 prescribes policies and procedures for providing Government property to Contractors, Contractors' use, and management of Government property, and reporting, redistributing, and disposing of Contractor inventory. For example, costs should be broken down by types and units, and include an analysis that it is more advantageous to purchase than lease.

Subcontracts: FAR 44.101 provides for any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract. For every subcontract that involves development services or deliverables AND is not expected to be awarded on a fixed-price basis, separate spreadsheets should be submitted for each such subcontract with the same detail, organization and format set forth above.

Allowances: AIDAR 752.7028 provides for differentials and allowances with further references to Standardized Regulations. For example, allowances should be broken down by specific type and by person, and should be in accordance with Offeror's policies and these regulations.

Participant Training: AIDAR 752.7019 and ADS 253 provides for participant training and training in development. For example, costs should be broken down by types and participants.

Other Direct Costs: FAR 31.202 and FAR 31.205 provide for the allowability of direct costs and many cost elements. For example, costs should be broken down by types and units.

Overhead, G&A, and Material Overhead: FAR 31.203 and FAR 42.700 provides for

those remaining costs (indirect) that are to be allocated to intermediate or two or more final cost objectives. For example, the indirect costs and bases as provided for in an Offeror's indirect cost rate agreement with the Government, or if approved rates have not been previously established with the Government, a breakdown of bases, pools, and method of determining the rates and description of costs. Any indirect cost rate agreements for the Offeror or a subcontractor should be included in the cost proposal.

Fixed Fee: FAR 15.404-4 provides for establishing the profit or fee portion of the Government pre-negotiation objective, and provides profit-analysis factors for analyzing profit or fee. For example, proposed fee with rationale supported by application of the profit-analysis factors.

4. Indirect Costs

Some Offerors may not have indirect pools, which allocate costs in the manner identified above. For those items, which the Offeror does not utilize to allocate indirect costs, please identify in the proposal that these categories are not applicable.

The Offeror and each proposed implementing partner shall include a complete copy of its most current Negotiated Indirect Cost Rate Agreement (NICRA) or other documentation from its cognizant Government Audit Agency, if any, stating the most recent final indirect cost rates. The proposal shall also include the name and address of the Government Audit Agency, and the name and telephone number of the auditor.

If the Offeror or any implementing partner does not have a cognizant Government Audit Agency, the proposal shall include:

a. Audited balance sheets and profit and loss statements for the last two complete years, and the current year-to-date statements (or such lesser period of time if the Offeror is a newly-formed organization). The profit and loss statements should include detail of the total cost of goods and services sold, including a listing of the various indirect administrative costs, and be supplemented by information on the prime contractor's customary indirect cost allocation method, together with supporting computations of the basis for the indirect cost rate(s) proposed; and
b. Most recent two fiscal year pool and base cost compositions along with derived rates, the bases of allocation of these rates and an independent certified audit by a certified accounting firm of these rates.

5. Budget Notes

Budget notes are required. While the Offeror has discretion to tailor the budget notes to its approach, between the detailed budgets and the budget notes, sufficient information must be provided to allow a thorough, complete and fair analysis of the costs proposed. For example, for salaries, the Offeror must demonstrate the calculations and the rational for the rates for the base daily labor rate utilized in calculating labor cost. No unburdened base daily rate may exceed the current maximum daily rate for Agencies without a Certified SES Performance Appraisal System (AWCPAS). See ADS 302.3.6.11 (http://www.usaid.gov/policy/ads/300/302.pdf).

6. Supporting Documents

The Offeror shall provide additional supporting budget documentation to substantiate all proposed costs. Negotiated Indirect Cost Rate Agreements should be included in the Cost Proposal. In addition, AID Form 1420-17 - Contractor Employee Biographical Data Sheets, must be submitted for each Key Personnel position (see Section J for link). Other supporting documentation should be submitted if the Offeror believes that it is necessary to substantiate or support costs proposed by the Offeror.

Additionally, the Cost Proposal should include the items listed below:

- All costs related to branding plan and environmental mitigation plan, where relevant.
- A certified version of the Contractor's written personnel policies, including established pay scale for equivalent job classifications of employees.
- Summary table of Level of Effort that matches the information in the technical proposal and includes cost information by category.
- Propose the maximum percent of annual salary increase.
- Written travel policies.
- Personnel policies.
- Procurement policies.
- List of proposed nonexpendable property.

c. Part 3 – Representations, Certifications, and Other Statements of Offerors

The Offeror and each proposed subcontractor shall complete Section K, "Representations, Certifications, and Other Statements of Offeror," and sign and date on the last page in the space provided.

d. Part 4 – Subcontracting Plan

If the Offeror is other than a small business, it must submit a Subcontracting Plan. Submitted Plans must address subcontracting with small business (SB), veteran-owned small business, service-disabled veteran-owned small business, HUBZone small business, small disadvantaged business, and women-owned small business concerns.

e. Part 5 – Joint Venture Information

If two or more parties have formed a partnership or joint venture (see FAR Subpart 9.6), for the purposes of submitting a proposal under this solicitation and, if selected, would perform the contract as a single entity, they must submit, as an attachment to the Cost/Business Proposal, the Corporate Charter, By-Laws, or Joint Venture or Partnership Agreement. In addition, the teaming arrangements must be identified, company relationships must be fully disclosed, and respective responsibilities and method of work must be expressly stipulated. The joint venture or partnership agreement must include a full discussion of the relationship between the organizations, including identification of the organization, which will have

responsibility for negotiation of Task Orders under the resultant contract, which organization will have accounting responsibility, how work will be allocated, and profit or fee, if any, shared. In addition, the principles to the joint venture or partnership agreement must agree to be jointly and severally liable for the acts or omissions of the other.

f. Part 6 – Evidence of Responsibility

The Offeror must submit sufficient evidence of responsibility for the Contracting Officer to make an affirmative determination of responsibility pursuant to the requirements of FAR Subsection 9.104-1. If the Offeror fails to submit sufficient evidence for the Contracting Officer to make an affirmative determination of responsibility, then the Contracting Officer may make a determination of non-responsibility and be precluded from awarding a contract to that Offeror. However, in the case of a US small business offeror, the Contracting Officer will comply with FAR 19.6. Accordingly, prime offerors should seriously address each element of responsibility. To be determined responsible, a prospective contractor must:

- Have adequate financial resources to perform the contract, or the ability to obtain them (see FAR 9.104-3(a)) [**Note – if Offerors do not submit sufficient evidence of adequate financial resources or ability to obtain them, the offer will be determined non-responsive and your proposal will not be considered**];

- Be able to comply with the required or proposed delivery or performance schedule, taking into consideration all existing commercial and governmental commitments;

- Have a satisfactory performance record (See FAR 9.104-3(b) and Subpart 42.15). A prospective contractor shall not be determined responsible or non-responsible solely on the basis of a lack of relevant performance history, except as provided in FAR 9.104-2;

- Have a satisfactory record of integrity and business ethics;

- Have the necessary organization, experience, accounting and operational controls, and technical skills, or the ability to obtain them (including, as appropriate, such elements as production control procedures, property control systems, quality assurance measures, and safety programs applicable to materials to be produced or services to be performed by the prospective contractor and subcontractors) (See FAR 9.104-3(a));

- Have the necessary production, construction, and technical equipment and facilities, or the ability to obtain them (See FAR 9.104-3(a)); and

- Be otherwise qualified and eligible to receive an award under applicable laws and regulations (e.g., Equal Opportunity, Clean Air and Water, Small Business Subcontracting, etc.).

The responsibility information that may be requested includes, but is not limited to, audited or certified financial statements, tax returns and other financial records necessary to establish responsibility.

g. Part 7 – Letters of Commitment (Subcontractors)

The Cost/Business Proposal must include a letter, on subcontractor letterhead, and signed by an authorized representative of each subcontractor, which specifically indicates the subcontractor's agreement to be included in the Offeror's proposed teaming arrangement.

h. Part 8 – Information to Support Consent to Implementing Subcontractors

The Offeror must address each of the elements in FAR 44.202-2 in order for the CO to grant subcontract consent.

i. Part 9 – Information Concerning Work-Day, Work-Week, and Paid Absences

- The Offeror and each proposed implementing partner shall indicate the number of hours and days in its normal work-day and its normal work-week, both domestically and overseas, for employees and consultants. In addition, the Offeror and each proposed implementing partner shall indicate how paid absences (US holidays, local holidays, vacation and sick) shall be covered.

- A normal work-year, including paid absences (holidays, vacations, and sick leave) is 2,080 hours (260 days x 8 hours per day). However, some organizations do not have an 8-hour workday, and some accounting systems normally provide for direct recovery of paid absences by using a work-year of less than 2,080 hours to compute individuals' unburdened daily rates. The Offeror and implementing partners shall describe their work-day and work-week policies.

[END OF SECTION L]

SECTION M – EVALUATION FACTORS FOR AWARD

M.1 GENERAL INFORMATION

(a) The Government may award a contract without discussions with Offerors in accordance with FAR 52.215-1.

(b) The Government intends to evaluate Offerors in accordance with Section M of this solicitation and make contract award to the responsible Offeror whose proposal represents the best value to the U.S. Government.

(c) The submitted technical information will be evaluated using the technical factors shown below. The evaluation committee may include experts who are not employees of the Federal Government.

(d) When evaluating the competing offers, the Government will consider the written qualifications/capability information provided by the Offerors, and any other information obtained by the Government through its own research.

(e) For overall evaluation purposes, evaluation factors other than cost or price, when combined, are significantly more important than cost or price.

M.2 EVALUATION FACTORS

The factors below are presented by major category, with relative weights identified, so that Offerors will know which areas require emphasis in the preparation of proposals. The factors below reflect the requirements of this particular solicitation.

1.	Technical Approach	40 points
2.	Management and Staffing: a. Overall Management Plan (10 points) b. Utilization of South African National Institutions & Nationals (20 points)	30 points
3.	Corporate Capabilities and Experience	10 points
4.	Contractor Past Performance Information	20 points
Total		**100 points**

Specific information on each evaluation factor and sub-factor is provided below.

M.3 TECHNICAL APPROACH FACTOR (40 POINTS)

The proposed technical methodology and approach will be evaluated in accordance with the following subcriteria:

1. A 5-year vision and strategy for the contract that addresses the Key Components, Tasks and Outcomes listed in Section C. The technical approach must reflect sustainability, feasibility, realism, and innovativeness in addressing the challenges facing the South African Government in managing

the TB epidemic. The Offeror should also show how project interventions will support cross-cutting goals related to vulnerable populations, gender and transparency described in Section C;

2. The narratives for a Year-1 Work Plan (to include assessments at the district level for upcoming annual training plans) should identify critical activities, milestones, deliverables and timelines, and describe a logical, practical, and feasible path for project transition from the current award and delivery of results;
3. A life of project (LOP) Work Plan and LOP Training Plan for long-term sustainability via partnerships with local South African national organizations that leverage the efforts of other donors and other USAID projects in the country (e.g., both existing and prospective TBSAP grants under contract), while the relationship to key host country counterparts focuses on capacity building and sustainability;
4. A logical framework and illustrative project management and evaluation plan (PMEP) that demonstrate activities are feasible and sustainable; that prove to be cost-effective; that show the causal linkages between objectives, outputs, and inputs; and that have clear and measurable indicators that align with both the Results Framework in Annex C, and the Offeror's approach for achievement of results.

M.4 MANAGEMENT AND STAFFING FACTOR (30 POINTS)

The Management and Staffing Factor will be evaluated in accordance with the following two subfactors, as stated below.

(a) Overall Management Plan (10 points)

The overall management plan will be evaluated in accordance with the following subcriteria:

- Soundness of the Offeror's overall management plan to manage staff performance, coordinate and manage diverse activities, anticipate and resolve implementation complexities, produce documented quantifiable results, and control costs against contract terms.
- Quality of the management plan which included policies, procedures and systems to support clear lines of communication and authority; as well as explains the role of, and contractual arrangements with, each subcontractor and other partners to include the Government of South Africa.

(b) Utilization of South African National Institutions & Nationals (20 points)

Offerors with staffing and personnel capabilities, and use of South African resources and experience, will be evaluated in accordance with the following subcriteria, in descending order of importance:

- Quality and suitability of proposed Key Personnel and non-Key professional technical staff/consultants, including but not limited to their relevant technical, professional, educational and field experience, particularly in South Africa.

- Demonstrated understanding of the Statement of Work (SoW) as evidenced by the overall Staffing Plan's appropriate mix of skills and number of proposed staff for program design and start-up, and demonstrated ability to develop collaborative relationships with counterparts, partners and other stakeholders during implementation and monitoring.
- Effectiveness of Staffing Plan to maximize use of South African skills and experience to promote sustainability.

M.5 CORPORATE CAPABILITIES AND EXPERIENCE FACTOR (10 POINTS)

Corporate capabilities and experience will be evaluated as follows in descending order of importance:

- Demonstrated capability and experience with capacity development programs in the component area(s), including the ability to effectively manage subcontractors, local partners, and GUCs, as set forth in the SoW (Section C);
- Demonstrated capacity to manage a project of similar type and complexity, including multiple and diverse projects/tasks from planning through execution, and to partner effectively and communicate with South Africa government entities; and
- Demonstrated ability to mobilize and support the technical assistance teams as reflected in a Staffing Plan, including effectiveness in the ability to recruit and maintain qualified personnel.

M.6 CONTRACTOR PAST PERFORMANCE INFORMATION FACTOR (20 POINTS)

The Contractor's performance information determined to be relevant to implementing TB programs in South Africa will be evaluated in accordance with the elements below:

a) Performance information will be used for both the responsibility determination and the best value decision. USAID will utilize information from the references provided in Section L. Instructions, Conditions, and Notices to Offerors of this acquisition, if and when the Contracting Officer finds the existing databases to be insufficient for evaluating an Offeror's performance.
b) Adverse past performance information to which the Offeror previously has not had an opportunity to respond, will be addressed in accordance with the policies and procedures set forth in FAR 15.3.
c) USAID will initially determine the relevance (i.e., size, scope and complexity) of similar performance information as a predictor of probable performance under the subject requirement. USAID may give more weight to performance information that is considered more relevant and/or more current.
d) The contractor performance information determined to be relevant will be evaluated in accordance with the six elements below:
    1) Quality of product or service, including consistency in meeting goals and targets. (4 points)

2) Cost control, including forecasting costs as well as accuracy in financial reporting. (4 points)
3) Schedule, including the timeliness against the completion of the contract, task orders, milestones, delivery schedules, and administrative requirements (e.g., efforts that contribute to or affect the schedule variance). (4 points)
4) Business relations, addressing the history of professional behavior and overall business-like concern for the interests of the customer, including the contractor's history of reasonable and cooperative behavior (to include timely identification of issues in controversy), customer satisfaction, timely award and management of subcontracts, cooperative attitude in remedying problems, and timely completion of all administrative requirements.(4 points)
5) Management of key personnel, including appropriateness of personnel for the job and prompt and satisfactory changes in personnel when problems with clients where identified. (2 points)
6) For prime Offerors who are not small business concerns, their utilization of Small Business concerns as subcontractors, including efforts in achieving small business participation goals. (2 points)

M.7 PRICE/COST EVALUATION

Price/cost analysis will include a cost analysis to establish reasonableness of the otherwise successful Offeror's price (including the competitiveness of the fee proposed); a cost realism analysis to determine what the Government should realistically expect to pay for the proposed effort, the Offeror's understanding of the work, and the Offeror's ability to perform the contract; and price analysis (cost plus fixed fee) to verify that the overall price offered is fair and reasonable.

M.8 DETERMINATION OF THE COMPETITIVE RANGE AND CONTRACT AWARD

(a) Competitive Range: If the Contracting Officer determines that discussions are necessary, he/she will establish a Competitive Range composed of only the most highly rated proposals. In certain circumstances, the Contracting Officer may determine that the number of most highly rated proposals that might otherwise be included in the competitive range exceeds the number at which an efficient competition can be conducted. Should that be the case, the Contracting Officer may then limit offers in the competitive range to the greatest number that will permit an efficient competition among the most highly rated offers.

(b) Award: In accordance with FAR 52.215-1(f), the Government intends to award a Contract from this solicitation to the responsible Offeror(s) whose proposal(s) represent the best value after evaluation in accordance with the factors and sub-factors as set forth in this solicitation. This procurement also utilizes the tradeoff process set forth in FAR 15.101-1. If the Contracting Officer determines that competing technical proposals are essentially equal, cost/price factors may become the determining factor in source selection. Conversely, if the Contracting Officer determines that competing cost/price proposals are essentially equal, technical factors may become the determining factor in source selection. Further, the Contracting Officer may award to a higher priced Offeror if a determination is made that the higher technical evaluation of

that Offeror merits the additional cost/price.

M.9 CONTRACTING WITH US SMALL BUSINESS CONCERNS

USAID encourages maximum participation of US small businesses, US veteran-owned small businesses, US women-owned small businesses, US small disadvantaged businesses, and US HUBZone small businesses. Accordingly, US organizations should make reasonable effort to identify and make use of such organizations.

[END OF SECTION M]

ANNEX A. MONITORING FRAMEWORK: TB SOUTH AFRICA PROJECT

Indicator	Baseline	Target	Data Collection Methods	Data Disaggregation	Responsibilities
Number of MDR-TB cases who initiate second line treatment	TBD	TBD	Recording	N/A	IP
Percentage of providers complying with national guidelines/standards for TB treatment at USG-supported facilities	TBD	TBD	Reports	Public sector	IP
Percent of USG-supported primary health care (PHC) facilities that submitted routine reports on time, disaggregated by public sector and private sector, and disaggregated by numerator and denominator	TBD	TBD	Recording	Public sector/private sector	IP
Number of new health care workers who graduated from a USG supported pre-service training institution within the reporting period, by select cadre	TBD	TBD	Recording	By cadres	IP
Number of individuals trained in any component of the WHO Stop TB Strategy with USG funding	TBD	TBD	Recording	By gender	IP
Number of civil society organizations (CSOs) receiving USG assistance engaged in TB activities	TBD	TBD	Recording	N/A	IP
Percent of registered new smear positive pulmonary TB cases that were cured and completed treatment under DOTS nationally (Treatment Success Rate)	TBD	90%	Recording	NA	IP
Number of new TB cases reported to National TB Programs (NTP) by non-MOH organizations.	TBD	TBD	Recording	N/A	IP
Number of improvements to laws, policies, regulations or guidelines related to improved access and use of health services drafted with USG support	TBD	TBD		N/A	IP
Percent of TB patients tested for HIV	TBD	TBD	Recording	N/A	IP
Percent TB treatment defaulter rate at USG supported districts	TBD	<5%	Recording	N/A	IP

ANNEX B.
LOGICAL FRAMEWORK: TB SOUTH AFRICA PROJECT

	Narrative/Intervention Logic	Verifiable Indicators (Based on baseline data)	Means of Verification	Assumptions
Project Goal (DO 1)	**Health outcomes for South Africans Improved**	Number of TB-related deaths	WHO Country Profile	
Project Purpose	**Reduce the burden of TB, X/MDR-TB, and TB/HIV in South Africa**			
Intermediate Results (IR 1)	**TB Infections Reduced**	Number (#) of people screened for TB # tested for TB # started on treatment # who complete treatment	ETR.net	Implementation of IPT is institutionalized Early ART for all eligible people living with HIV All HCWs trained on new TB guidelines and using GXP appropriately.
Outcomes	1.1. Increase public awareness of TB transmission	# of people reached through Advocacy, Communication and Social Mobilization (ACSM) # of NGOs providing ACSM	Project Reports ETR.Net	Funded NGOs CHWs trained
	1.2. Effective implementation of Infection Control	# of sites with Infection Control according to national standards Increased use of masks in health facilities # of Quality Improvement tools for IC used by health facilities	Project Reports Quality Assurance(QA) Reports ETR.Net	National standards are posted, and masks are available, in every health facility
	1.3. Improved TB screening, including key populations	# of persons screened for TB, disaggregated by key population # of persons screened and referred for	ETR.net HCT Reports Project Reports	

		testing, by method used (GXP/sputum smear) # of TB cases detected and started on treatment		
Project Sub-Purpose (IR 2)	**1. Sustainability of effective TB Response Systems increased**	TB treatment success rate # of patients diagnosed with MDR-TB # MDR-TB patients started on treatment # of patients diagnosed with XDR-TB # of XDR-TB patients started on treatment # of TB patients tested for HIV #r of TB/HIV co-infected patients initiated on ART	ETR.Net EDR.Net	Capacity building efforts will lead to institutionalized and improved systems Recording and reporting systems are working effectively Patients present to facilities early
Outcomes	1.1. Strengthened management capacity at all levels	# of national and provincial quarterly meetings supported by evidence-based planning and performance # of stakeholder meetings to review progress and use data to plan (stakeholders include DOH, PPP, TB patients) # of new tools and approaches	District and Project Reports	Integration of HIV and TB care with an efficient chronic-care delivery system
	1.2. Strengthened service delivery capacity at all levels	Proportion of TB cases diagnosed using GeneXpert with results returned in 2 days # of health providers trained # of TOT trainings # of nursing colleges including TB in the curriculum # of monitoring visits to follow up on those trained	Project Reports	
	1.3. Improved data reporting and recording systems at all levels	Reduction from baseline of # of gaps in data reported from each level of the TB	ETR.net Project Quarterly	

		Cascade of Services	Reports	
Project Sub-Purpose (IR 3)	**2. Care and treatment of vulnerable populations improved**			It will be possible to develop new partnerships with the public and private sectors
Outcomes	2.1. Increased contact tracing among communities, including key populations	# of documented TB contact investigations # of successful contact investigations # of new tools developed to facilitate contact tracing	ETR.net	
	2.2. Improved TB case management in communities, including key populations	# of completed TB treatments # of persons defaulted	ETR.net	
	2.3. Increased Direct Observation of TB Treatment (DOTS), including key populations	# of community members engaged in DOTS delivery # of community organizations engaged in DOTS delivery # of delivery points for DOTS # of facilities delivering DOTS # of individuals receiving DOTS Treatment success rate	District Reports ETR.net DOTS Supporters' Reports/Interviews Project and Facility Reports	
	2.4 Strengthened comprehensive systems and partnerships for care.	# of new partners and entry points established in public or private sector to facilitate, screen, or deliver TB programs # of agreements with organizations # of stakeholder meetings held	Agreements with organizations Project Reports	

ANNEX C: RESULTS FRAMEWORK

The following is the results framework for the Tuberculosis South Africa Project: