Comments for Draft Statement of Work: PEPFAR Gender Initiative on Girls' Vulnerability to HIV

Timeframe

1a. Please clarify how addressing the antecedents of risk listed in the background section can be successfully "addressed" in the given time frame of only two years? Such antecedents cannot usually be significantly affected by programs of 12-18 months duration.
1b. If the scope of work entails implementation and scale-up, will option years be considered?
1c. We strongly recommend allowing a longer timeframe for the achievement of demonstrable results as well as the development and dissemination of the Toolkit.
1d. Is there any flexibility with regard to the timeframe? The two-year timeframe is a short period of time to start a program and demonstrate measurable change in cultural norms and behaviors.
1e. With regard to comments on the draft Statement of Work, one concern that we had was with the time frame for the Task Order. The scope was quite broad for the 24-month time period. Clearly the expectation is that offerors will take into account the existing country situation including building presumably some ongoing initiatives; however, it still seems a tight timetable to develop programs that will fully address the full range of risk factors adolescent girls face and allow for an assessment of the 'replicability, feasibility, scale-up and sustainability' of the proposed approaches.

The scope of the program is development of a program and evaluation, not scale-up. The task order aims to implement (including but not limited to adaptation) and evaluate programs to address girls' vulnerability to HIV. The time frame has been extended to 3 years. An illustrative timeline can be:

- Year 1: Design/Baseline Measurement/Implementation
- Year 2: Implementation/Measurement
- Year 3: Evaluation and Analysis

Target Population and Definition of Vulnerability

2a. Is this RFTOP requesting a programmatic focus on only among 13-19 year old orphaned girls, or is it open to all "vulnerable girls" in that age group? If the target group is only orphaned girls, must girls only be HIV-related orphans? Is the target group out-of-school HIV-orphaned girls? The relationship between the PEPFAR Gender initiative target populations referenced on page two and the acceptable target populations for this RFTOP is unclear.
2b. "the program aims to prevent HIV infection among 13-19-year-old orphaned girls..."However, the rest of the document talks about vulnerable girls. Is the program to work only with orphaned girls aged 13-19 or all vulnerable girls aged 13-19?
2c. In response to the description of family protection at the top of page 3, we suggest that the RFTOP clarify that "social orphans" as well as "biological orphans" are particularly vulnerable. In many areas in Mozambique and Botswana, owing to migrancy and other factors, child rearing is not dominated by the nuclear family context. Hence death of a parent does not automatically equate to lack of support. Many 'social orphans' may still have living parents yet are also at high risk and these children should be included.

2d. Could you please clarify whether the RFTOP is specifically targeting orphaned girls, or a wider range of adolescent girls? While it is clear on page 2 that the PEPFAR Gender Initiative aims to prevent HIV infection among 13 to 19-year-old *orphaned* girls, the rest of the proposal mainly refers to adolescent girls with no indication of orphan status. An argument for focusing not only on orphaned girls (in addition to the issue of biological versus social orphans mentioned above) is that often in resource-scarce settings, targeting orphans especially with poverty alleviation/income generation/school support interventions as envisaged in the RFTOP can be divisive and contribute to stigma including self-stigma.

2e. Can you please clarify the target population? Is it orphaned girls 13-19 only, orphans and girls vulnerable for other reasons, or all adolescent girls age 13-19?

The program is to work with 13-19-year-old vulnerable girls, not just orphans. The task order has been revised accordingly. The offeror should determine the "sub-set(s)" of vulnerable girls to target, according to local context.

3a. One apparent programmatic gap in the statement of work is prevention among young girls already infected with HIV especially those prenatally infected. Both Botswana and Mozambique are high prevalence countries. Mozambique in particular, has high prevalence of peri-natal HIV infection. With increased access to ART, it can only be anticipated that the population of young girls (10-19 years) infected with HIV is growing. Emerging evidence from Population Council's work with young people perinatally infected with HIV in Uganda demonstrates that:

a) The population of young people perinatally infected with HIV is rapidly growing;
b) About 75 percent of surviving young people perinatally infected with HIV are females;
c) Young people perinatally infected with HIV are extremely vulnerable: i) almost half have lost both parents; ii) about one quarter are out of school; iii) several have taken on adult roles of caring for younger siblings;
d) About half are dating and prefer to have a partner who is HIV+ or HIV- or someone who can support them materially;
e) About one third are sexually active and see no reason why they should not have sex and about half of them fear disclosing their HIV sero status
f) About three quarters of those sexually active do not use any method to prevent HIV; infection or re-infection and about half of them are not using any form of contraception;
g) Pregnancy is common – about 10 percent of the females have experienced a pregnancy

This evidence suggested a need to focus on the growing population of perinatally infected young in high prevalence countries such as Mozambique and Botswana.

Addressing the fact that HIV-positive young girls, including perinatally infected youth, are likely beneficiaries of many youth-focused interventions in highly generalized epidemics can certainly be a part of program design, but this population is not intended to be the main focus of this program.

Intervention and Evaluation

4a. Please clarify to what extent the offeror is expected to design and test effective programs or propose modifications to existing programs and evaluate them versus evaluate the existing national portfolio of programs in each country to identify "best practices".

4b. Intervention: While the RFTOP specifies a multi-component approach on page 4, could you please clarify whether either of the following would also be acceptable: a) a single component model, with variation per country, or b) distinct multi-component models for each country

4c. Please clarify whether the objective of the RFTOP is to evaluate programs previously funded in these countries or whether the intention is for new interventions to be developed and evaluated at both the community and individual levels.

4d. It would also be prudent for USAID to distinguish more specifically between demonstration of impact of interventions at pilot or limited scale, and scaling up: again, the reality is that scale-up almost always never works as well as the 'promising' pilot or demonstration project. These realities could be reflected in the document, e.g. by requesting investigators to assess the prospects and challenges for scale up in each instance.

While variation is expected due to local cultural, normative, and programmatic realities, we expect that the offerors will focus on a comprehensive set of interventions that are believed to be promising in their likelihood of reducing girls' vulnerability. While the balance and focus of these core interventions will likely vary by country, we are interested in identifying a core set of interventions and approaches that could be replicated and adapted. A realistic assessment and analysis of the challenges and constraints to adaptation and scale-up can be addressed along with the process evaluation, however actual scale-up is not intended to be part of this scope of work.

The objective of the task order is to evaluate an intervention, but the intervention should be complementary and not duplicative to existing programs. Implementation should be planned in consultation with the USG country team and build on existing efforts. The evaluation tool should have some core components that are flexible enough that it could be used as a basis for assessing programs in other countries as well.

4e. What is meant by "non-material support" in the second illustrative activity?

No commodities such as school fees, uniforms, books, etc. This example has been added into the RFTOP.

4f. Can you please define what is meant by "evaluation model" on p.5? Does this refer to a conceptual framework for the evaluation?

Yes, this refers to a conceptual framework for evaluation.

4g. With reference to page 3 bullet 1, please clarify the level of contextual analysis required in the technical submission; should it consist of a review of the available data/literature for each country on major factors associated with high rates of infection among adolescent girls, or is a more in-depth look at variations by ethnic group, geographical regions, and socioeconomic status expected?

The contextual analysis should consist of a review of the available data/literature for each country on major factors associated with types of risks faced by adolescent girls and high rates of infection among them.

4h. On page 4. Under “programmatic approaches” the term “risk behavior” makes it seem like they are responsible and the essence of this is that they are not. Perhaps the term could be changed to “based on different types of risks girls face”

We made this change in the RFTOP

4i. Also on p.4. bullet 4, we suggest changing the term “Wrap-around or direct support for…” to “development of appropriate age- and gender-specific financial literacy, development of savings products and related social support mechanisms, sustainable livelihoods and/or improved access to economic resources, including government-provided entitlements and health services.”

We made this change in the RFTOP

4j. Are there policy issues that need to be addressed, especially regarding girls’ school attendance and pregnancy? If so, policy work/advocacy should be integrated into the document.

Policy formulation and policy change is not the intended focus of the program, but they can be addressed as it relates to local operational/implementation aspects of the program.

4k. The tone of the document is very 'positivist', i.e. there is a strong assumption that interventions in this area can succeed in the terms set out. In practice these are some of the most difficult social and cultural issues to address, and especially as the document emphasizes reaching those hardest to reach the chances of "success" are in reality quite limited. Thus a more measured and provisional tone would be more consistent with the realities. There is a risk that bidders will be tempted to overstate what can be achieved, which would mean that achievable aims such as incremental progress in reducing vulnerability among young women will be lost sight of or considered insignificant.

The objective of this task order is to identify and evaluate program models that contribute to reducing vulnerability of adolescent girls. It is recognized that reducing vulnerabilities requires a long-term approach. Offerors are encouraged to have a broad programmatic approach and goal, yet be realistic in terms of specific (short-term) outputs and outcomes, especially in the context of specifying the evaluation model.

Indicators and Targets

5a. Under “Results and Indicators” there’s much more that these programs could and should do. We suggest the following as examples of additional things that these programs should do:

- Reduce girls’ social isolation
- Increase the density of their peer networks
- Increase their access to girl-only programs
- Increase their measured access to safe and supportive spaces
- Create girl-only programming within existing youth center, peer education, and other conventional youth initiatives
- Develop financial literacy programs tailored to age, gender, marital status, and context

    - Increase assess to appropriate microfinance and savings products
    - Reduce the reported harassment experience in the public space
    - Reduce reported levels of coerced sex, proportion of first sexual encounters that are defined as tricked or coerced
    - Increase access to personal documentation required to assist in health access, citizenship, and social inclusion, and participation in many economic programs
    - Include girl-only peer education programs
    - Include patient and HIV information-giving and health programs tailored for girls
- Some of the illustrative indicators could be better defined, especially the first output and outcome indicators that focus on the number of programs as the unit of measurement.

Thank you for these examples. Offerors are welcome to include similar results and indicators in their proposals.

5b. Documentation of costs and cost-effectiveness would presumably be included as part of the M&E. Further, it would be useful if wherever possible the project could include the collection of indicators that have been adopted by the countries to track their national OVC response, in addition to the PEPFAR indicators.

Documentation of cost-effectiveness can be part of the proposal, however, please note that it is not part of the evaluation and will not be part of the scoring for the proposal.

Linkage with local USG teams and partners

6a. Will all the current implementers of programs for vulnerable girls in Botswana and Mozambique be required to work with the successful offeror, or is each offeror expected to secure local partners specific to their proposal?
6b. We strongly recommend the identification of a lead person on the USG team in country for engaging with USG partners and other stakeholders given the multiple goals and objectives of this RFTOP and the short time-frame.
6c. Please you please define capacity building as it relates to this specific RFTOP?

Successful candidates are expected to work in collaboration with the USG country team and select relevant partners on the ground. Utilization of local partners is encouraged. Offerors may identify local partners in their proposal; however, it is anticipated that finalization of local partners will happen after the Award, in consultation with the USG country teams. Once the award is made, USG team contacts will be identified.

With regard to capacity building, offerors should outline their plans and demonstrate ability to partner with local organizations. Capacity building is not the main focus of this task order, although we recognize that partnering with local organizations is essential for long-term sustainability. The task order has been revised accordingly.

Budget, Costs and Staffing

7a. What is the value of the proposed program?

USAID cannot respond to this question due to competition integrity.

7b. Please clarify whether there are geographic location preferences for any of other the possible key positions besides the country/regional program manager positions.

The offeror should determine staff location based on program design and implementation, with the aim of maximizing program effectiveness.

7c. Will the project funds be evenly applied across both countries?

No, the offeror should determine use of project funds according to local context and principles of cost-effectiveness. Deliverables are expected in all 3 countries (Malawi has been added as a third country).

7d. On page 12, could you please clarify the difference, if any, between the budget narrative and the requested Budget Notes.

There is no difference; the task order has been revised to be consistent.

PHE

8a. In reference to the evaluation protocol review process by the PHE subcommittee, please further explain the procedures and expected timeframe.
8b. How will the evaluation process work with the PHE subcommittee? Can the PHE subcommittee and IRB review(s) take place simultaneously?

The evaluation protocol will be developed in collaboration with the USG country teams, and forwarded to the PHE subcommittee for review. The PHE procedures are still in development, but it is estimated that the PHE review and clearance will take approximately 3-4 weeks. PHE and IRB reviews may take place simultaneously.