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REQUEST FOR PROPOSAL (RFP)

Reference Number: 1000151403

ISSUE DATE: August 7, 2013

CLOSING DATE & TIME: August 22, 2013

PROJECT TITLE Aboriginal Diabetes Initiative Capacity Building Special Study

DIVISION Health Promotion Disease Prevention

DIRECTORATE Inter-professional Advisory and Program Support

BRANCH First Nations and Inuit Health Branch

DEPARTMENT Health Canada

For any clarification or additional information, please e-mail: FNIHB_PPSU_PSMA_DGSPNI@hc-sc.gc.ca

Bid Submission Envelopes are to be delivered only to the following address:

Health Canada Bid Receiving Unit
Federal Records Centre Building
161 Goldenrod Driveway
Address Locator 1801B
Ottawa, ON K1A 0K9

RFP Reference Number: 1000151403

Attention: Marie-France Gagnon (Contracting Officer)

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PART I STATEMENT of WORK

1.0 Scope

1. 1 Title

Aboriginal Diabetes Initiative Capacity Building Special Study

1.2 Introduction

The Health Promotion and Disease Prevention (HPDP) Division within Health Canada's First Nations and Inuit Health Branch (FNIHB) supports community-based and culturally relevant programs and policies that promote health and prevent chronic disease across the lifespan. Within the Healthy Living (HL) cluster of HPDP, the Aboriginal Diabetes Initiative (ADI) supports the delivery of community-based projects and services to promote healthy living. ADI funding reaches over 600 First Nations and Inuit communities and is used to implement activities in the areas of health promotion, diabetes and chronic disease prevention, screening and management.

Capacity Building is one of five activity themes that contribute to key outcomes for ADI and other HPDP programs. In this context, capacity building refers primarily to development of the workforce that supports health systems and services in First Nations and Inuit communities. FNIHB Regions support the delivery of training, continuing education and professional development for community workers and health professionals to acquire and maintain the core competencies and skills necessary for the delivery of effective ADI and health promotion community programming.

1.3 Estimated Value

The total value of any contract(s) resulting from this RFP shall not exceed **$73,000**, including travel and living expenses (if applicable), other expenses and all applicable taxes.

1.4 Objectives of the Requirement

This study aims to assess progress and impacts of ADI capacity building and training activities for community workers, and provide evidence of the contribution that these activities have made toward achieving key program outcomes. This information is required to build a strong base of evidence for program evaluation and renewal.

1.5 Background, Assumptions and Specific Scope of the Requirement

Background

The Aboriginal Diabetes Initiative (ADI) supports the delivery of community-based projects and services to promote healthy living, and reduce the impact of diabetes and other chronic diseases. ADI funding reaches over 600 First Nations and Inuit communities and is used to implement activities in the areas of health promotion, diabetes and chronic disease prevention, screening and management. The ADI was first implemented in 1999, and has since been renewed on five-year

funding cycles. The current phase of ADI (Phase 3) will sunset in 2015.

Since 2006, ADI funding has supported over 400 community workers to complete post-secondary training programs in diabetes, chronic disease prevention, and community health promotion. To assist Regions in the selection of appropriate training programs, ADI National Office developed a Community Diabetes Prevention Worker (CDPW) competency framework and some ADI Regions have adapted or developed their own competency frameworks. Once community workers have received a certificate or diploma from a recognized post-secondary program, they are regarded within ADI as certified Community Diabetes Prevention Workers (though actual job titles vary between Regions and communities). Regions have used a variety of different post-secondary programs and delivery models. ADI funding also supports a variety of continuing education and professional development opportunities for community workers.[1] Continuing education activities (e.g. workshops, short courses) are developed and delivered by Regions to enhance skills and knowledge of community workers in specific areas identified within the ADI Program Framework 2010 or at the Regional level.

A process evaluation of three pilot training projects was completed in 2009 and found that all programs successfully delivered the intended CDPW skills and competencies. A follow-up study assessed ongoing impacts of the training. A majority of CDPW-trained workers and key informants reported enhanced skills and knowledge in key competency areas, and a variety of improvements to community activities as a result of training. This project builds on the results of previous studies.

Scope

The contractor will be responsible for the implementation of the ADI Capacity Building Special Study (see Annex "A" for a complete study framework) which addresses the following research questions:

1. What are the current levels of education and training among community workers who deliver ADI/HL programming?
2. How have capacity building and training activities enhanced the knowledge, skills and abilities of community workers to implement effective ADI programming?
3. How has capacity building and training for community workers contributed to intermediate program outcomes?
    a) Quality of programs and services
    b) Integration of programs and services
    c) Healthy practices
    d) Supportive environments
4. How has capacity building and training addressed ADI priority areas?
5. What are other impacts to community capacity as a result of ADI capacity building and training activities?
6. How cost effective are ADI capacity building and training models?
7. What are the barriers that prevent community workers from accessing education and training?

1 ADI funding also supports continuing education activities for health professionals. These activities are delivered primarily through the FNIHB Home and Community Care program, and will not be assessed through this study.

8. What are future priorities to enhance the capacity of community health workers to deliver effective programming?

These research questions will be addressed for the program overall, and also with attention to differences between Regions and training models.

The following data will be collected and analyzed:

1. Program documentation and related literature:
    - Training curricula and outlines
    - ADI program framework
    - National/regional competency frameworks
    - Project budgets
    - Related internal studies and evaluations
    - Research/literature on cost effectiveness and HHR training
2. ADI Community Worker survey:
    - Target population of 350 workers in 6 Regions
    - Minimum sample size of 220
    - Option to complete electronic or paper survey
    - Data will be entered into Excel or SPSS for quantitative analysis
    - Survey data will be provided to FNIHB to analyze links with other program reporting data
3. Regional key informant interviews:
    - 6-10 key informants will be FNIHB Regional program leads and others to be identified by Advisory Committee
    - Interviews will be conducted by telephone
    - Interviews will be transcribed for qualitative data analysis

Assumptions:
FNIHB Regional program leads will assist with implementation of the community worker survey by disseminating the survey through their networks and encouraging participation. It is assumed that Regional leads have current contact information and viable means of contacting community workers.

The Contractor may offer non-monetary incentives for survey respondents in order to increase response rate and ensure minimum sample size. For example, respondents may be entered in a draw to win prizes that would be useful in their work such as health education resources or materials to support community healthy living activities. It is assumed that the total budget for survey incentives would not exceed $1000 (including product cost and shipping).

Contractor will provide raw survey data in MS Excel or SPSS to HC Project Authority prior to final report writing. This data will be analyzed internally to identify relationships with other program performance data. Findings from this analysis will be incorporated into the final project report.

2.0 Requirements

2.1 Tasks, Activities, Deliverables and Milestones

The Contractor shall:

- Meet with HC Project Authority (by telephone or in person) to finalize project work plan and expectations
- Review and analyse program documents identified as data sources and shared by HC Project Authority
- Implement a survey of 350 ADI community workers in 6 Regions to obtain a minimum of 220 responses, including the following steps:
    - Develop a draft survey and consent form in collaboration with HC Project Authority; format should be user-friendly and allow respondents to return electronically or fax
    - Revise survey and consent form as required following pre-test (pre-test will be coordinated and feedback provided by HC Project Authority)
    - Develop and submit a data analysis plan to HC Project Authority for review and feedback
    - Survey will be disseminated to community workers by HC Regional program leads
    - Receive and track survey responses (electronic and fax)
    - Arrange non-monetary incentive for survey respondents
    - Enter survey data in MS Excel or SPSS
    - Conduct quantitative analysis of complete data set, and for each Region
    - Provide raw survey data to HC Project Authority for analysis linked to internal program reporting data
- Develop draft key informant interview guide;
- Revise key informant interview guide as required to address feedback provided by HC Project Authority;
- Conduct a maximum of 10 key informant interviews by telephone;
- Conduct qualitative analysis of interview data;
- Develop a model for assessing cost effectiveness of CDPW training and submit to HC Project Authority for review and feedback;
- Assess cost-effectiveness of CDPW training based on average per-worker training costs (to be calculated based on a sample of project budgets);
- Produce and submit a preliminary project report (20-25 pages in length) that addresses all research questions and offers recommendations;
- Produce and submit Regional data summary reports;
- Revise preliminary project report as required, based on feedback from HC Project Authority;
- Submit final evaluation report.

Please refer to section 4.0 Project Schedule for deadlines of key deliverables.

2.2 Specifications and Standards

Project deliverables must be submitted to the Project Authority in electronic format. Survey database must be MS Excel or SPSS, and other document(s) must be in MS Word format. Acceptability of deliverables will be determined by the Project Authority, as per section 2.4 (below).

2.3 Technical, Operational and Organizational Environment

The work will be carried out on the premises of the contractor.

2.4 Method and Source of Acceptance

Acceptability of the work will be determined by the HC Project Authority, based on the following criteria:

- Data analysis methods, limitations and procedures are clearly described and consistent with accepted methods of quantitative and qualitative data analysis;
- Data and information are presented clearly and effectively (e.g. plain-language, charts, graphs), with clear and logical relationships to project findings and recommendations;
- The content of preliminary and final evaluation reports clearly and thoroughly addresses the research questions as identified in the evaluation framework (see Annex "A");
- Recommendations based on project findings are provided;
- The format and presentation of deliverables is of a generally-accepted professional standard.

2.5 Reporting Requirements

The Contractor must submit one (1) electronic report to the Project Authority outlining the accomplishments for the given period, open issues and upcoming milestones on a bi-weekly basis (every two weeks).

2.6 Contractor Project Management Control Procedures

The Health Canada individual identified in the RFP as the Departmental Representative or Project / Technical Authority shall ensure that the project activities and deliverables are completed on time, on budget, and are of an acceptable quality. Draft deliverables as identified in section 4.2 will be submitted for review and feedback. Regular meetings will take place between the Project Authority and the Contractor to monitor the progress of the work, resolve any problems that may arise and to ensure that the project will meet its objectives. The Project Authority will ensure that invoices are aligned with time lines and deliverables.

2.7 Change Management Procedures

Changes to the scope of the project are not anticipated, but should they arise will be managed collaboratively by the contractor and Project Authority within the project budget and timeline.

2.8 Ownership of Intellectual Property

The Crown will own copyright, invoking section 6.5 of the "Policy on Title to Intellectual Property Arising Under Crown Procurement Contracts": "where the Foreground consists of material subject to copyright, with the exception of computer software and all documentation pertaining to that software."

The ownership of new Intellectual Property created through this project will be determined by the underlying law (i.e. the person who creates it will own it).

3.0 Other Terms and Conditions of the SOW

3.1 Authorities

The Health Canada Project Authority will be the point of contact for all work, as well as any issues related to project administration and invoicing:

Senior Program Officer, Education and Training
Healthy Living, Aboriginal Diabetes Initiative
Health Promotion Disease Prevention Division
First Nations and Inuit Health Branch, Health Canada

3.2 Health Canada's Obligations

The HC Project Authority, upon contract award, will provide the Contractor with copies of all requisite documents and information pertinent to this project, and as identified in the ADI Capacity Building Special Study framework (see Annex "A").

The HC Project Authority will collaborate with the Contractor to develop data-gathering tools (survey and interview guide). The HC Project Authority will coordinate survey pre-tests and provide feedback within a period of 5 business days.

The HC Project Authority is responsible for the French translation of original project documents as may be required.

The HC Project Authority is responsible for coordinating dissemination of the ADI Community Worker survey in collaboration with Regional program leads. The HC Project Authority will identify and provide contact information for up to 10 key informants to be interviewed by telephone by the Contractor.

The HC Project Authority will coordinate review and provide feedback on draft deliverables (key informant interview guide, survey data analysis plan, cost effectiveness model) within a period of 5 business. Feedback on the draft final project report will be provided within a period of 10 business days.

The Contractor will have access to the HC Project Authority by phone or email to answer questions, provide additional information as required and assist with primary and secondary data collection activities.

3.3 Contractor's Obligations

The Contractor must use its own equipment and software for the performance of this Statement of Work.

3.4 Location of Work, Work Site and Delivery Point

The majority of work is expected to be completed at the Contractor's normal place of business.

Any contract resulting from this RFP will be interpreted and governed by the laws of the Province of Ontario.

Due to existing workload and deadlines, all personnel assigned to any contract resulting from this RFP must be ready to work in close and frequent contact with the Departmental Representative and other departmental personnel.

All work is to be delivered to the following location:
First Nations and Inuit Health Branch, Health Canada
Jeanne Mance Building
Ottawa K1A 0K9

3.5 Language of Work

There is a requirement for the Contractor to have bilingual project staff. The ADI Community Worker Survey in Quebec Region will be disseminated in both French and English. Health Canada is responsible for translation of original project documents, however the Contractor must be able to understand and use survey data provided in either language.

3.6 Special Requirements

Data, information and documents collected during this project will be accessible only to the contractor and project personnel, and kept confidential. Data, information and documents will be returned to the Health Canada Project Authority upon completion of the project.

3.7 Security Requirements

There are no security requirements for this proposed contract.

3.8 Insurance Requirements

The Contractor must obtain and maintain an appropriate level of professional liability insurance coverage.

3.9 Travel and Living Expenses

No travel required. All meetings, interview or communication will be conducted via telephone or email.

4.0 Project Schedule

4.1 Expected Start and Completion Dates

The services of the Contractor will be required for a period of approximately 6 months upon contract award. Anticipated start date is September 3, 2013. The final project report must be submitted by February 28, 2014.

4.2 Schedule and Estimated Level of Effort (Work Breakdown Structure)

Task/Deliverable	Days Required	Completed By
Attend project kick-off meeting with HC Project Lead; finalize project work plan.	1 day	September 6, 2013
Develop data-gathering tools (survey, consent form, interview guide) for pre-test	4 days	September 16, 2013
Develop and submit analysis plan for survey data	1 day	September 16, 2013
Produce final survey and consent form for translation/dissemination	1 day	September 25, 2013
Conduct document review	5 days	September 30, 2013
Collect, manage and enter survey response data	12 days	October 31, 2013
Provide raw survey data to HC for internal analysis	.5 days	November 1, 2013
Conduct key informant interviews	5 days	November 15, 2013
Develop cost effectiveness model and submit for review	3.5 days	November 15, 2013
Conduct quantitative and qualitative data analysis	10 days	December 6, 2013
Produce and submit Regional data summary reports	2 days	December 30, 2013
Produce and submit draft project report	10 days	December 30, 2013
Revise and submit final report	4 days	January 30, 2014
Presentation of findings to project Advisory Committee	1 day	February 28, 2013

5.0 Required Resources or Types of Roles to be Performed

Refer to Section 12, Mandatory Requirements.

6.0 Applicable Documents and Glossary

6.1 Applicable Documents

Annex A – ADI Capacity Building Special Study Framework

6.2 Relevant Terms, Acronyms and Glossaries

ADI – Aboriginal Diabetes Initiative
CBRT – Community Based Reporting Template
CDPW – Community Diabetes Prevention Worker
FNIHB – First Nations and Inuit Health Branch
HC - Health Canada
HL – Healthy Living
HPDP – Health Promotion Disease Prevention Division

PART II PROPOSAL REQUIREMENTS

7.0 Administrative Instructions for Completion of the RFP

7.1 General Information

7.1.1 Components, Language and Number of Copies

You are invited to submit written copies in either official language (English or French) of **both** the Technical and Cost Proposals. The RFP Reference Number and the name of the Departmental Representative must be marked on all documents, binders and respective envelopes. Your proposal must be structured in the following manner:

- one covering letter, signed by an authorized representative of your firm;
- One (1) electronic copy and three (3) hard copies of the Technical Proposal; and
- One (1) copy of the Cost/Price Proposal, contained in a ***separate sealed envelope*****.**

The Financial Proposal (hard copy and electronic) must be submitted in a separate, sealed envelope or other packaging. There must be no financial information on any hard copy or electronic copy of the covering letter or the Technical Proposal.

7.1.2 Bid Validity Period

Certify below that all pricing identified in the bid/ proposal will be valid for a period of ninety (90) days (*or other period*) from the closing date of the RFP.

_____ _____

Signature of Authorized Representative of the bidder Date

7.1.3 No Payment for Pre-Contract Costs

No payment will be made for costs incurred in the preparation and submission of a proposal in response to this RFP. No costs incurred before receipt of a signed contract or specified written authorization from the Departmental Representative can be charged to the proposed contract.

7.2 Delivery Instructions for Bid / Proposal

Bid submission envelopes are to be returned to the following address:

Health Canada Bid Receiving Unit
Federal Records Centre Building,
161 Goldenrod Driveway (Loading Dock),
Ottawa, Ontario K1A 0K9
Attention: Marie-France Gagnon

RFP Reference Number: 1000151403

All bids must be time stamped at the Bid Receiving Unit. Each bid submission envelope must include the RFP reference number and the name of the responsible Contract Officer

Proposals are to be submitted directly to the attention of the Contract Officer and address shown as the "Issuing Office" on the cover page of this RFP package.

The onus for submitting bids on time at the specified location rests with the bidder. It is the responsibility of the bidder to ensure correct and timely delivery of the entire bid to the Crown, including all required information and proposal pages.

7.3 Non-Acceptance of Proposal by Facsimile or Electronic Means

Proposals sent by fax, telex, e-mail and telegraphic means will **not** be accepted.

7.4 Closing Date and Time

All proposals must be received at the specified location by August 22, 2013,14:00 (EDT). Proposals received after this time will be returned unopened.

7.5 Time Extension to Closing Date

Requests for a time extension to the closing date will not be considered.

7.6 Non-Compliance / Unacceptable Proposals

Failure to meet the mandatory requirements of this RFP will result in your proposal being declared non-responsive.

Proposals received after the proposal closing time will not be considered and will be returned unopened to the bidder. Further, for any proposals which are found to be non-compliant, the financial part of the bid or proposal will be returned unopened with a letter from Health Canada indicating that the bid/proposal was non compliant.

7.7 Bidders Conference / Site Visits

Not applicable for this RFP.

7.8 Announcement of Successful Contractor

The name of the successful bidder will be announced on BuyandSell.gc.ca only upon contract award and sign-off.

7.9 Rights of the Crown

The Crown reserves the right to:

- reject any or all proposals received in response to this RFP;
- accept any proposal in whole or in part; and
- cancel and/or re-issue this requirement at any time.

7.10 Sample Long Form Contract

The successful bidder for this requirement will be expected to enter into agreement with Health Canada as per departmental contract terms and conditions.

7.11 Employment Equity

The Federal Contractors Program for Employment Equity requires that some organizations bidding for federal government contracts make a formal commitment to implement employment equity, as a pre-condition to the validation of their bids. All bidders must check the applicable box(es) below. **Failure to do so may render the bid non-responsive.**

Program requirements do not apply for the following reason(s):

( ) bid is less than $200,000;
( ) this organization has fewer than 100 permanent part-time and/or full time employees across Canada;
( ) this organization is a federally regulated employer;

or, program requirements do apply:

( ) copy of signed Certificate of Commitment is enclosed; or
( ) Certificate number is _____

NOTE: *The Federal Contractors Program for Employment Equity applies to Canadian-based bidders only. The Certificate of Commitment criteria and other information about the Federal Contractors Program for Employment Equity are available in the PWGSC Standard Acquisition Clauses and Conditions (SACC) Manual, Section 2, and on the Government Electronic Tendering Service.*

7.12 Procurement Business Number (PBN)

Public Works and Government Services Canada (PWGSC) has adopted the Procurement Business Number (PBN) for all its purchasing databases, and now requires that its suppliers have one for each of their offices that may be awarded contracts. Register with Contracts Canada's Supplier Registration Information (SRI) service to obtain your PBN. As an existing or potential supplier to the Department, you must obtain a PBN to avoid possible delays of any contract award. It is Health Canada's intention to use this sourcing system for all its procurements of goods and services to which the trade agreements do not apply.

SRI is a database of suppliers who have registered to do business with the Government of Canada. The

PBN is created using your Canada Customs and Revenue Agency Business Number to uniquely identify a branch, division or office of your company. Unlike many existing departmental vendor databases, your information in SRI is accessible to all federal government buyers. SRI can help to open up new opportunities with the federal government for requirements not posted on the electronic tendering service, BuyandSell.gc.ca.

Visit the Contracts Canada Internet site at http://contractscanada.gc.ca/en/busin-e.htm for information and registration procedures. Alternatively, you may contact a Supplier Registration Agent at: 1-800-811-1148 or, in the National Capital Region, at 956-3440.

7.13 Order of Precedence

In the case of any dispute which may arise during the period which may be covered by any ensuing contract, the following documents will be considered in order of precedence in terms of importance in resolving any disputes between the parties:

- The Health Canada Contract;
- Any changes to the terms and conditions contained herein which have been approved by General Counsel for Health Canada;
- The Statement of Work in this RFP;
- The terms identified in this RFP; and
- The Contractor's Proposal (technical and price).

8.0 Technical Proposal

8.1 General Information

The technical proposal must address all the requirements of the SOW and demonstrate that the Bidder is capable of meeting all obligations of the contractor specified in the same.

The technical proposal must meet **all of the Mandatory Requirements** listed in Section 12.0, as well as the **minimum scores identified for the Point Rated Requirements** in Section 13.0.

8.2 Understanding of the Requirements

A brief statement that demonstrates that the contractor understands the requirements of the SOW, including the objectives, scope of work and deliverables.

8.3 Approach and Methodology:

8.3.1 General Approach

Refer to Section 12, Mandatory Requirement M3.

8.3.2 Methodology

Identify methodologies and techniques to be used, including identifying any proprietary information which is proposed to be used in the program.

8.3.3 Work Plan / Project Schedule

Break down the work by task - show phases, planned start, completion dates and the estimated level of effort (i.e. person days) needed to complete the task. The work plan may include a matrix and/or time line charts. A project schedule structured in weeks, reflecting milestones and deliverables, should be included.

8.3.4 Performance and Quality Control

The Bidder must specify how you propose to deal with the performance and quality assurance of the work provided by your organization to the Crown. Include information about quality control methods and reporting mechanisms.

8.4 Proposed Team

8.4.1 Personnel

If applicable, identify all proposed personnel, including **Project Manager**, who will be assigned to this contract, describe the role they will be performing, including the amount of direct time dedicated to the project by principals and/or senior personnel, and explain why they are well suited for the work, referring to their qualifications, certifications, education and experience.

If applicable, include a list of proposed sub-contractors, with reference to their capabilities, experience and degree of involvement in the work.

The bidder must certify in the technical proposal that the information provided in all the personnel résumés has been verified to be true and accurate. In addition, for every resource proposed by the bidder who is not an employee of the firm, the actual resource must certify that they are aware that they are being bid as part of the bid/ proposal and state their relationship with the firm.

8.4.2 Contingency Plan

If the contract cannot be completed by the assigned personnel, the following individual(s) will complete the work. *Attach résumés.*

8.5 Contractor Profile

8.5.1 Organization

If applicable, provide background information about your company, including its legal name and the province in which the company is incorporated.

8.5.2 Relevant Work Experience

Describe your company's capacity and experience in this field.

8.5.3 References

Refer to Sections 12 and 13, Mandatory and Rated Criteria. Health Canada reserves the right to verify any information or references provided.

8.6 Résumés of Personnel

Attach résumés of proposed personnel.

9.0 Financial Proposal

9.1 General Information

The Financial Proposal must contain a detailed breakdown of the **total quoted price**, by phase, or by major tasks, or both. The Financial Proposal should address each of the following, if applicable:

9.1.1 *Per Diem*

For each individual and/or labour category to be employed on the project, including subcontractors, indicate the proposed time rate and the estimated time requirement. Although detailed support for the rates is not requested at this time, you should be prepared to substantiate the proposed rates.

9.1.2 Travel

Not applicable under this RFP.

9.1.3 Other Expenses

List any other expenses which may be applicable, giving an estimated cost for each (e.g. long distance communications, survey incentives, shipping, etc.).

9.1.4 Goods and Services Tax / Harmonized Sales Tax

Various items in your cost proposal may be subject to GST / HST or custom duties, and this charge must be included in the cost estimates where applicable.

9.2 Price Justification

The Bidder must provide, on Health Canada's request, one or more of the following price justification:

- a current published price list indicating the percentage discount available to Health Canada; or
- a copy of paid invoices for the like quality and quantity of the goods, services or both sold to other customers; or
- a price breakdown showing the cost of direct labour, direct materials, purchased items, engineering and plant overheads, general and administrative overhead, transportation, etc., and profit; or
- price or rate certifications; or
- any other supporting documentation as requested by Health Canada.

10.0 Enquiries

All enquiries or issues concerning this procurement must be submitted **in writing only** to the Departmental Representative named on the front cover page of this RFP document **not later than seven (7) calendar days prior to the bid closing date.**

To ensure consistency and quality of information to Bidders, the Departmental Representative will provide, simultaneously to all bidders to which this solicitation has been sent,

- any information with respect to significant enquiries received, and
- the replies to such enquiries without revealing their sources,

provided that such enquiries are received no less than seven (7) calendar days prior to the bid closing date.

All enquiries and other communications with government officials throughout the solicitation and evaluation period are to be directed **only** to the Departmental Representative named on the front cover page of this RFP document. **Non compliance with this condition during the bid solicitation and evaluation period may be sufficient reason for bid disqualification.**

PART III BID SELECTION PROCESS

11.0 Introduction

12.0 Mandatory Requirements

12.1 Method of Evaluation

Mandatory requirements are evaluated on a simple pass or fail basis. Failure by bidders to meet any of the mandatory requirements will render the bidder's proposal **non-responsive**. The treatment of mandatory requirements in any procurement process is absolute.

Proposers must meet **all** the mandatory requirements described below. This will be evaluated as either "**Yes**" or "**No**". Proposals not receiving "**Yes**" for any mandatory requirement will ***not*** be considered further. Health Canada reserves the right to verify any information or references provided.

12.2 Mandatory Requirements

Attention Bidders: Write beside each of the criteria the relevant page number(s) from your proposal which addresses the requirement identified in the criteria.			
Criteria *Project examples may be used to address more than one mandatory requirement, provided that project descriptions provide sufficient information to address each requirement.*	**Page #**	**Yes**	**No**
Company/Firm Experience **M1.** The bidder must possess a minimum of 5 years of experience conducting studies or evaluations of health, education or social programs/services. At least 2 examples (brief project descriptions) must be provided.			
M2. The bidder must possess a minimum of 5 years of experience conducting projects or research focusing on First Nations, Inuit or Aboriginal communities or programs. At least 2 examples (brief project descriptions) must be provided.			
Approach **M3.** The proposal must describe the bidder's proposed approach and methods for data analysis.			

Resources Experience **M4.** Project resources must include personnel with expertise and experience in survey design, implementation and analysis. At least 2 examples (brief project descriptions) must be provided.			
M5. Project resources must include personnel with expertise and experience in assessing cost effectiveness of programs or services. At least 2 examples (brief project descriptions) must be provided.			

13.0 Point Rated Requirements

13.1 Method of Evaluation

A proposal with a score less than 70% for technical compliance in each section and/or as a whole will be considered **non responsive**, and eliminated from the competition.

13.2 Point Rated Requirements

Attention Bidders: Write beside each of the criteria the relevant page number(s) from your proposal which addresses the requirement identified in the criteria.				
Criteria *Project examples may be the same as those provided for mandatory criteria. Clearly identify which project is to be used for the point-rated assessment.*	**Page #**	**Points allocated for the criteria**	**Minimum points required**	**Score**
Provide one (1) example of a study or evaluation previously completed by the bidder that involved the collection and analysis of both qualitative and quantitative data to assess the impact or effectiveness of a health, education or social program/service. *Up to 20 points will be allotted for the given example.* *16-20 = Superior example provided;* *11-15 = Very good example provided;* *6-10 = Good example provided;* *1-5 = Weak example provided;* *0 = No example provided*		20		

Provide one (1) example of a project that involved assessment of the cost effectiveness of programs or services. Describe how cost effectiveness was assessed. *Up to 20 points will be allotted for the given example.* *16-20 = Superior example provided;* *11-15 = Very good example provided;* *6-10 = Good example provided;* *1-5 = Weak example provided;* *0 = No example provided*		20		
Proposal shows a thorough understanding of the objectives for this requirement, including the nature of the program, services and communities that will be studied. *Up to 20 points will be allotted based on demonstrated understanding.* *16-20 = Proposal shows a superior understanding;* *11-15 = Proposal shows a very good understanding;* *6-10 = Proposal shows a good understanding;* *1-5 = Proposal shows a weak understanding;* *0 = Proposal shows minimal understanding*		20		
Describe the process and methods that will be used to manage and analyze survey data for this project. *Up to 20 points will be allotted for the given approach and methods.* *16-20 = Superior approach/methods given;* *11-15 = Very good approach/methods given;* *6-10 = Good approach/methods given;* *1-5 = Weak approach/methods given;* *0 = No approach/methods*		20		
Describe the approach and methods that will be used to manage and analyze interview data for this project. *Up to 10 points will be allotted for the given approach and methods.* *7-10 = Superior approach/methods given;* *5-6 = Very good approach/methods given;* *3-4 = Good approach/methods given;* *1-2 = Weak approach/methods given;* *0 = No approach/methods*		10		

Describe how various data will be synthesized to answer research questions for this project. *Up to 10 points will be allotted for the given approach and methods.* *7-10 = Superior approach/methods given;* *5-6 = Very good approach/methods given;* *3-4 = Good approach/methods given;* *1-2 = Weak approach/methods given;* *0 = No approach/methods*		10		
TOTAL SCORE		**100**	**70**	

14.0 BASIS OF AWARDING CONTRACT

Highest Compliant Combined Rating of Technical Merit and Price:

It is understood by the parties submitting proposals that, to qualify, bidders **must** meet all mandatory requirements as well as the minimum score identified for the point-rated criteria. The contract will be awarded based on a determination of best value taking into account both the technical merit of the proposals and the price evaluations. To arrive at an overall score achieved by a firm, a weighting has been established whereby technical merit will be valued at 70% of the bid and price at 30%.

Example 1 - Contractor Ranking

For the purpose of ranking all technically complaint proposals, the following ratio will factor the technical and the price component to establish a total percentage score:

Technical: 70%
Price: 30%

Technical Score = $\frac{\text{Bidder's Points}}{\text{Maximum Points}}$ **x** 70% **Cost Score** = $\frac{\text{Lowest Bid}}{\text{Bidder's Cost}}$ **x** 30%

Total Score = Technical Score + Cost Score

The contract will be recommended to **the highest total technical and price score**.

15.0 DEBRIEFING

Not applicable under this RFP.

16.0 CERTIFICATIONS

Compliance with Terms and Conditions

The Bidder by signing below hereby certifies that it has read the RFP in its entirety, including the Statement of Work, and signifies compliance with and acceptance of all the articles, clauses, terms and conditions contained or referenced in this RFP document.

Signature of Authorized Representative of the bidder	**Date**

Certification of Education and Experience

To be considered responsive, the proposals must contain the following certification:

"The Bidder hereby certifies that all statements made with respect to education and experience are true and that any person proposed by the Bidder to perform the work or part of the work is either an employee of the Bidder or under a written agreement to provide services to the Bidder."

The Crown reserves the right to verify the above certification and to declare the bid non-responsive for any of the following reasons:

a) unverifiable or untrue statement;
b) unavailability of any person proposed on whose statement of education and experience the Crown relied to evaluate the offer and award the Contract.

Signature of Authorized Representative of the bidder	**Date**

Certification of Availability and Status of Personnel

Availability of Personnel and Facility

The Bidder certifies that, should it be authorized to provide services under any Contract resulting from this solicitation, the persons and facility proposed in its offer will be available to commence performance of the work within a reasonable time from Contract award, of within the time specified herein and will remain available to perform the work in relation to the fulfilment of this requirement.

Signature of Authorized Representative of the bidder	**Date**

Bid Validity Period:

Certify below that all pricing identified in the bid/ proposal will be valid for a period of not less than ninety (90) days from the closing date of the RFP.

Signature of Authorized Representative of the bidder	**Date**

Annex A

Aboriginal Diabetes Initiative Capacity Building and Training –
Special Study on Progress and Impacts

Project Framework

A. Background and Rationale

The Health Promotion and Disease Prevention (HPDP) Division within Health Canada's First Nations and Inuit Health Branch (FNIHB) supports community-based and culturally relevant programs and policies that promote health and prevent chronic disease across the lifespan. Capacity Building is one of five activity themes that contribute to key outcomes for HPDP programs. In this context, capacity building refers primarily to development of the workforce that supports health systems and services in First Nations and Inuit communities. FNIHB Regions support the delivery of training, continuing education and professional development for community workers and health professionals to increase their knowledge, skills and ability to implement community-based programs and services.

Within the Healthy Living (HL) cluster of HPDP, the Aboriginal Diabetes Initiative (ADI) supports the delivery of community-based projects and services to promote healthy living. ADI funding reaches over 600 First Nations and Inuit communities and is used to implement activities in the areas of health promotion, diabetes and chronic disease prevention, screening and management. The ADI was first implemented in 1999, and has been renewed for five-year funding cycles. The current phase of ADI (Phase 3) will sunset in 2015.

Since 2006, ADI funding has supported over 400 community workers to complete post-secondary education programs in diabetes, chronic disease prevention, and community health promotion. Once community workers have received a certificate or diploma from a recognized post-secondary program, they are regarded within ADI as certified Community Diabetes Prevention Workers (though actual job titles vary between Regions and communities). ADI funding also supports a variety of continuing education and professional development opportunities for community workers and health professionals.

This study aims to assess progress and impacts of ADI capacity building and training activities for community workers[1] and provide evidence of the contribution that capacity building and training activities have made toward achieving key program outcomes. This information is required to build a strong base of evidence for program evaluation and renewal.

B. Research Questions

To assess progress and impacts of capacity building and training activities, research questions were developed based on the Healthy Living Logic Model. The Logic Model is shown below, with attention drawn to the Capacity Building theme. Immediate outcomes are described for each theme area, while intermediate and longer term outcomes are understood to be outcomes to which all activities contribute. The current study is designed to assess the immediate outcomes linked to capacity building, as well as the contribution that capacity building activities have made to intermediate program outcomes. To support ADI/HL evaluation and upstream renewal, the study will also gather information relative to specific program priorities ("enhanced focus areas" as identified in the 2010 ADI Program Framework), cost effectiveness, and to inform future approaches to capacity building and training for community workers.

1 Training for health professionals is supported primarily through the Home and Community Care program, and will not be assessed through this study.

Annex A

HEALTHY LIVING LOGIC MODEL

Objective	**To fund and support the development, implementation, monitoring, and evaluation of community-based and culturally relevant programs (i.e. Aboriginal Diabetes Initiative, Educational Components for Nutrition North Canada, Oral Health) and policies that promote health and prevent chronic disease across the life-span.**
Target Group	**First Nations residing in traditional First Nations Communities, Inuit communities and some support for all Aboriginal peoples.**

Theme	**Stakeholder Engagement and Collaboration**	**Capacity Building**	**Data Collection, Research and surveillance**	**Policy Development and Knowledge Sharing**	**Service Provision**
Outputs	• **Collaborative processes and practices (e.g. consultations, agreements, joint projects, committees/working groups) initiated**	• **Training, continuing education, and professional development opportunities provided**	• **Data collection tools and support developed** • **Data/Information relevant to services, determinants of health and health status**	• **Program guidance tools (e.g. policies, procedures, frameworks, guidelines) developed/refined** • **Mechanisms and processes to share promising practices developed/ implemented**	• **Funding provided for community-based HL programs/ services : ADI, NNC, Dental Therapy** • **Dental Therapy services directly provided by FNIHB**
Reach	**National, regional and community partners and stakeholders, both internal and external**	**Community workers and health professionals**	**Community representatives (e.g. workers, and Health Directors), regions and partners/ stakeholders at all levels**	**Partners and stakeholders at community, regional and national levels**	**Recipients of funding and/or services: First Nations and Inuit individuals, families and communities & Territorial governments**
Immediate Outcomes	**Improved community and stakeholder engagement and collaborations to support policy/program development and**	**Increased community capacity (knowledge, skills and ability) to support community-**	**Increased ability to collect, monitor and provide information for policy or program development and implementation** **Increased use of tools and evidence-based information (e.g., promising practices) to inform policy and program delivery and improvement**		**Ongoing access to healthy living programs/services** **Increased individual knowledge of healthy living**

	service delivery	**based HL programs and services.**		**issues and practices**

Intermediate Outcomes	• **Improved coordination and integration of healthy living programs and services** • **Improved quality of healthy living programs and services** • **Increased adoption of healthy practices** • **Increased supportive physical and social environments for Healthy Living**
Longer Term Outcomes	**First Nations and Inuit communities, families and individuals receive healthy living services that are responsive to their needs so as to improve FN/I health status**

Research Questions

This study will provide information in response to the following questions:

1. **What are the current levels of education and training among community workers who deliver ADI programming?**
2. **How have capacity building and training activities enhanced the knowledge, skills and abilities of community workers to implement effective ADI programming?**
3. **How has capacity building and training for community workers contributed to intermediate program outcomes?**
    a. **Quality of programs and services**
    b. **Integration of programs and services**
    c. **Healthy practices**
    d. **Supportive environments**
4. **How has capacity building and training addressed ADI priority areas?**
5. **What are other impacts to community capacity as a result of ADI capacity building and training activities?**
6. **How cost effective are ADI capacity building and training models?**
7. **What are the barriers that prevent community workers from accessing education and training?**
8. **What are future priorities to enhance the capacity of community health workers to deliver effective programming?**

C. Research Matrix

The matrix below identifies indicators and data sources linked to each research question. Note that there are no indicators for Q 7-8, as these questions will generate descriptive responses.

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Question	Indicator	Data Sources	Lead
1. What are the current levels of education and training among community workers who deliver ADI programming?	• **Proportion (%) of community workers delivering ADI activities who have completed post-secondary training[2]** • **Proportion (%) of community workers who regularly participate in continuing education activities**	• **ADI Community worker survey**	**Contractor**
2. How have capacity building and training activities enhanced the knowledge, skills and abilities of community workers to implement effective ADI programming?	• **Levels of correspondence between training programs and activities and national/regional competency frameworks** • **Perceived levels of efficacy in key competency areas linked to worker education and training**	• **Training curricula and topics** • **National/regional competency frameworks** • **Internal studies and evaluations** • **ADI Community worker survey** • **Regional key informant interviews**	**Contractor FNIHB (HQ and Regions)**
3. How has capacity building and training for community workers contributed to intermediate program outcomes? **a. Quality of programs and services** **b. Integration of programs and services** **c. Healthy practices** **d. Supportive environments**	• **Type/range of community activities linked to worker education and training** • **Integration of community activities linked to worker education and training** • **Perceived levels of community participation linked to worker education and training** • **Perceived changes in health practices linked to worker education and training** • **Community activities addressing supportive environments linked to worker education and training**	• **ADI Community worker survey** • **Regional key informant interviews** • **Internal studies and evaluations** • **CBRT[3] community-specific data (2012/13 sample)**	**Contractor FNIHB (HQ and Regions)**

2 A list of eligible training programs will be provided.

3 FNIHB Community-Based Reporting Template (CBRT) is completed annually by most funding agreement recipients; it provides basic program activity data at a community level. This data is held at FNIHB HQ. Community worker survey data will be provided to FNIHB for analysis linked to CBRT data.

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Question	Indicator	Data Sources	Lead
4. How has capacity building and training addressed Phase 3 ADI priority areas?	• **# and type of training activities since 2010 addressing food security, diabetes in pregnancy, children/families, multi-disciplinary teams** • **Community ADI activities addressing food security, diabetes in pregnancy, children/families** • **Multi-disciplinary team models**	• **ADI Program Framework** • **Training curricula and topics** • **ADI Community worker survey** • **Regional key informant interviews**	**Contractor FNIHB (HQ and Regions)**
5. What are other impacts to community capacity as a result of ADI capacity building and training activities?	• **Other community health roles of ADI workers** • **Participation of ADI workers in community health planning linked to education and training** • **Career progression (planned or actual) of ADI workers linked to education and training**	• **ADI Community worker survey** • **Regional key informant interviews** • **Internal studies and evaluations**	**Contractor**
6. How cost effective is the ADI capacity building and training model?	• **Average cost of certification** • **Average cost of continuing education activities** • **Evidence of impact (findings from Q 1-5)** • **Duration of CDPW employment** • **Other community health roles of ADI workers** • **Model to assess cost-effectiveness**	• **Internal project budgets[4]** • **Research and literature on HHR training and cost effectiveness** • **Regional key informant interviews**	**Contractor FNIHB (HQ and Regions)**
7. What are the barriers that prevent community workers from accessing education and training?	**N/A**	• **ADI community worker survey** • **Regional key informant interviews** • **Internal studies and evaluations**	**Contractor**
8. What are future priorities to enhance the capacity of community health workers to deliver effective	**N/A**	• **ADI community worker survey** • **Regional key informant**	**Contractor**

4 A sample of budgets for post-secondary programs and continuing education activities will be provided.

Question	Indicator	Data Sources	Lead
programming?		**interviews** • **Internal studies and evaluations**	

D. Data Sources

The data sources referred to in the evaluation matrix are of three main types:

1. **Program documentation and related literature:**
   - **ADI Program Framework**
   - **Training curricula and outlines**
   - **Project budgets**
   - **National/regional competency frameworks**
   - **Internal studies and evaluations**
   - **Research/literature on cost effectiveness and HHR training**
   - **FNIHB Community-Based Reporting Template (2012/13 results)**

2. **Community Healthy Living Worker survey:**
   - **Disseminated to all ADI/HL workers**
   - **Target population of 350 workers in 6 Regions**
   - **Minimum sample of 220**
   - **Option to complete an e-survey, or print and fax-back a paper version**
   - **Data will be entered into Excel or SPSS for quantitative analysis**

3. **Regional key informant interviews:**
   - **Key informants will be FNIHB Regional ADI/HL program leads and others to be identified by Advisory Committee**
   - **Anticipate 6-10 key informants**
   - **Interviews will be conducted by telephone**
   - **Interviews will be transcribed for qualitative data analysis**

E. Key Tasks and Timeline

Task	*Responsible*	*Timeline*
Finalize project design and SOW	**FNIHB HQ with Advisory Committee**	**June, 2013**
Hire evaluation contractor	**FNIHB HQ**	**August, 2013**
Project kick-off meeting	**Contractor, FNIHB HQ**	**September, 2013**
Develop and pilot test data-gathering tools	**Contractor, FNIHB HQ, Advisory Committee**	
Develop data analysis plan	**Contractor**	
Finalize and translate data-gathering	**Contractor, FNIHB HQ**	

tools		
Conduct document review	**Contractor**	
Implement community worker survey	**Contractor, FNIHB HQ and Regions**	**October, 2013**
Survey data entry and management	**Contractor**	
Conduct key informant interviews	**Contractor**	**October-November, 2013**
Develop cost effectiveness model	**Contractor**	
Analyze survey data for links to CBRT	**FNIHB HQ**	**November, 2013**
Qualitative and quantitative data analysis	**Contractor**	
Produce Regional data summary reports	**Contractor**	**December, 2013**
Synthesize survey results, interviews, and document review	**Contractor**	
Produce preliminary project report	**Contractor**	
Review findings and provide feedback	**FNIHB, Advisory Committee**	**January, 2014**
Prepare final report	**Contractor**	
Present project findings	**Contractor**	**February, 2014**