USAID | PERU
FROM THE AMERICAN PEOPLE

February 12, 2008

VIA ELECTRONIC MAIL

Subject: RFTOP No. 527-08-008, Technical Assistance Group for the Health Sector Program Population, Health and Nutrition Technical Assistance and Support Contract Three – Global Health (TASC 3 – Global Health) IQC

Dear Sir/Madam:

The purpose of this letter is to inform you that USAID/Peru intends to award a Task Order under the Population, Health, and Nutrition Technical Assistance and Support Contract Three – Global Health (TASC 3 – Global Health) IQC. USAID is requesting a proposal from your organization based on IQC Section F.5 Fair Opportunity.

Enclosed please find the scope of work for the provision of technical assistance to the Peru health sector. The purpose of this activity is to strengthen that part of Peru's health sector that is funded and operated by the government, and which includes the central Ministry of Health, regional directorates, health services networks and micro-networks, and selected functions within the regional and municipal governments.

A Task Order will be issued under the basic contract and will be a Cost-Plus-Fixed-Fee (CPFF) award. The procedures for selection will consist of a Best Value source selection process based upon past performance, technical approach, skills and experience of key personnel.

Under a best value source selection, non-price evaluation factors, when combined, are significantly more important than price. USAID will consider an offeror's past performance to be more important than its price, and experience to be more important than past performance. However, USAID will not select an offeror for award on the basis of a superior capability without consideration of the amount of its price. In order to select the winning proposal, USAID will rank each offeror by making a series of paired comparisons between them, trading off the marginal differences in capability and the price. The selection authority will decide whether the marginal difference in capability is worth the marginal difference in price.

The anticipated period of performance is for 60 months. The planned budget for the activity is between $18.3 million, with a maximum ceiling of $20 million. The approximate amount available for the first year is $4.3 million. Award of a task order is contingent on normal congressional notification requirements, approval of the annual Operational Plan, and availability of funds for this purpose.

This RFTOP includes the following attachments: (a) Scope of Work, (b) Instructions to offerors, (c) Evaluation Criteria, and (d) Required Certifications and other information.

All questions concerning this RFTOP should be addressed to Mrs. Rosario O. de Saldaña, Acquisition and Assistance Specialist at (511) 618-1434, or via e-mail at rsaldana@usaid.gov or to Mr. Luis A. Rivera, Contracting Officer at lrivera@usaid.gov. We expect to receive your questions related to this RFTOP not later than February 22 2008. Answers will be provided within three days. Please ensure that proposals are received by COB March 12, 2008 at the delivery address listed below.

The Technical and Cost proposals should be addressed by e-mail or mail to Mr. Luis A. Rivera (Av. La Encalada S/N, Cdra. 17 Monterrico-Surco, Lima, Peru, care of Ms. Veronica Leo, c/o RCO/Lima, same address, vleo@usaid.gov) and to Mrs. Rosario O. de Saldaña, A&A Specialist, same address, rsaldana@usaid.gov. Electronic submission is the preferred method for submitting all proposals.

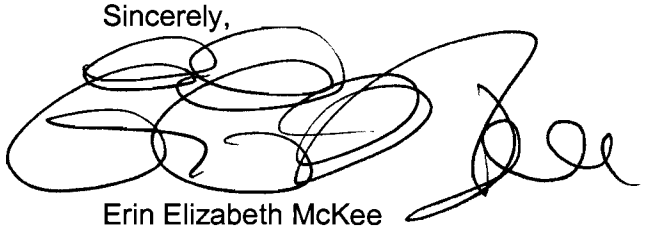
The receipt of this RFTOP must be confirmed through written notification (by e-mail or by fax (511) 618-1354) to the negotiator identified above. It is the responsibility of the recipient of this RFTOP document to ensure that it has been received in its entirety. USAID bears no responsibility for any data errors resulting from the transmission or document conversion processes.

Organizations must inform Mr. Rivera and Mrs. Saldaña through e-mail of their intent to submit a proposal by February 15, 2008. Offerors are advised that funds are not yet available for award at this time. This solicitation in no way obligates USAID to award a contract, nor does it commit USAID to pay any cost incurred in the preparation and submission of the proposal. Furthermore, the Government reserves the right to reject any and all offers, if such action is considered to be in the best interest of the Government.

If there are problems in downloading this RFTOP, please contact us directly.

Thank you for your consideration of this USAID/Peru initiative.

Sincerely,



Erin Elizabeth McKee
Supervisory Contracting Officer

Enclosures: Section I , Scope of Work
Section II, Instructions to offeror
Section III, Evaluation Criteria
Section IV, Required Certifications and other information

SECTION I - SCOPE OF WORK

1. PURPOSE AND SCOPE

The purpose of this task order is to create and implement a mechanism that will provide expert technical assistance to Government of Peru health agencies in three programmatic areas: (1) Infectious Disease prevention and control, (2) Maternal and Child Health, and (3) Family Planning and Reproductive Health. This activity will mainly address practical and operational problems, primarily in the public sector, that impair the delivery of effective, quality health services and public health programs in these three areas. This task order will be a key component of USAID/Peru's health portfolio. It will entail close cooperation with the central Ministry of Health and with selected regional and municipal governments in the context of government-wide decentralization. Through this task order, USAID will provide technical assistance, training, and limited commodity and equipment purchases to these governmental entities.

This activity will complement other components of the USAID/Peru Health Program ("Program") to advance its central goal: assisting Peru to strengthen systems and more effectively use resources in the health sector in order to produce real and lasting improvements in the health status of the poor and near-poor population. Responsibility for funding many of the sub-activities implemented under this task order is expected to be shared with the government agencies receiving assistance.[1] Arranging such co-funding will be an important part of carrying out this task order. No USAID funding will be transferred to Peruvian government agencies through this task order.

USAID/Peru's Health Program is now based on the premise that Peru's economy produces adequate fiscal resources to deliver good quality basic health care, and to carry out appropriate public health programs for disease prevention and health promotion, for its entire population. However, the current reality is instead one of very low quality health care services for the majority of Peruvians and markedly inadequate public health programming for the population as a whole. This reality can be broadly attributed to chronic underinvestment in the public health sector and to the sector's weak institutions and management -- factors that are mutually reinforcing. To remedy current deficiencies will require the sustained commitment of the Government of Peru (GOP), and the dedicated work of people throughout the health sector. USAID's role is to partner with Peru's health authorities and institutions and provide highly targeted technical inputs to leverage and "incentivize" broad and meaningful improvements in this sector. In this way, the Health Program aims to help Peru mobilize its own considerable human and financial resources to move the health sector toward greater effectiveness, efficiency, equity, and adequate domestic financial support.

The work performed under this intended task order will contribute to the achievement of the *Investing in People* Objective in the U.S. Foreign Assistance Framework under the Health Area. (See: http://www.state.gov/documents/organization/88433.pdf.) The task order will be financed with funds earmarked for activities in each of these five elements, and will achieve significant results related to each of them:

[1] In some cases, public-private partnerships may also be appropriate.

- HIV/AIDS
- Tuberculosis (TB)
- Other Public Health Threats (OPHT)
- Maternal-Child Health (MCH)
- Reproductive Health/Family Planning (RH/FP)

It is expected that during the life of this project all of USAID/Peru's bilateral activities related to HIV/AIDS and TB will be carried out through this instrument (i.e. this task order.) MCH, FP, and OPHT work will be implemented through other instruments in the Mission's health portfolio as well as this task order.

The intended task order is currently planned for a 5-year implementation period, subject to availability of funds, Congressional approvals, Mission priorities, and satisfactory evaluation of performance. The planned budget for the activity is $18.3 million, with a maximum ceiling of $20 million. Please note that award of the task order contemplated herein cannot be made until funds have been fully appropriated, allocated, and committed through internal USAID procedures. While it is anticipated that these procedures will be successfully completed, the TASC III IQC holders are hereby notified of these requirements and conditions for award and subsequent obligations of incremental funding.

2. BACKGROUND

Development Context

Despite being ranked by the World Bank as a lower-middle income country, Peru is still classified as a "developing" country under the U.S. Foreign Assistance Framework (U.S. Department of State, 2006.) About 45% of the population of 28 million remains poor, and 16% are extremely poor, even though Peru has sustained strong economic growth for several years. Poverty and extreme poverty rates are highest among rural and indigenous groups, though urban poverty is also high. Peru's severe and enduring socioeconomic disparities fuel dissatisfaction with the state, its institutions and political leaders, posing the major threat to Peru's political stability.

The country's challenging terrain, especially in the jungle and the Andes mountain range, coupled with poorly developed communication and transportation systems, has contributed to the problem of low state presence and poor quality government services in many areas. Compounding these practical challenges to reducing disparities, Peru has a long history of cultural and economic discrimination against indigenous peoples.

To help Peru address the still-critical issues on its development agenda, the USAID Mission's overall assistance program in Peru is aimed at reducing poverty through broad-based economic growth, modernizing key institutions, improving state-run services, and strengthening civil society. In addition to working at the national level, USAID/Peru currently concentrates its field presence in a seven-region area[2] where coca is grown for cocaine, and narco-trafficking activity is common. USAID's multi-sectoral Alternative Development strategy aims to promote licit and secure lifestyles through its activities in economic growth, democracy and governance, basic education, and environmental protection, as well as health.

[2] Ayacucho, Cusco, Huanuco, Junín, Pasco, San Martín, and Ucayali.

In 2008 Peru is expected to initiate a Millennium Challenge Corporation (MCC) Threshold Program that has two major components: (1) reduction of government corruption, and (2) boosting childhood immunization rates. The Government of Peru (GOP) would like to qualify for an MCC Compact grant by the end of this decade.

Health Context

Peru's aggregate national indicators show major advances since the 1980s in prenatal care, skilled attendance at birth, reduction of maternal, infant, and under-5 mortality, Total Fertility Rate (TFR), and Contraceptive Prevalence Rate (CPR). Yet, for each of these indicators, large gaps[3] persist between upper and lower income groups, owing to vast disparities in standard of living, access to health care services, and the quality of services provided. Rural populations, including poor indigenous groups, continue to have high unmet need for basic health services, and are the most difficult to reach. For instance, use of modern contraceptives in urban areas according to 2004/06 DHS estimates was 53%, but in rural areas was 38%, with an unsatisfied need for contraceptives of more than 11%. Over half of all births in rural areas still occur at home, and maternal mortality remains high.

The national chronic childhood malnutrition rate of 31%[4] has remained essentially unchanged for over a decade, and is mostly concentrated in rural areas where the percentage reaches 70% or more of children in some communities. Childhood illness goes untreated in many areas due to the inaccessibility of health care and basic drugs, coupled with poor understanding of effective home management. In the absence of strong public health programs, there is low awareness in many rural and urban settlements of the importance of clean water, hand washing, good sanitation practices, and sound nutrition for child health.

In the arena of infectious disease control, Peru is slowly recovering from disruptions in key programs that occurred when the MOH shifted from vertical programs to a more modern and integrated model of health care delivery in 2002. The HIV/AIDS, tuberculosis, and childhood vaccination programs, which had been highly effective as vertical programs, declined markedly due to resource and management problems after the reorganization. Although prevalence in the general population is currently low, HIV/AIDS is a significant health threat in Peru. The concentrated epidemic primarily affects most-at- risk populations (MARPs), especially men who have sex with men (MSM) and commercial sex workers (CSWs). Among the former, prevalence is reported at 13.6% nationally; in Lima it has reached 22.8%.[5] Unchecked, spread of the epidemic would impose considerable costs on the people and GOP, undermining health, longevity, and general development gains realized in recent years.

[3] The USAID-sponsored Demographic and Health Survey in Peru is piloting a "continuous" methodology that generates estimates for major indicators in the form of rolling averages, based on continuous data collection. The first full set of estimates for the period 2004-2007 is expected in early 2008. This data is available with other background information to Offerors at the TASC3 website.

[4] In 2007 WHO published revised standards for child growth and development. WHO re-estimated the percentage of Peruvian children who are chronically malnourished is 31% rather than 25% (estimated under the old standards.). Applying either the old or new criteria retrospectively reveals that there has been no significant reduction during the last decade. See http://www.who.int/childgrowth/standards/tr_summary/en/index.html .

[5] Plan Estratégico Multisectorial para la Prevención y control de las ITS y VIH/SIDA en el Perú. Ministerio de Salud, Lima, Mayo 2007.

Tuberculosis also remains a significant challenge for Peru's health sector: according to MOH estimates, over 45,000 persons are infected with tuberculosis, including multi-drug resistant strains. Currently the Global Fund is providing substantial funding for work in TB and HIV/AIDS (see: http://www.theglobalfund.org/.) A range of other infectious diseases including dengue fever and Chagas' disease are also common in Peru. High rates of hospital-based infections and inadequate safety of the blood supply reflect generalized weakness in the enforcement of standards in the health system.

While Peru's public health and clinical standards and guidelines are generally rigorous, the actual quality of state-provided health services is low, and the quality of professional practice among health care providers varies greatly. The Ministry of Health, which provides health services to the country's poor and near-poor population (almost 70% of Peru's 28 million inhabitants), has instigated many interventions to improve the public health care system. However, it remains weak as a result of many factors, including: inadequate government investment; historic centralization of health sector resources in Lima leading to inefficiencies and poor response to needs in the rest of the country; frequent turnover in personnel in both management and clinical cadres; inadequate training and supervision for both clinicians and managers; upper management in the MOH that is highly vulnerable to political change; inadequate information systems for epidemiological surveillance, clinical, and management functions; weak logistics and regulatory systems for drugs, contraceptives, and vaccines; an inefficient and non-transparent government procurement system; and low capacity to enforce quality standards and standards in the sector.

Today, important major transformations are underway on four fronts in Peru's health sector, simultaneously: (1) continuing adjustment to an integrated (rather than vertical) approach to organizing and delivering health care services that was begun in 2002; (2) decentralization of management and budgeting to the regional and municipal levels under a government-wide decentralization mandate; (3) a push to expand health financing and insurance mechanisms, especially for the poor; and (4) the rapid expansion of national programs targeting the poor, especially: Juntos (a conditional cash transfer program), CRECER (a strategy to combat chronic childhood malnutrition), and the Seguro Integral de Salud ("SIS" - a health insurance system for the poor.) These sea-changes make the sector very dynamic and present many opportunities for system strengthening.

The health sector decentralization process is now behind schedule as the planned transfer of most health service functions to the regional level by December 2007 did not occur. Despite delays, regional and local governments are working on plans and budgets for a range of health services: maternal and peri-natal services, family planning and reproductive health programs, child health services, and infectious disease control are priorities for regional and local health planning and budgeting. According to Peru's decentralization plan, core functions will remain centralized in the Ministry, including: setting national health policy and global regulation for the health sector; conducting long-term planning; aggregating and analyzing epidemiological and other data, and coordinating with international donors.

Decentralization has the potential to improve the responsiveness of health services to local needs and to increase public support for health and family planning services through community mobilization – but it also involves considerable risk that service

provision will fail where receiving units are inadequately prepared to assume new functions. Besides preparing regional and municipal staff for the decentralization process, more effective execution of the rector role by the central MOH will be critical to the success of the decentralization process.

USAID/Peru's Health Program: Overview

As noted above, USAID/Peru's Health Program comprises five program elements: HIV/AIDS; tuberculosis; other public health threats; maternal and child health; and family planning and reproductive health; Focusing on improved health outcomes in those fiver areas, the Mission's health strategy is designed to respond to Peru's dynamic health sector, and prioritizes effective partnering with host country institutions. This is a mature assistance program that is seeking practical, durable solutions for some of the most persistent and difficult problems that plague Peru's health sector, especially inadequate financing, poor service quality, and vast inequalities in health status and access to quality services. We anticipate that funding from international donors to this sector will continue to diminish as Peru's GDP grows, making the next few years critical for USAID's contributions in health. In this spirit, USAID and the Ministry of Health have recently agreed to establish a Joint Steering Committee to plan and monitor USAID's health activities in Peru for maximum coordination and impact.

It is important to underscore that the MOH has made major advances during the last ten years in establishing strong standards and guidelines for Peru's health sector. However, implementation and enforcement of these standards are generally weak. USAID is increasingly focused on developing approaches to narrow the gap between the MOH's own high standards and the realities of the health system. This remains a central and formidable challenge for the Health Program.

Training of health care workers has been a major modality of USAID's health program in Peru. USAID is re-balancing its program toward more technical assistance (TA), including TA to establish quality training systems that will be sustained by Peru itself. The health sector, by its nature, is characterized by very high training needs, and building capacity in human resources is a prerequisite for the critical improvements needed in the sector. Pre-service training is required at some level for virtually all health workers, and the initial training requirements for physicians, midwives, and nurses are considerable. Moreover, the knowledge and skills of all health workers must be refreshed and updated regularly to maintain required competencies. Through extensive in-service training in the health sector over the last four decades, USAID has contributed significantly to improving Peru's health system performance. However, the combined impact of frequent turnover in public sector personnel and the natural inflow of new health workers over time mean that the benefits of non-institutionalized training will decline – sometimes quite rapidly – until systems are created and sustained to provide pre- and in-service training to the health workforce. Because Peru's economy is strong, and the country has many highly competent health professionals, USAID will increasingly focus its health training investments to strengthen Peru's own training and supervision systems. The GATS activity will play an important role in that transition.

As background and orientation to USAID/Peru's current Health Program, we provide summaries of recent and current work viewed from several angles: by broad approaches; cross-cutting themes; program elements; the overarching topic of decentralization; new activities; and specific forerunner activities to this task order.

Extensive background information about Health Program activities will soon be available at: http://ghiqc.usaid.gov/tasc3/index.html.

Four Broad Approaches

USAID's Health Program emphasizes four approaches to upgrade health sector performance, as listed below.

Table 1. USAID/Peru Health Program: Broad Approaches

Approach	Incumbent (Project Name)
Support for macro-structural reform through technical assistance for the overall design and implementation of the sector's decentralization process, sector financing, insurance for the poor, and sector-wide regulatory structures.	Abt. Associates (PRAES)
Development of effective regulatory systems to strengthen human resources, pharmaceutical, service delivery, and information systems. This approach focuses principally at the regional level, including articulation with the MOH and municipal level.	Constella Futures (Health Policy Initiatives - HPI)
Strengthening key operations at the functional level of the health sector. This approach will trouble-shoot high-yield operational problems related to poor implementation of approved technical procedures and practices, focusing especially on technical capacity of health providers.	*This Scope of Work*
Community health promotion uses a multi-sectoral approach to address basic determinants of health at the community level. This approach works to empower community members and increase utilization of improved health care services.	Management Sciences for Health (Healthy Communities and Municipalities - HCM)

The level of effort devoted to the central, regional, district, and community levels varies by project. The four approaches outlined above are not mutually exclusive but *interlocking* approaches and require significant communication and coordination among the program's implementing partners. Monthly partners' meetings with the USAID technical team facilitate information-sharing and collaboration toward those ends.

Recent/Current Activities by Eight Cross-Cutting Capacities and "Sub-Systems"
The matrix below (Table 2) represents the USAID/Peru Health Team's analysis that significant improvements in the cross-cutting factors or "sub-systems" listed on the left axis are required for sustainable improvements in health outcomes in the areas of maternal/child and reproductive health and infectious disease control (across the top axis.) The decentralization process underway is the dynamic context in which all health sector work now takes place.

Table 2. USAID/Peru Health Program Matrix: Cross-Cutting Themes

		MAJOR HEALTH SUB-SYSTEMS & CAPACITIES TO BE STRENGTHENED	**PROGRAMMING AREAS**		
			Maternal Child Health	**Reproductive Health / Family Planning**	**Infectious Diseases** (HIV/AIDS, Tuberculosis, Other Public Health Threats)
Decentralization & Strengthening MOH Rector Role	1	HUMAN RESOURCES (capacity-building, supervision, management and organization)	*USAID's Health Program aims to improve the eight cross-cutting capacities or "sub-systems" listed in the left column in order to make significant and sustainable impacts in the three programming areas above.* *The intended primary beneficiaries of the Program are the half of Peru's population that is at high risk for poor health due to poverty, malnutrition, unhealthy behaviors, and limited access to quality preventive and curative health care services.* *The decentralization process now underway, including strengthening the central Ministry's regulatory role, is a "meta" process that affects all aspects of public health sector functioning.* *Evaluation of the impact of work done under the Health Program is gauged both in terms of system performance indicators related to the left axis (e.g. reduced stock-outs of contraceptives), and in terms of health outcome indicators related to the top axis (e.g. increased percentage of births with healthy maternal and infant outcomes.)* *USAID collaborates closely with the Peruvian Government, as well as civil society organizations (including NGOs, universities, professional organizations, political parties), private firms, and other international donors.*		
	2	DATA & INFORMATION SYSTEMS (epidemiological, clinical and administrative data collection, analysis and use)			
	3	PHARMACEUTICAL REGULATION & LOGISTICS (systems to guarantee the availability of essential medications and contraceptive security)			
	4	SERVICE QUALITY IMPROVEMENT (implementation and enforcement of MOH standards at all levels of the health care system)			
	5	HEALTH PROMOTION & BEHAVIOR CHANGE (community-organization for public health; health communications via health providers and mass media.)			
	6	FINANCING/ BUDGETING (public sector finance in the decentralization context; insurance mechanisms for the poor)			
	7	MANAGMENT AND ADMINISTRATION (toward competent and effective executive functioning in the public sector)			
	8	POLICY MAKING & REGULATORY CAPACITY (competent design, enforcement, and monitoring of public policies in health by government and other stakeholders)			

Below is a summary of USAID's work in each of these eight sub-systems.

Human Resources: USAID is working with universities, professional training institutions, professional organizations, and hospitals to institutionalize pre- and in-service training systems and for periodic certification of doctors, nurses, and midwives. USAID is also working with authorities at the national and sub-national levels to promote funding and implementation of policies and systems for management, supervision, and training of health system personnel to achieve impacts in MCH, FP/RH and ID control. USAID advocates a "continuous quality improvement"[6] approach to human resources management. USAID supported the initiative of Peruvian institutions to enact a law creating a National System for Accreditation of Superior Education (SINEACE), designed to tighten quality standards for training in health and other professions. USAID also supported a study to estimate supply needs for physicians and schools of medicine.

Data & Information Systems: USAID funds Peru's Continuous Demographic Survey (CDHS), and provides ongoing technical assistance to the National Institute of Statistics and Information (INEI). Preliminary work has been done to support selected regional and municipal governments to upgrade their routine information systems for epidemiological, health care services, and administrative data. This has included monitoring of quality standards of health services, maternal and perinatal care, and logistics management via SISMED.

Pharmaceutical Regulation & Logistics: USAID continues to support the improvement and dissemination of the SISMED national logistics system for medication and contraceptive distribution in the public health sector. USAID has recently provided: technical assistance for a major national procurement of medications; analysis of key weaknesses in the regulation of Peru's pharmaceutical sector; design and implementation of an e-learning Diploma in Supply Chain Management; analysis of pending legislation regarding pharmaceuticals, including stakeholder perspectives on reform Peru's drug regulatory agency, DIGEMID.

Service Quality Improvement: USAID has been a main sponsor of efforts to develop and enact MOH policies setting explicit quality standards for each type of health facility in the public system: posts, centers, and hospitals (by level of complexity.) Continuous quality improvement approaches are being used by USAID partners to help apply the standards for facilities and for human resources management. USAID continues to support upgrading of family planning and reproductive health services in particular, and monitoring for compliance with a range of MOH standards.

Community Health Promotion & Behavior Change: Community-organizing for behavior change and improved public health is underway in 557 communities and 61 districts in the Mission's 7-region focus area, in coordination with USAID's Alternative Development Program. This community health program focuses on promoting healthy behaviors including: use of safe water; hand washing and sanitation; improved nutrition for young children; and, appropriate use of reproductive, peri-natal, and child health services.

[6] The CQI approach emphasizes customer-focus, teamwork, and an ongoing effort to improve the quality of work "outputs." It is based on a high degree of employee involvement in trouble-shooting specific problems, evaluating the impact of interventions, adjusting the approach if necessary, and moving on to tackle other issues, as identified by the team itself, customers, or managers. This approach aims to improve workplace systems in order to support individuals in performing their responsibilities well. Extensive resources exist on this topic and can be accessed via the internet.

Financing: USAID provides assistance related to public health system financing and budgeting. This includes work in the following areas: analysis of health sector accounts; advocacy for increased funding to meet basic health care needs in the public health sector; and, identifying health sector budget priorities through participatory processes. USAID is also providing technical assistance to the Seguro Integral de Salud (SIS) for expanding health insurance coverage to the poor, and strengthening the integrity of that system. Insurance can be highly effective in increasing the appropriate use of health care services and protecting people from impoverishment related to or exacerbated by illness or injury. USAID is supporting analytical work related to: estimating the burden of disease; developing provider reimbursement mechanisms; "incentivizing" provision of high quality of care; and developing sustainable financing approaches.

Management and Administration: USAID continues to support planning and training to prepare health system managers for continuous quality improvement in service delivery, decentralization, and execution of the health authority's rector role.

Policy Making & Regulatory Capacity: USAID is providing technical assistance to lawmakers, ministry, regional, and municipal authorities, and NGOs in advancing key policy improvements in the lines of work listed above. USAID also works with political parties to develop informed leadership in these areas.

Recent/Current Activities in Health Sector Decentralization

Since Peru's decentralization law was adopted in 2002, USAID has provided extensive support to the MOH and GOP to design an orderly approach for the transfer of functions from the central MOH to the regions and municipalities. This included "mapping" those functions, analyzing the competencies required, and helping the MOH establish criteria for "accrediting" regions to receive new responsibilities. USAID has provided extensive support to nine regions in developing their own integrated Health Plans and participatory budgets, requirements under the decentralization process. USAID has also funded a Decentralization Monitoring and Evaluation system designed to track the impacts of decentralization on the health sector. In addition, USAID has recently supported the development of formal agreements between regional and municipal authorities ("*acuerdos de gestion*") through which they coordinate health programming.

Five Program Elements: Summary of Recent/Current Activities

The summary below provides an element-by-element description of recent and current work conducted by USAID's Health Program. Note that this section is provided as background; the specific scope of work for the task order that is the subject of this RFTOP is delineated in the section "Statement of Work."

HIV/AIDS

USAID aims strengthen the MOH and DIRESAs capacity to conduct prevention activities to reach high risk or vulnerable populations. USAID's current work includes:

- Training peer educators for interventions that address high risk populations
- Training in voluntary counseling and testing (VCT)
- Evaluation of interventions targeting men who have sex with men (MSMs)

- Strengthening referral centers for treatment of sexually transmitted infections (STIs)
- Training in syndromic management of STIs
- Inclusion of issues of stigma and discrimination related to HIV/AIDS among criteria for evaluating quality of health services
- Inclusion of stigma and discrimination related to HIV/AIDS in the GOP's Ombudsman's oversight
- Complementing and supporting projects financed by the Global Fund for AIDS Tuberculosis and Malaria (GFATM), including training in provision of Highly Active Antiretroviral Therapy (HAART.)

In addition, USAID has supported: development and dissemination of a National Multi-sector Strategic Plan for the Prevention and Control of HIV/AIDS and STIs; formulation of the National Policy for HIV/AIDS; and the formulation and implementation of a National Plan for the Prevention of Vertical Transmission of Syphilis and HIV; and education programs in public schools. Note that education about HIV/AIDS in public schools, even in a low-prevalence setting, may help build support for HIV programs and investment.

Tuberculosis

USAID has provided technical assistance at the national and sub-national levels to: the office of the National Strategy for the Prevention and Control of Tuberculosis (equivalent to the National TB control Program); update of the National Technical Guidelines for TB Control; formulate the National Strategic Plan for TB Control; develop training in (DOTS) and DOTS Plus in selected regions, the deployment of rapid diagnostic methods for MDRTB, and the implementation of the "Study on the Annual Risk for TB infection," and others.

TB is also an area addressed by the South American Infectious Diseases Initiative (SAIDI) a USAID sub-regional program. Assistance provided under SAIDI focuses on improvements in medication warehousing (storage conditions and practices), quality control of TB drugs, and the diagnosis of MDRTB.

As in the case of HIV/AIDS, USAID seeks to complement Projects financed by the GFATM.

Other Public Health Threats

USAID has provided technical assistance to public hospitals for the formulation and implementation of plans to prevent and control of hospital infections. "Model units" have been formed with USAID's support (Neonatal Intensive Care, Hospital Infection Control Committees, Hospital Epidemiology Unit, Microbiology laboratory, Pharmacy, and Disinfection and Sterilization Units), which are now being used in training activities. Training and technical assistance have been provided to upgrade prescribing practices for antimicrobials in hospitals and their outpatient clinics.

USAID has also provided technical assistance for the preparation of: the National Formulary of Essential Drugs; the Guidelines on Good Prescription Practices; Guidelines for the implementation of a system for dispensing unitary doses; and collaboration in implementation of regulations for reporting adverse effects of medicines.

In addition, USAID has supported educational interventions addressing dengue and other vector-borne diseases, other dengue control activities, a national yellow fever immunization campaign, and Avian Influenza preparedness. USAID is also an active partner in two broad base public-private partnerships: The Handwashing Initiative for decreasing acute diarrheal disease and the Alternative Solutions for Sanitation Initiative.

USAID is also active in Peru in the area of antimicrobial resistance through SAIDI, which provides TA to the National Drug Regulatory Agency and the National Quality Control Laboratory. The SAIDI project also works with the Region of Callao Health Directorate to implement a multi-sectoral intervention specifically to decrease inappropriate use of antimicrobials for respiratory infections in children under-five.

Maternal/Child Health

USAID provided key technical support for the development of the MOH's Standards of Quality for Maternal and Perinatal health care services that were adopted in 2007, including a norm for vertical delivery that accommodates traditional and ethnic birthing practices. In USAID's seven focus regions, USAID has collaborated with regional directorates to establish Centers for Development of Competencies (CDCs) where staff from health centers and posts receive training to upgrade skills and knowledge related to primary care, emergency obstetric care, and appropriate use of the referral system. USAID supported the design and implementation of the strategy of providing waiting homes for women who live in remote areas, enabling them to be located near a health facility to give birth. USAID also supported research that led to the inclusion of FP counseling among services covered by the health insurance system for the poor, SIS.

At the community level in the 7-region focus area through its Healthy Communities and Municipalities (HCM) activity, USAID supports community organizing for effective low-cost public health interventions (e.g., improved cook stoves and latrines, hand washing, infant and child nutrition, and others), and stronger links and community referral systems with health care facilities for antenatal care, skilled birth attendance, and child health services (including growth monitoring and immunization.)

USAID is providing expert technical assistance to the GOP's new CRECER strategy to reduce chronic childhood malnutrition, focusing on these community-level models, as well as inter-governmental implementation agreements (e.g. between the regional and the district levels), and strategic planning and budgeting. USAID has collaborated with the MCC to support the GOP's design to strengthen its basic childhood vaccination program.

Family Planning and Reproductive Health

USAID ended donations of contraceptives to Peru in 2004, when the Peruvian government assumed full responsibility for purchasing a range of contraceptive commodities for the public sector. USAID has also promoted the availability of condoms and oral contraceptives via the private sector, and that segment of the market has grown significantly over the last decade from 8% to 23% (DHS 2004/06.) In 2002, the MOH decided to merge its contraceptive logistics system and its system for essential medications and supplies into an integrated supply system called the Sistema Integrado de Suministro de Medicamentos y Material o Insumos Médicos Quirúrgicos del

Ministerio del Salud (SISMED). USAID has provided technical assistance for development of the computer program used to manage this system, and helped implement it in targeted regions. USAID financed remodeling of a warehouse that is now used for training of public sector personnel in best practices related to storage and logistics for contraceptives and medications.

Through Centers for Capacity Development (Centros para Desarollo de Capacidades – CDCs), USAID has supported training to improve the quality of care in reproductive health and compliance with stringent MOH standards, which require technically sound and respectful care to all patients. USAID trained regional trainers, promoted training in FP and RH in schools of medicine and midwifery nation wide and donated anatomic models for training in clinical examination. USAID has worked extensively with the GOP Ombudsman to build a surveillance system for violations of patients' rights under Peruvian standards to quality care and information. In parallel, USAID annually assesses compliance with Tiahrt amendment principles in Peru's health sector.

Forerunner Activities to This Task Order

During the last decade, USAID has implemented three major projects through the MOH, as described in **ANNEX A-1**. This intended task order will build on the work accomplished through these activities. The activity to be implemented under the intended task order will be operating in a different, decentralizing context, and within USAID's newly restructured relationship with the MOH.[7]

New Health Activities Planned for FY2008

In addition to the GATS activity for which this RFTOP is being issued, the Health Program expects to manage a new activity to improve Peru's basic childhood vaccination program. The vaccination activity will be financed by the Millennium Challenge Corporation (MCC) as part of Peru's Country Threshold Program. Initiation of this activity is subject to approval and signature of a bilateral agreement by the governments of the U.S. and Peru, which will specifically govern the MCC Threshold Program.

3. STATEMENT OF WORK

The selected Contractor shall carry out this scope of work under the direction of USAID/Peru, in collaboration with Peru's health authorities, and in coordination with other USAID implementers. The Contractor shall form a Technical Assistance Group for the Health Sector (in Spanish: Grupo de Asistencia Técnica al Sector Salud – "GATS"), composed of public health experts with strong skills in management and demonstrated effectiveness in working with public sector counterparts in Peru. The GATS[8] shall provide direct technical assistance and may also manage technical assistance sub-contracts to achieve predefined goals. The GATS shall work to strengthen the

[7] The restructured relationship is governed by a bilateral agreement that establishes a joint USAID/MOH committee for joint coordination and evaluation of all of USAID's health activities.
[8] In this statement of work, all responsibilities assigned to "GATS" are ultimately the responsibility of the Contractor.

performance of the central Ministry, selected Regional Health Directorates (DIRESAs), and selected municipalities in order to upgrade provision of health services and programs at the interface with the end-user. This in turn will improve health outcomes for each of the following five program elements:

(1) HIV/AIDS
(2) Tuberculosis (TB)
(3) Other Public Health Threats (OPHT)
(4) Maternal-Child Health (MCH)
(5) Reproductive Health/Family Planning (RH/FP)

The GATS shall develop work plans with appropriate input from the national and/or sub-national health entities (MOH, DIRESAs, municipal governments), and will, when appropriate and feasible, arrange co-financing of activities by these government entities. Thus, close and effective collaboration with public sector managers will be a key ingredient in this activity.

The GATS activity shall prioritize the central MOH and the Mission's 7-region focus area, but may also work with other regions based on need, economies of scale, and counterpart commitment subject to approval of the CTO. Additional information about the geographic scope of this activity is included below in the discussion of each program element. During the implementation of this task order, CTO for this activity will provide direction on geographical concentration questions.

As described above (see Table 1), USAID/Peru's Health Program addresses systemic weaknesses in the health sector through four broad approaches; the work contemplated under the proposed task order will concentrate on the third approach: "Strengthening key operations at the functional level of the health sector." That is, the GATS activity will focus on strengthening essential processes, procedures, and practices in health facilities and programs. This will entail improving compliance with existing policies and clinical guidelines to correct inadequate operations and programs related to MCH, FP, and ID, through strengthening public sector employees' clinical and management performance.

The GATS activity's focus on the functional level will consider the following cross-cutting capacities ("sub-systems") whose weaknesses explain much of the poor performance in Peru's health sector.

[CONTINUED FOLLOWING PAGE]

Table 3. GATS Activity: Cross-Cutting Factors

Capacity or Sub-system	GATS will assist public sector counterparts to…
• **Human Resources**	• operate HR systems for ongoing capacity building that will improve job performance and adherence to MOH standards in MCH, RH/FP, and ID, and competencies related to gender and cultural issues. This will include systems for supervision and management as well as increasing individual technical competence.
• **Data & Information Systems**	• strengthen the routine collection of clinical, epidemiological, and administrative data at the functional level of the health system. Data should be recorded in an accurate, timely, efficient, and consistent manner, and comply with the requirements of the higher level information systems to which operating units must contribute.
• **Pharmaceutical Regulation & Logistics**	• improve operating units' capacity to order, manage, and track essential medications and contraceptives. This will include strengthening contraceptive security at the health network and micro-network levels.
• **Service Quality Improvement**	• strengthen the use of protocols and guidelines for self-evaluation and continuous quality improvement in health care facilities and apply new MOH accreditation standards. A similar approach may be applied to laboratories, warehouses, and other health system operations.
• **Health Promotion & Behavior Change**	• develop and expand health education content and capacities among clinical service providers to address community needs.
• **Management and Administration**	• strengthen evidence-based decision-making in health networks and micro-networks; build leadership and management capacity to upgrade service and program quality.

The GATS team will be expected to function well both in the cross-cutting areas above, and the program element-specific areas (HIV/AIDS, TB, OPHT, MCH, FP/RH) to avoid unnecessary "stove-piping," and achieve synergies.

The selected Contractor shall use lessons learned in Peru and internationally and shall also seek creative and new solutions for addressing barriers to effective operations. The selected Contractor shall incorporate gender and cultural considerations and activities in the implementation of this task order in order to reduce stigma and discrimination, promote gender and cultural equity, and increase access to services by marginalized groups. Health communications strategies will be used as appropriate to support the objectives of the activity.

As a result of the detailed understanding of problems that will be gained through working at the functional level, USAID anticipates that the GATS activity may generate recommendations for policy and structural reform, as well as community-level health promotion initiatives. In order to clearly define responsibilities for each of USAID's health partners, all decisions regarding USAID's interventions in the areas of policy and structural reform will be under the purview of

the USAID/Peru Health Office, and implemented by partners in accordance with their respective scopes of work.

Given the broad scope of work outlined here, the selected Contractor must carefully design the activity for coherence, health impact, sustainability, and cost-effectiveness. The Contractor shall frequently evaluate progress with USAID managers, and make necessary adjustments according to USAID's priorities and comparative advantage.

The following describes more specifically the work to be performed under each of the five program elements that constitute contract line items (CLINs) for this activity.

(1) HIV/AIDS

The overall goal of the USAID's work in HIV/AIDS is to strengthen the public health sector's capacity to control the spread of HIV/AIDS. The GATS activity shall emphasize prevention strategies, including: a) promotion of abstinence/be faithful behaviors, and b) condom use and other prevention activities. Behavior change and prevention activities will target MARPs, and specific interventions will be tailored to prevent transmission in different groups. Complementary activities will include: c) host country strategic information, including surveillance and information systems for HIV/AIDS and high-risk behaviors, d) policy analysis and other systems strengthening, and e) strengthening laboratories to ensure sustained diagnostic and treatment capacity within Peru. Activity lines will include institutionalizing clinicians' and managers' training, limited procurement of equipment and supplies, prevention and outreach training and activities, and strategic studies and research.[9]

The GATS activity shall provide technical assistance and limited training to the central level staff of the National Strategy for the Prevention and Control of Sexually Transmitted Diseases and HIV/AIDS (NSHIV) as well as to the NSHIV equivalents at the regional level. Some activities will be targeted geographically to reach underserved regions where transmission rates are high, especially the regions of Ucayali and Loreto.

The near-term objectives of this CLIN are to improve key areas of work in the public health sector, such as organization and planning, surveillance and information management, preparation of guidelines and regulations, monitoring and evaluation (including compliance with guidelines and regulations), and coordination with other stakeholders. GATS may conduct a limited number of studies or evaluations if determined to be necessary to guide the work of the NSHIV or their equivalent at regional level.

The GATS shall build on previous work of USAID with: the Ministry of Health (MOH), Regional Directorates for Health (DIRESAS),other partners including UN organizations, the principal recipient of GFATM grants (CARE), the country coordinating mechanism for GFATM grant implementation (CONAMUSA), people living with HIV/AIDS (PLWHA), and other civil society organizations in Peru.

[9] These emphasis areas are specified in USAID/Peru's FY07 Operational Plan and are expected to be continued.

(2) Tuberculosis

The overall goal of USAID's work in TB over the next five years is to strengthen the MOH, DIRESAs and non-government stakeholders' capacity to implement surveillance, analysis, prevention, and treatment programs, resulting in a sustainable system that will reduce the incidence and impact of TB and MDRTB on Peruvians.

Under GATS, activities will focus on: strengthening the country's capacity for timely diagnosis, treatment, and reporting of TB and MDRTB; improving surveillance and public information about TB and MDRTB in Peru; increasing cure rates with effective implementation of DOTS protocols; expanding prevention, detection, and treatment of MDRTB; and developing clinical capacity in the management of co-infections related to TB and MDRTB. The activity may include the provision of selected equipment and supplies (e.g. TB diagnostic kits), depending on the GATS' analysis and recommendations to USAID.

The GATS shall provide technical assistance and limited training to the central level staff of the National Strategy for the Prevention and Control of Tuberculosis (NSTB) as well as to the staff of NSTB equivalents at the regional level. Areas for TA could include: organization and planning, training, supervision, monitoring and evaluation, surveillance and data collection, biosafety, and infection control. Significant emphasis should be placed on institutionalizing training networks for health workers in affected rural and urban areas. An area of particular interest to USAID is identifying successful models and approaches that can be replicated with marginalized populations.

The GATS shall build on previous work conducted by USAID and others with the MOH and the DIRESAs aimed at building capacity to prevent and control TB and MDRTB in Peru. Other agents that have implemented important TB activities in Peru include the Centers for Disease Prevention and Control (CDC), the Pan American Health Organization (PAHO).

(3) Other Public Health Threats

The goal of USAID's work under this CLIN is to improve the quality and use of data regarding hospital-acquired (nosocomial) infections for decision-making and interventions at the operational level. GATS will focus on the control of hospital infection, building on previous work of USAID with the MOH, DIRESAs, and a number of selected hospitals in the country. It will take into account current knowledge and experience gathered by other organizations including WHO, PAHO, CDC, and other Peruvian and international organizations. This line of work will also be coordinated with USAID's TA to upgrade the quality of health care services and the accreditation of health care facilities.

GATS will provide technical assistance and training/education to hospital staff (managers, physicians, nurses, pharmacists, etc.) aimed at strengthening and institutionalizing surveillance, prevention, and control of hospital infections. GATS may conduct advocacy on this topic with national and regional health authorities as well as with hospital staff for ensuring a favorable environment for prevention and control of hospital infections.

GATS will collaborate with hospital managers who are committed to installing systems for better prevention and control of hospital infections, and to routinely produce and utilize reliable information on the surveillance of hospital infections.

GATS will explore the viability of publishing information on hospital infection control, and its use by financing agents as part of the criteria for evaluating and funding hospitals.

(4) Maternal/Child Health

The general goal of USAID's work in the MCH element is to partner with government authorities to support targeted interventions that will significantly boost the effectiveness of Peru's programs for poor mothers and young children. Under this CLIN, the GATS shall provide technical assistance and training to the central MOH and regional directorates in the technical content and requirements of Peru's recently approved Maternal and Infant Health standards. In close coordination with the MOH, the GATS activity will develop plans and methods for narrowing the gap between those standards and current practice, especially in USAID's 7 target regions. Attention to gender and cultural dimensions will be important. This program will be fully integrated into central, regional, and local information systems for human resources and health care quality improvement.

The GATS shall also provide targeted assistance to support the GOP's integrated strategy to combat childhood malnutrition, CRECER. This may include training in management, administrative, and health care topics relevant to the implementation of the program. Help may be provided to design training for front-line workers who will implement the CRECER program. Health care content will be based on the MOH's standards for maternal nutrition and health promotion, perinatal care, care of well infants and young children (including breast feeding, appropriate weaning practices) and prevention and integrated management of childhood illnesses. These interventions will be fully integrated into central, regional, and local information systems for human resources and health care quality improvement. The GATS activity will also coordinate with the MCC-funded basic vaccination activity which is expected to be underway during part of the period of performance for this task order.

The GATS activity shall build on USAID's previous work in maternal child health with the MOH and DIRESAs, and harmonize efforts with the GOP's programs that target poor women and children: CRECER, JUNTOS, and SIS.

(5) Family Planning and Reproductive Health

USAID's general goals in FP/RH element are to improve the quality of service provision in public sector, the uninterrupted availability of contraceptives, and the reach and effectiveness of reproductive health education. Under this CLIN, the GATS shall provide technical assistance and training to public sector counterparts in order to: improve the quality of FP/RH service delivery (including respectful treatment of patients, and provision of vital health education messages); upgrade the contraceptive logistics system with the aim of eliminating unmet need for family planning methods; implement integration of quality FP/RH services in the Seguro Integral de Salud (SIS) insurance system; advance compliance with MOH standards related to FP/RH that are required for

health care facility accreditation; and identify and address gaps in MOH information systems for FP/RH. The GATS shall support the implementation and enforcement at the service-provision level of MOH guidelines and policies that are designed to improve patient care.

GATS shall provide technical assistance and training to the central MOH and regional DIRESAs and will develop plans and methods for narrowing the gap between FP/RH standards and current practice, especially in USAID's 7 target regions. Attention to gender and cultural dimensions should be emphasized.

The GATS shall build on USAID's previous work in family planning and reproductive health in Peru and exercise good judgment in the complex policy environment surrounding this important health priority.

Gender and Cultural Considerations

The delivery of equitable, high quality health care services is impaired by prejudice, discrimination, and inadequate provider skills. The GATS activity shall address gender and cultural issues in health care provision through several approaches, some of which are suggested here:

- Human Resources: requiring equal access to training; training content that emphasizes gender/ethnic/cultural considerations in the delivery of health care services and public health communications; and, promotion of the MOH's vertical birthing norm among health care practitioners.
- Data and Information: disaggregating data by sex, ethnic group, and age; requiring that reports assess impacts on sub-populations; developing health communications that are effective, appropriate and respectful of intended sub-populations.
- Pharmaceutical Regulation and Logistics: improving the availability of contraceptives in rural areas to reduce or eliminate unmet need for family planning.
- Service Quality Improvement: including gender/culture in the service quality paradigm: training for provision of appropriate treatment irrespective of gender, ethnicity or age; emphasizing respect for patients as a key element in quality of care; strengthening adherence to health services norms; installing feedback systems for users of health care services.
- Management and Administration: integrating gender and cultural dimensions into program planning, implementation, and monitoring.
- Health Promotion and Behavior Change: identifying community-based factors that adversely affect the health and well-being of women, such as limited access to nutrition counseling, contraception, or gender-based violence counseling; promoting partner participation in MCH and FP/RH.

Counterparts and Partners

The following table is a non-exclusive list of major Peruvian counterpart institutions with whom the selected Contractor shall collaborate in implementing the GATS activity.

Table 4. Major Counterpart Institutions & Agencies	
Activity Area	**Principal Counterpart Institutions**
1. HIV/AIDS	Central MOH; CONAMUSA (Country Coordinating Mechanism for projects supported by the Global Fund to Fight Aids, Tuberculosis and Malaria); Regional DIRESAs; Regional and Municipal governments; Universities; Health Professional Associations; UN organizations, particularly UNAIDS; PAHO; NGOs including organizations of PLA.
2. Tuberculosis	Central MOH; CONAMUSA (Country Coordinating Mechanism for projects supported by the Global Fund to Fight Aids, Tuberculosis and Malaria); Regional DIRESAs; Regional and Municipal governments; Universities; Health Professional Associations; UN organizations, particularly PAHO; NGOs including organizations of TB.
3. Other Public Health Threats	Central MOH; CONAMUSA (Country Coordinating Mechanism for projects supported by the Global Fund to Fight Aids, Tuberculosis and Malaria); Regional DIRESAs; Regional and Municipal governments; Universities; Health Professional Associations; UN organizations, particularly PAHO.
4. Maternal/ Child Health	Central MOH; DGSP, National Strategy for Reproductive Health, National Strategy for Infant Health, Regional DIRESAs; Regional and Municipal governments; Universities; Health Professional Associations; and international organizations including UNICEF and PAHO.
5. Family Planning/ Reproductive Health	Central MOH; DGSP, National Strategy for Reproductive Health, Regional DIRESAs; Regional and Municipal governments; Universities; Health Professional Associations; UNFPA.

Budget Distribution by Program Element

The first year's budget breakdown is provided below by activity line. The distribution of funding across these five elements may vary from year to year, depending on budget resources available. In preparing a task order proposal, please use the "subsequent year planning distribution."

Table 5. GATS: Approximate Distribution of Budget for Year 1 by Program Element

3.1. HEALTH	Year 1 Approximate Distribution	Years 2 – 5 Tentative Distribution
3.1.1. HIV/AIDS	30%	25%
3.1.2. Tuberculosis:	15%	15%
3.1.5. Other Public Health Threats	15%	15%
3.1.6. Maternal/Child Health	10%	20%
3.1.7. Family Planning /Reproductive Health	30%	25%
TOTAL	100.00%	100.00%
APPROXIMATE TOTAL FUNDING	4.3 million	3.5 million

Results to be achieved

Below are illustrative goals to be achieved through this activity.

(1) HIV/AIDS:

Year one goals:

- NSHIV prepares and disseminates its annual activity plan based on evidence and articulated with plans of other key stakeholders (donor and cooperating agencies, research and education institutions, Global fund projects, etc.).
- NSHIV effectively leads multisector planning for HIV/AIDS prevention and control.
- No less than 75% of NSHIV guidelines (related to prevention, diagnosis, treatment, etc.) are current with generally accepted scientific knowledge, WHO recommendations and guidelines, and other relevant reference documents.
- NSHIV equivalents in DIRESAs of Lima, Ucayali and Loreto effectively produce and utilize quality information relevant to HIV/AIDS and STIs control (e.g. incidence, prevalence, program indicators, coverage, cure rates, etc.)
- NSHIV equivalents in DIRESAs of Lima, Ucayali and Loreto, are using a multisector approach to plan and implement HIV/prevention and control interventions addressing most at risk populations based on evidence and responding to local needs.

Year five goals:

- 100% of NSHIV guidelines are current with generally accepted scientific knowledge, WHO recommendations and guidelines, and other relevant reference documents.
- NSHIV equivalents in 85% of all DIRESAs effectively produce and utilize quality information relevant to HIV/AIDS and STIs control (e.g. incidence, prevalence, and program indicators such as coverage, cure rates, etc.
- NSHIV equivalents in 85% of all DIRESAs, using a multisector approach, plan and implement HIV/prevention and control interventions addressing most at risk populations based on evidence and responding to local needs.

(2) TUBERCULOSIS:

Year one goals:

- Regional NSTB equivalents in Ancash, Callao, Ica, La Libertad, Lambayeque, Lima, Madre de Dios, Tacna and Ucayali produce and utilize information relevant to TB control (e.g. incidence, prevalence, and program indicators, such as coverage and cure rates.)
- Sustainable and sustained DOTS programs in place in Callao, Lima, Madre de Dios, Tacna and Ucayali with 65% of health networks in DIRESAs performance for case detection at or above 95% and cure rates at or above 95%.
- Sustainable and sustained DOTS Plus programs in place in Ancash, Callao, Ica, Lima, La Libertad and Lambayeque, with 65% of health networks in DIRESAs performance at case detection at or above 75% and cure rates at or above 90%.

Year five goals:

- NTSB and its all its regional equivalents produce and utilize reliable information relevant to TB control (e.g. incidence, prevalence, and program indicators, such as coverage and cure rates.)
- Sustainable and sustained DOTS programs in place in 90% of all DIRESAS with 100% of health networks in each DIRESA performing at case detection at or above 95% and cure rates at or above 95%.
- Sustainable and sustained DOTS Plus programs in place in all DIRESAS with 100% of health networks in each DIRESA performing at case detection at or above 95% and cure rates at or above 90%.

(3) OTHER PUBLIC HEALTH THREATS

Year one goals:

- 18 hospitals (where activities have been initiated under VIGIA) producing and utilizing local information on occurrence of hospital infections for designing, implementing, monitoring and evaluating prevention and control interventions, and with structures in place ensuring continuity of these activities.
- A model program for extending the same activity to other hospitals is drafted.

Year five goals:

- A model for institutionalizing hospital infection prevention and control activities tested.
- 85% of major public hospitals (approximately 70) in the country are producing and utilizing local information on occurrence of hospital infections for designing, implementing, monitoring and evaluating prevention and control interventions, and with structures in place ensuring continuity of these activities.
- National, regional, and local level health authorities, as well as key health care financers (including but not limited to the Seguro Integral de Salud and ESSALUD), monitor and evaluate hospital performance regarding hospital infection.
- The public is informed of performance of 85% of major hospitals (approximately 70) in the country regarding hospital infection prevention and control.

(4) MATERNAL/CHILD HEALTH

Year One Goals:

- 50% of micro-health networks in 4 of USAID's 7 priority regions have functioning programs for regular in-service training, supervision, and evaluation in maternal/child and reproductive health focused on the main causes of obstetric, perinatal and infant health complications.
- Technical assistance is provided to DIRESAs in at least 4 regions to coordinate health services with the CRECER, SIS, and Juntos programs, including monitoring and evaluation of impacts.
- Successful coordination with the MCC Basic Immunization program is underway to achieve integrated child health services, monitoring and evaluation.

Year Five Goals:

- 90% of micro-health networks in at least 7 regions have functioning, integrated human resources programs that provide regular in-service training, supervision, and evaluation in maternal/child health and reproductive health.
- Funding to sustain at least 90% of these programs is built into regional and/or municipal budgets.
- Technical assistance is provided to DIRESAs in 7 regions to integrate best clinical and management practices into employee training systems, addressing the main causes of maternal and infant morbidity and mortality, and linking with CRECER, SIS and Juntos.
- Reliable data on child health, nutrition, and services is available in "friendly" formats to the public in (at least) all 7 priority regions.

(5) FAMILY PLANNING AND REPRODUCTIVE HEALTH

Year One Goals:

- 50% of micro-health networks in 4 of USAID's 7 priority regions have functioning programs for regular in-service training, supervision, and evaluation in FP/RH topics that are most relevant to local user needs.
- Technical assistance is provided to DIRESAs in 4 regions to link in-service training to other systems for information management, drug supply, and quality improvement, among others.
- 50% reduction in stock-outs of family planning commodities in public facilities in 4 of the 7 priority regions(compared to pre-activity baseline.)
- Effective support provided to DIGEMID to trouble-shoot SISMED system centrally, and build in-house capacity to do so.
- Ongoing basic and refresher training programs established in 4 regions for SISMED and logistics management. 50% of micro health networks in 4 regions are using SISMED appropriately.
- In USAID's seven priority regions, quality of reproductive health care improved as measured by compliance with MOH standards. *Year One Goal:* develop survey and baseline using MOH standards.
- Educational content for IEC plans for FP/RH is differentiated for adults and adolescents in at least 4 of the 7 priority regions.

Year Five Goals:

- 90% of micro-health networks in USAID's 7 priority regions have functioning programs for in-service training, supervision, and evaluation in FP/RH topics that are most relevant to local user needs, including coordination.
- FP counseling services are routinely covered by SIS in the 7 regions.
- 90% reduction in stock-outs of family planning commodities in public facilities in 7 priority regions (compared to pre-activity baseline.)
- Ongoing basic and refresher training programs established in the 7 regions for SISMED and logistics management.
- 90% of micro health networks and 100% of DIRESAs in the 7 priority regions are using SISMED appropriately.
- In USAID's seven priority regions, quality of reproductive health care improved as measured by compliance with MOH standards. *Year Five Goal:* 50% increase in compliance among micro health networks in the 7 regions.
- Funding to sustain these programs is built into regional and/or municipal budgets.
- At least 70% of RH/FP patients are "satisfied" with services provided.
- Increase by 50% in knowledge of fertile days amongst adolescents in selected settings of the 7 regions.

See **Annex A-2** for a list of the indicators that USAID and the MOH are using to monitor the summary impact of their cooperation in the health sector through a several activities, one of which will be GATS.

4. MEASURING RESULTS: MONITORING AND EVALUATION

The selected Contractor shall adhere to regular reporting requirements set forth by USAID/Peru, and will be expected to respond to intermittent requests from USAID for information needed for management and reporting purposes. Illustrative indicators from the Mission's FY07 Operational Plan that pertain to the programming elements included in the contemplated task order are listed below. In most cases these are to be disaggregated by sex.

(1) HIV/AIDS

- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful
- Number of individuals trained to promote HIV/AIDS prevention programs through abstinence and/or being faithful
- Number of targeted condom service outlets
- Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful
- Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful

(2) Tuberculosis

- Number of people trained in DOTS with USG funding
- Number of people trained in monitoring and evaluation

(3) Other Public Health Threats
- Number of people trained in monitoring and evaluation

(4) Maternal/Child Health
- Number of people trained in child health and nutrition through USG-supported health area programs
- Number of children reached by USG-supported nutrition programs
- Number of people trained in monitoring and evaluation
- Number of people trained in other strategic information management

(5) Family Planning and Reproductive Health
- Number of institutions with improved Management Information Systems, as a result of USG Assistance
- Number of people trained in monitoring and evaluation

Recognizing the limitation of Agency-wide indicators for effectively monitoring of accomplishments of this particular activity, the selected Contractor shall be responsible for developing and executing a Monitoring and Evaluation (M&E) plan, in consultation with the USAID M&E team. Expected program results with illustrative indicators, mid-term milestones/ benchmarks, end-of-project results described in this document should be further elaborated in the M&E plan. Data sources and collection methodologies should also be documented for each indicator in accordance with USAID data quality assessment guidelines.

In addition to being a tool for tracking progress of this activity, the M&E plan should be designed to capture its key outputs and outcomes; identify tools specifically suited for monitoring technical assistance for a decentralizing health sector; and – potentially – providing models that can serve other countries, as well as contributing to USAID/Peru's reporting in the future. Qualitative assessments may supplement the Contractor's quantitative monitoring plan, as appropriate.

During the initial implementation period, the selected Contractor shall work closely with USAID/Peru's Health Program to establish final indicators, as well as baseline data and performance targets for each indicator. The final M&E plan shall be submitted to the CTO for approval within 60 days of the award of the Task Order. USAID/Peru and the select Contractor will conduct periodic performance reviews to monitor the progress of work and the achievement of results as based on the targets specified in the M&E plan. Financial tracking data will be required on a quarterly basis.

The M&E plan will be revised as appropriate on an ongoing basis in collaboration with USAID/Peru.

5. COLLABORATION AND COORDINATION

Productive collaboration and coordination are required for the successful implementation of this task order and will be a key dimension in the assessment of contractor performance by the Health Team. The selected Contractor shall demonstrate effective collaboration with other projects within USAID/Peru's Health Program and with USAID projects in other sectors, as appropriate, as well as with relevant civil society groups, donor programs, and, of course, GOP agencies.

6. PROGRAM MANAGEMENT AND STAFFING

A. Technical Direction and Coordination: The TASC3 CTO will be responsible for all day-to-day management, oversight, and technical direction of the selected Contractor and overall HIV/AIDS Prevention, Care and Treatment program. The CTO shall provide technical directions during the performance of this Task Order, both in writing and orally. The selected Contractor shall meet at least bi-weekly (via conference call or in person) with the CTO or his/her designee to review the status of activities, and shall provide periodic oral and written briefings to USAID and U.S. Embassy staff as appropriate.

B. Personnel Requirements. The selected Contractor shall maintain key personnel and other technical and support personnel required to implement, administer, and monitor the complex tasks described in Section C.

If during the life of the contract additional long-term technical staff is required, the Contractor may request written approval to add personnel from both the Contracting Officer and USAID Cognizant Technical Officer. Such a request shall include a justification and description of responsibilities for the proposed personnel.

The selected Contractor is strongly encouraged to hire Peruvian staff for this activity, since there is a large pool of Peruvian professionals who have extensive knowledge and experience related to this task order, many of whom have played important roles in health activities funded by USAID and other organizations.

Key Personnel

A. The Contractor shall identify the following key personnel for the performance of this contract:

   - Chief of Party
   - Deputy Chief of Party
   - Team Leader for Infectious Diseases
   - Team Leader for MCH/RH/FP
   - Chief Financial Officer

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

C. USAID reserves the right to adjust the level of key personnel during the performance of this Task Order.

7. REPORTING REQUIREMENTS

A. Annual work plan: The selected Contractor will develop annual work plans in collaboration with the CTO and other appropriate partners for each U.S. fiscal year of the contract. The Contractor shall provide an illustrative annual work plan for the first 12 months of the task order, which will be finalized in consultation with USAID during the first 30 days following the award. Subsequently, through the end of the task order, draft 12-month work plans will be prepared and submitted to the USAID/Peru CTO no later than 30 days before the close of each preceding operating year.

Annual work plans should include at a minimum:

1. Proposed accomplishments and expected progress towards achieving task order results and performance measures in the M&E plan
2. Timeline for implementation of the year's proposed activities, including milestones and target completion dates
3. Information on how activities will be implemented
4. Personnel requirements to achieve expected outcomes
5. Planned collaboration with other major partners
6. Detailed budget
7. Cost-sharing by GOP entities and other agencies
8. Any sub-contracts anticipated
9. Any equipment or commodities to be procured
10. Adjustments required and justification
11. Environmental Compliance Plan including monitoring and mitigation measures

B. Quarterly progress reports: The selected Contractor shall prepare and submit to the USAID/Peru CTO a quarterly report within 30 days after the end of the Contractor 's first full quarter, and quarterly thereafter. These reports will be used by USAID/Peru to fulfill electronic reporting requirements to Washington; therefore, they need to conform to certain requirements. The report will describe results in relation to the approved workplan. It will include an executive summary. The report should contain, at a minimum:

1. Progress (activities completed, benchmarks achieved, performance standards completed) since the last report by country and program area
2. Problems encountered and whether they were solved or are still outstanding
3. Proposed solutions to new or ongoing problems
4. Success stories (if available)
5. Documentation of best practices that can be taken to scale
6. List of upcoming events with dates
7. Environmental Compliance

C. Quarterly Financial Reports will be submitted to USAID/Peru. They should be disaggregated by country and at sub-element level and contain, at a minimum:

1. Total funds awarded to date by USAID into the task order;
2. Total funds previously reported as expended by Contractor by main line items;

3. Total funds expended in the current quarter by the Contractor by main line items;
4. Total unliquidated obligations by main line items; and
5. Unobligated balance of USAID funds.

The Contractor is solely responsible for not exceeding obligated amounts.

D. Reports on Short-Term Technical Assistance: The Contractor shall submit within ten days after a consultant's departure a report by that consultant. The reports will describe progress and observations made by the expert, identify significant issues, describe follow-on activities and plans for the Contractor, and provide names and titles of all assignment-related contacts.

E. Branding Strategy:

Objective: To provide prospective offerors with areas to be addressed in the development of the Branding Implementation Plan and the Marking Plan to deliver the message that the assistance is from the American people.

Program Name: USAID – Technical Assistance Group for the Health Sector (GATS)

Positioning: The Technical Assistance Group (GATS) is a new mechanism that aims to strengthen Peru's health systems at the operational level to improve the delivery of health services. It will provide expert technical assistance to the decentralizing public health sector. The audiences of the program will be national and regional decision makers (including the MOH, regional directorates, professional societies, health training institutions, legislators), civil society, and public opinion at large. The main message will be that USAID is collaborating closely with Peruvian health authorities to improve the quality of health services for poor and marginalized populations.

Public Outreach: the Technical Assistance Group for Health will promote the visibility of the partnership of USAID and the GOP in addressing key health issues in Peru.

Counterparts: Government of Peru counterparts Ministry of Health and/or Regional/Municipal Governments will be acknowledged by their identities on similar standing as USAID, strictly following USAID marking regulations.

Partners: USAID partners' identities will be acknowledged adhering to USAID's regulations. They include PRAES, Healthy Communities and Municipalities, Health Policy Initiatives, and MACRO, the names of which will be used as appropriate in the public outreach for the program and according to USAID regulations.

Level of visibility: For the Technical Assistance Group (GATS) activity, the USAID identity will have a high level of visibility in cases in which its audience needs to grasp the extent of the aid provided by the American people. In cases

in which its audience needs to recognize the ownership of the program by the GOP, the visibility will be at a medium level.

Anticipated elements of marking plan: Deliverables to be marked, including products, equipment and inputs delivered; places where program activities are carried out; external public communications, studies, reports, publications and informative and promotional products; and workshops, conferences, fairs and any such events. Disclaimers will be used in the case of materials whose publication USAID is funding but not fully supporting in its contents and should read: USAID will not be held responsible for any or the whole of the contents of this publication. Threats and restrictions to the security of the program need to be identified and assessed in order to request any necessary exception from the marking requirement in accordance with ADS 320.3.2.

USAID's web page contains the electronic version of the Graphic Standards Manual that is compulsory for all contractors.

F. Special Assessments and Reports: The Contractor shall provide an electronic copy and hard copy of each individual study and research conducted under this contract.

G. Final Report: Thirty days prior to the end of this contract, the Contractor shall submit a draft Final Report providing a final accounting of its activities, progress made, results obtained, lessons learned and comments and suggestions for the continuation of activities. Fifteen days after submission of the draft, the USAID CTO will provide the Contractor with comments. The Final Report will he submitted one week prior to the end of the contract.

8. ENVIRONMENTAL REQUIREMENTS

The selected Contractor shall ensure that all activities and services provided under the Contract are consistent with the environmental requirements and procedures for the Activity. This will include compliance with applicable Peruvian and U.S. environmental policies.

ACRONYMS & ABBREVIATIONS

AMI	Amazon Malaria Initiative: Regional USAID program
CD	Global Health and Child Survival Account
CDC	U.S. Center for Disease Control
CDCs	Centros para el Desarrollo de Capacidades
CLIN	Contract Line Item
CONAMUSA	Coordinadora Nacional Multisectorial de Salud
CPR	Contraceptive Prevalence Rate
CRECER	"GROW": Government of Peru's strategy against childhood malnutrition

CSW	Commercial Sex Workers
CTO	Cognizant Technical Officer
DGSP	Dirección General de Salud de las Personas
DHS	Demographic and Health Survey
DIGEMID	Dirección General de Medicamentos, Insumos, y Drogas
DIRESA	Dirección Regional de Salud
DOTS	Directly Observed Therapy, Short-course
DOTS-PLUS	Directly Observed Therapy with drugs for Multi-Drug Resistant Tuberculosis
ENDES	Encuesta Demográfica y de Salud Familiar
ESSALUD	El Seguro Social de Salud
EU	European Union
FAF	U.S. Foreign Assistance Framework (U.S. Department of State, 2006.)
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis, and Malaria
GOP	Government of Peru
HAART	Highly Active Anti-Retroviral Therapy
HCM	Healthy Communities and Municipalities
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HPI	Health Policy Initiatives
IEC	Information, Education and Communication
JUNTOS	“Together”: Government of Peru’s conditional cash transfer program
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MCC	Millennium Challenge Corporation
MCH	Maternal-Child Health
MDR-TB	Multi-Drug Resistant Tuberculosis
MOH	Ministry of Health
MSH	Management Sciences for Health
MSM	Men who have Sex with Men
NGO	Non-Governmental Organization
NSHIV	National Strategy for the Prevention and Control of Sexually Transmitted Diseases and HIV/AIDS
NSTB	National Strategy for the Prevention and Control of Tuberculosis
OPHT	Other Public Health Threats
PAHO	Pan American Health Organization
PLWHA	People Living With HIV/AIDS

PRAES	Promoviendo Aliances y Estrategias
RFTOP	Request for Task Order Proposal
RH	Reproductive Health
SAIDI	South American Infectious Diseases Initiative: USAID Regional program
SIS	Seguro Integral de Salud
SISMED	Sistema Integrado de Suministro de Medicamentos e Insumos Medico Quirúrgico
STI	Sexually Transmitted Infections
TA	Technical Assistance
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	Government of the United States
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

[CONTINUED FOLLOWING PAGE]

Annex A-1

Table 6. Joint USAID-Ministry of Health Projects in Phase-out*

Joint Projects	Scope & Key Accomplishments
COBERATURA CON CALIDAD **Implementation Period**: 1996 - 2007 (transitioning to GATS) **Health Sector Counterparts:** • DGSP • DQUAL • Regional DISAs	SCOPE: Maternal, Perinatal, and Reproductive Health and Family Planning • Developed a model for continuous improvement of maternal-perinatal and reproductive health, including standards for health posts, health centers, district hospitals and national hospitals. • Developed MOH Standards for Family Planning in 1999. • Developed and disseminated guidelines in family planning emphasizing voluntary access and informed consent, and developed capacity building for appropriate FP counseling. • Developed capacity of teams in 14 regions (of the 24 in Peru) to manage continuous improvement based on standards for maternal and infant health. • Conducted training for improved service delivery in teams of 100% of 300 micro health networks in selected regions. • Trained teams of trainers in 100% of DIRESAS nation wide to use New Standards of FP in 1999. • Strengthened integrated reproductive health services in the MOH, linking FP to prevention of HIV-AIDS, cervical cancer, and gender based violence, and promoting adolescent social skills, improving information about natural family planning methods. • Developed educational materials, videos, and leaflets, in compliance with USAID directives for comprehensible information for FP decisions and users rights. • Donated equipment to reduce maternal and infant mortality by upgrading 300 health facilities in most need, including: radio equipment; coolers for vaccines; oxygen therapy sets; sphygmomanometers; and Doppler for assessment of fetal status.
HEALTH PROMOTION FOR PERUVIANS AT HIGH RISK **Implementation Period:** 1993 – 2007 (transitioning to GATS) **Health Sector Counterparts:** • DGSP • DPROM • Regional DISAs	SCOPE: Health Promotion and Disease Prevention • Supported the activities of the General Directorates of Health Promotion (DGPROM) and Health Care for Persons (DGSP), particularly those under the National Health Strategies: (1) Immunization; (2) Metaxenic Diseases and other Transmitted by Vectors; (3) Mental Health and Promoting a Culture of Peace; (4) Healthy Feeding and Nutrition; (5) HIV_AIDS and Other STDs; (6) TB and (7) Sexual and Reproductive Health. Illustrative activities include the following: • Supported technical meetings and training of multidisciplinary teams of the health networks and micro-networks in TB, Malaria and other diseases transmitted by vectors (Dengue, Bartonelosis and Yellow fever), HIV/AIDS, and other STDs. • Designed and developed IEC materials for local levels of the health system related to: Maternal and Child Care (Pregnancy, Immunizations, Feeding and nutrition, Breastfeeding, complementary feeding, other), Reproductive Health, Mental Health and Infectious Diseases (Malaria, Bartonelosis, TB, ITS and HIV/AIDS). • Supported supervision and training of health personnel Regional and local Level involved in the following activities: Healthy Families and Houses, Healthy Municipalities and Communities; and Health Promotion in Schools. • Supported the implementation and dissemination of the MAIS (Modelo de Atencion Integral de la Salud) at Regional and local levels.

* *See background materials, including annual reports for these activities, on TASC3 website.*

Joint Projects	Scope & Key Accomplishments
VIGIA **Implementation Period** 1996 - 2008 (transitioning to GATS) **Health Sector Counterparts** • INS • DGSP • DGE • DIGESA • DIGEMID • Regional DISAs	SCOPE: This project was designed to strengthen Peru's capacities to address infectious diseases, with emphasis on HIV/AIDS, tuberculosis, malaria, antimicrobial resistance, hospital infections, and epidemiological surveillance. Illustrative outputs and results are presented below. **Malaria** • Prepared study on the economic impact of malaria with analysis of alternative strategies for malaria control in Peru. • Implemented a new policy for antimalarial treatment, based on evidence gathered through studies on the efficacy of drugs previously used and of candidate replacements, including the monitoring of efficacy and side effects of treatments, and improved management of drugs and supplies. • Introduced the utilization of rapid diagnostic tests for malaria in Peru. Introduced intermittent rice irrigation for malaria control. • Trained of health workers in malaria diagnosis and treatment. **Tuberculosis** • Prepared study on the economic impact of tuberculosis. • Prepared a study of risk factors for delayed diagnosis, abandoning therapy, and for relapses. • Prepared guidelines for TB control. • Provided laboratory equipment for diagnosis of TB. • Trained health workers in TB and MDRTB management. • Designed and produced an IEC campaign against discrimination related to TB, MDRTB, etc. **Hospital Infection Control** • Prepared national guidelines for hospital infection control and hospital waste management. • Prepared manuals for hospital patient isolation, hospital disinfection and sterilization, and organization and functioning of a hospital epidemiology unit. • Developed protocols for studying the prevalence of hospital infections. • Prepared a study on costs of hospital infections. • Conducted a KAP study among health workers regarding hospital infection control. • Prepared a manual for the prevention and control of hospital infections. • Trained staff from 70 hospitals in infection control. • Provided critically needed laboratory equipment to 18 hospitals **Epidemiological Surveillance** • Implemented a "Sanitary Intelligence" approach. • Strengthened and supported Ministry of Health training program in epidemiology. **HIV/ STIs** • Designed and produced IEC material for prevention of congenital syphilis and HIV.

Annex A-2

Table 7. Monitoring Indicators for USAID-Ministry of Health Bilateral Agreement (2007-08)*

(1) MCH
- Chronic malnutrition rates in children under 3 years old
- Basic vaccination rates in 1-year old children
- Quality of household drinking water
- Percentage of pregnant women with full pre-natal care and a delivery plan

(2) FP/RH
- Percentage of health posts and centers with more than one stock-out of FP commodities per quarter
- Quality of FP/RH care as measured by a client survey index
- Knowledge of fertile days among girls 12 – 18 years old.

(3) Infectious Diseases
- Information on HIV incidence in five hot spot areas published
- National plan to monitor MDR-TB approved by MOH
- Number of public hospitals where protocols for controlling intra-hospital infections are adopted.

(4) Cross-Cutting
- Number of women and children covered by SIS, nationally and in 7- regions
- Number of regions actively enforcing service quality standards in primary care facilities.

* Note: these indicators are being used by USAID and the MOH to monitor the impact of their cooperation in the health sector through several activities, one of which will be GATS.

[END OF SECTION I]

SECTION II -INSTRUCTIONS TO OFFERORS

I. GENERAL INSTRUCTIONS

A. Separateness

Technical Proposals must not make reference to costs or pricing data. If the delivery of hard copies is used instead of delivery by electronic mail, then the technical proposal and the cost proposal must be physically separated from each other in separate envelopes. All envelopes must clearly identify the offeror, the Request for Task Order Proposals number, and whether technical or cost material is contained therein.

B. Copies

A separate technical proposal and cost proposal must be submitted. All materials submitted must be in English. An electronic version of both proposals must be delivered in all cases as an attachment to electronic mail. The technical proposal must be in Microsoft Word format while the Cost Proposal must have text in Microsoft Word format and with budgets/spreadsheets in either Microsoft Word or Microsoft Excel format. Hard copy submittals shall include an original plus one copy.

C. Proposal due date

Proposals must be received by COB Wednesday, March 12, 2008. **Late proposals will not be considered.**

D. Delivery

Technical and Cost Proposal should be delivered by mail or by electronic mail as follows:

1. Delivery by Mail
   Mr. Luis A. Rivera
   Contracting Officer
   USAID/Peru
   Av. La Encalada S/N
   Cdra. 17 Monterrico - Surco
   Lima, Peru
   Phone No.: (511) 618-1321
   Re: RFTOP No. 527-08-008
   And c/o Ms.Veronica Leo
   (same address)

   In order to avoid delays from the customs clearance process, proposals sent via courier should not weight more than 5 kg. (10 lbs.). Packages should include

printed documents only. CDs, videos, catalogues and magazines should not be included as they will cause the package to be re-routed to customs.

2. Electronic Delivery

Technical and Cost Proposal shall be submitted in two separate parts: (a) technical and (b) cost proposal. Technical and cost portions of the proposal should be submitted as an attachment to an electronic mail. The technical proposal must be in Microsoft Word format while the Cost Proposal must have text in Microsoft Word format and with budgets/spreadsheets in Microsoft Excel format. Electronic document size should not exceed 1.5MB and shall be delivered to the following addresses:

Mr. Luis A. Rivera (Technical and Cost Proposal)
Internet Address: lrivera@usaid.gov

Ms. Veronica Leo (Technical and Cost Proposal)
Internet Address: vleo@usaid.gov

Mrs. Rosario O. de Saldaña (Technical and Cost Proposal)
Internet Address: rsaldana@usaid.gov

E. Unnecessarily Elaborate Proposals

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective proposal in response to this request for proposals are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

F. Authority to Obligate the Government

The Contracting Officer is the only individual who may legally commit the U.S. Government to the expenditure of public funds. No costs chargeable to the proposal may be incurred before receipt of either a task order signed by the Contracting Officer or a specific, written authorization from the Contracting Officer.

G. Task Order Clauses

The following clauses or requirements will be incorporated into any task order issues pursuant to this request for proposals, if considered applicable.

a. Language Requirements

Long Term consultants, if any, are expected to have speaking and reading abilities in the Spanish language at a minimum at the FSI 4/4 level. Local or third country national are expected to have English language speaking and reading abilities at the FSN 3/3 level.

Specific language requirements for the Key Personnel are listed below under "Personnel Qualifications".

c. Six-Day Work Week

A six-day work week will be authorized under this task order **only** for short-term technical assistance.

d. Title to and Care of Property

The Task Order will state who will receive the title of the property after the TO estimated completion date.

e. Duration

All proposals should be prepared based on the expectation that the task order will have an estimated period of performance of 60 months. The offeror shall clearly describe how results will be achieved for each year of the contract.

II. INSTRUCTIONS FOR THE PREPARATION OF THE TECHNICAL PROPOSAL

The general format for the Technical Proposal is:

- ***Cover Page*** Title, name of organization(s) submitting Proposal, contact person, telephone and fax numbers, address, and e-mail.

- ***Technical Proposal Body*** (not to exceed **20 pages** excluding attachments and resumes) – *THE TECHNICAL PROPOSAL BODY SHALL NOT EXCEED TWENTY 8.5 x 11 INCH SINGLE SPACED PAGES USING 11 POINT SIZE ARIAL TYPE AND 1" MARGINS.*

1. Technical Proposal Contents

a) Technical Proposal: The proposal shall include:

- The proposal shall include measurable performance standards and benchmarks against which the program will be evaluated. The proposal should include a description of the team and outline the functions, roles, estimated engagement, and a brief CV. The CVs shall be included in the attachments (and will not be counted against the page limit). A list of any proposed partner institutions and their proposed roles shall also be included as an attachment.

- The proposal shall include the Offeror's technical and management approach to the Scope of Work included herein. The proposal should also demonstrate the Offeror's full understanding of the purpose and objectives of contract activities and the constraints that the offeror shall need to overcome to achieve desired results.

- A proposed time schedule.

- An implementation plan with measurable key performance standards, benchmarks and suggested results indicators, and target dates to each specific benchmark proposed for the entire estimated period of performance by year.

- Describe its strategy, tactics, coverage (geographically and frequency) and timing of activities to be undertaken.

***b) Technical Approach*:** This section shall include:

- The Offeror's understanding of the technical, institutional, and political constraints and bottlenecks that currently impede delivery of high quality health care services and programs in Peru's public sector, and discussion of solutions;

- Strategy, tactics, and timing of activities to be undertaken to reach objectives for each CLIN.

- Creativity, innovativeness and technical soundness of the approach to increase adherence to the MOH's and other relevant guidelines and standards.

- Understanding of cultural and gender dimensions in training and patient care, and appropriate interventions to reduce adverse treatment stemming from discrimination.

- Expected impact and magnitude of expected results to be achieved over the next five years (2008 - 2012);

- Proposal of lessons learned and diagnoses and evaluations from past development efforts to maximize the likelihood of success;

- Approach and methodology for collaborating with different actors involved (public, private sector, other donors and other USAID projects, etc.)

- Presentation of effective approaches to maximize the sustainability of the investments represented by this task order.

c) Personnel Qualifications

The requirements for key personnel are broadly described in Section 6 of the SOW. A proposed organizational chart is required as pat of the submission package which may be included as an attachment. All permanent staff proposed is required to dedicate 100% of their time to this project.

- **Chief of Party (COP) – Senior Public Health Specialist**

The COP will be responsible for the overall planning, managerial, and technical leadership of the activity. The COP will have high level training at a PhD or Master's level in the area of Public Health, Public Policy, or Management. The COP will have a minimum of 10 years of relevant experience working in health system performance improvement, with solid, demonstrated experience working with high level officials. He/she must have experience working in at least two of the five program element technical areas (HIV/AIDS, TB, OPHT, FP and/or MCH.) A minimum ten years of supervisory experience is required. He/she should have experience with contracting short-term technical personnel. The COP should have experience in agenda setting, coordination, obtaining support for initiatives, and successfully carrying out interventions. The COP must have demonstrated capacity to implement competently US Government policies and procedures. He/she must have a demonstrated ability to work with cooperating partners in implementing a complex program in a collegial manner. He/she should have considerable autonomy and the authority to commit funds and resources during the implementation of the contract. The DCOP must have demonstrated professional excellence, excellent writing ability, and strong interpersonal skills. The COP must be fluent in English (FSI Level 4.)

- **Deputy Chief of Party (DCOP): Senior Analyst, Public Health Specialist**

The DCOP will have high level training at a PhD or Master's Level in the area of Public Health, Public Policy, or Management. The DCOP should have extensive recent experience in designing, promoting, and evaluating programs to improve health services and health programs. He/she should have demonstrated success in overcoming constraints to program implementation in health sector settings. The DCOP must have demonstrated capacity to implement competently US Government policies and procedures. He/she should have experience with contracting short-term technical personnel, and in data analysis and report preparation. The DCOP must have demonstrated professional excellence, excellent writing ability and strong interpersonal skills. The DCOP must be fluent in English (FSI Level 4).

- **Chief Financial Officer (CFO): Budget Planner and Controller**

The CFO must have demonstrated professional excellence and command of financial management and record keeping requirements for a project of this complexity and size. It is expected that he/she will have at least 10 years of experience in financial management in the context of large organizations and/or projects. He/she must have extensive, successful experience with preparing financial reports, contracting short-term personnel, and supervising administrative personnel. He/she must have strong interpersonal skills and a demonstrated capacity to collaborate successfully with technical and managerial staff.

- **Infectious Diseases Team Leader (IDTL): Senior Public Health Specialist**

The Team Leader for implementation of the Infectious Diseases components of the task order will be a technical expert in this field, with high level training at a PhD or Master's Level in the area of Public Health, at least 10 years of work experience related to infectious diseases. He/she should have demonstrated strong planning, managerial, and interpersonal skills. He/she should have successfully worked with public health sector counterparts and have a demonstrated ability to train health workers, advise clients in technical and organizational matters, and supervise technical and administrative staff and consultants. The IDTL must have demonstrated professional excellence and communication skills.

- **Maternal-Child and Reproductive Health Team Leader (MCRTL): Senior Public Health Specialist**

The Team Leader for implementation of the Maternal-Child Health and Family Planning/Reproductive Health components of the task order will be a technical expert in this field, with high level training at a PhD or Master's Level in the area of Public Health, at least 10 years of work experience related to maternal, child, and/or reproductive health. He/she should have demonstrated strong planning, managerial, and interpersonal skills. He/she should have successfully worked with public health sector counterparts and have a demonstrated ability to train health workers, advise clients in technical and organizational matters, and supervise technical and administrative staff and consultants. The MCRTL must have demonstrated professional excellence and communication skills.

d) Mobilization Plan: The offeror shall include a mobilization plan with a detail of the timeframe for starting-up activities and implementing the various elements of their technical plan, deadlines for deliverables, and periods of employment for local staff. The offeror may incorporate this information in a chronogram which may be submitted as an annex.

e) Other: USAID requires the maintenance of a country office in Lima. Satellite offices are not encouraged.

2. Past Performance Information

(a) The offeror (including all partners of a joint venture) must provide performance information for itself and each major subcontractor (One whose proposed cost exceeds 20% of the offeror's total proposed cost) in accordance with the following:

1. List in an annex to the technical proposal up to 10 of the most recent and relevant contracts for efforts similar to the work in the subject proposal. The most relevant indicators of performance are contracts of similar scope and/or complexity. Offeror's need to demonstrate a successful track record in providing services and achieving results under large, multi-sector, high-pressure, integrated development programs and projects. The offeror will begin this section with a detailed description of the key principles and lessons learned under past programs and projects that make the offeror especially well experienced and qualified to work as a contractor under the proposed program. Of special interest to USAID is demonstrated success achieving results under

programs with multi-sector, technical challenges and while operating in an ever-changing and a politically difficult environment. The offeror shall describe successful experiences using subcontractors to implement major technical components. Once an offeror's proposal is received, reference checks may be undertaken at any time, at the discretion of USAID.

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 you 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 [Required by FAR 15.305(a)(2)].

(c) Describe any quality awards or certifications that indicate exceptional capacity to provide the service or product described in the statement of work. This information is not included in the page limitation.

(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 of this solicitation, USAID will evaluate the extent you 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 your SB subcontracting plan or other similar small business incentive programs set out in your contract(s).

(3) 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:

(A) Provide a narrative summary of your organization's use of small business concerns over the past three years. Describe how you actually use small businesses--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 your compliance with your SB subcontracting plan(s) or other similar SB incentive programs set out in your contract(s) and explain any mitigating circumstances if goals were not achieved.

(B) To supplement the narrative summary in (A), provide with your summary a copy of the most recent SF 294 “Subcontracting Report for Individual Contracts" for each contract against which you were required to report for the past 3 years.

(C) Provide the names and addresses of three SB concerns for us to contact for their assessment of your performance in using SB concerns. Provide a brief summary of the type of work each SB concern provided to your organization, and the name of a contact person, his/her title, phone number, and e-mail address for each.

3. The Annex:

The following information shall be provided in the *Annex*.

a) Curriculum Vitae:

For **every** person identified as part of the Staff (both key personnel and short-term specialists), the offeror shall provide a copy of that person’s resume or CV. For key staff include at least three work references. USAID may or may not check references, but given the compressed time schedule for evaluation and selection it seems prudent to have this information available.

b) Past Performance:

In *the Annex***,** the offeror shall provide the information required in section 2 above. This includes the list of lists of its most recent contracts or sub-contracts, task orders or agreements where the offeror believes that it provided services similar to those described in this request for proposals. As a reminder, reference information should include recent email, fax and phone address and numbers.

The following information, and only the following information, is authorized to be included in *the Annex*:

a. Resumes/CVs.
b. Past Performance information.
c. Timelines/Chronograms. *(THE NUMBER OF PAGES SHALL NOT EXCEED TEN (10) SINGLE - SIDED)*

III. INSTRUCTIONS FOR PREPARATION OF THE COST PROPOSAL

The cost proposal shall consist of five general parts: 1. Development Focused Budget; 2. Detailed Budget disaggregated by inputs; 3. Budget Notes; 4. Attachments; and 5. Certifications. Each is discussed in more detail below.

A. Development Focused Budget

Offerors are required to summarize cost data using development-focused budgeting (DFB) in cost proposals submitted in response to this solicitation. DFB is a customer-based, performance-driven, results-oriented budget system underpinned by outcome management. Outcome management is a management approach that focuses on the

development results achieved by providing a service. DFB involves summarizing cost data corresponding to development results/outcomes. Cost data must be summarized into DFB categories. If an input serves multiple development results, the offeror must allocate the input across the corresponding results and provide a rationale in the budget narrative for the method used for each allocated input.

In addition, cost proposals must include all supporting input-based budgeting for the DFB summary and other cost formats that comply with instructions for cost proposals (e.g., breakout of costs at the country versus headquarters level) contained elsewhere in this solicitation.

Program Element 3.1 Health							
		Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
3.1.1	HIV/AIDS						
3.1.2	Tuberculosis						
3.1.5	Other Public Health Threats						
3.1.6	Maternal and Child Health						
3.1.7	Family Planning and Reproductive Health						

Input Categories	Element 3.1.1.	Element 3.1.2.	Element 3.1.5.	Element 3.1.6.	Element 3.1.7.	Total
Labor (Long & Short Term) Fringe Benefits Travel & Transportation Equipment Subawards Monitoring ODCs Indirect Costs Fee						
Total						

B. Detailed Budget

The detailed budget must provide the inputs and other cost elements supporting the development focused budget proposed in accordance with Section A above.

1. For each U.S. individual who shall perform directly under the Task Order, the following information shall be required in the following format:

Table 1:

Name and Labor Category	Number of Work Days	Proposed Daily Rate	Total

Total _____

2. For each CCN/TCN individual who shall perform directly under the Task Order, the following information shall be required in the following format:

Table 2:

Name & Proposed Labor Category	Number of Work Days	Proposed Daily Rate	Total

Total _____

3. *Other Direct Costs*: A complete breakdown of costs is required for each Task Order, as requested by the Contracting Officer, such as:

   a. *Travel, Transportation, and Per Diem:* Estimated travel and transportation costs shall be in accordance with the clause of the Contract entitled "Travel and Transportation" (AIDAR 752.7002). The proposal for each Task Order shall specify, for each traveler, the itinerary (in terms of locations, and, if possible, dates), the estimated air fares, any transportation (i.e., excess baggage) cost [to include the weights, mode of transportation (air, vessel), and unit prices], and the subtotal of all travel and transportation costs. Estimated per diem shall not exceed the most recent Department of State Maximum Travel Per Diem Allowances for Foreign Areas and prescribed Maximum Per Diem Rates for CONUS.

   b. Short-Term Technical Assistance: Estimated costs for Short-Term Technical Assistance should be included, and shall reflect the number of days and estimated costs when possible.

   c. Non-expendable Property and Commodities: The Mission does not anticipate any nonexpendable property and commodities to be purchased, if the contractor deems it necessary, the proposal shall also include the type of equipment required and an explanation of the need for such property and commodities, and further discussions/coordination will be required, as the Mission has non-expendable property from prior contracts that can be used for continuation of Local Government activities

   d. Miscellaneous Costs: Miscellaneous costs, to include but not limited to, passports and visas, medical examinations and inoculations, communications, etc., shall be specified in terms of the number of units, the estimated unit cost, and total cost

4. Indirect Cost Information

   a. The Offeror 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.

b. The breakdown of all costs associated with the program according to costs of, if applicable, headquarters, regional and/or country offices, fringe benefits, etc.

2. Budget Notes

The offeror should provide text in the form of budget notes to ensure that its costs are clear and adequately explained. The amount and content of the budget notes is left to the sound judgment of the offeror; however, when combined with the budget, there must be sufficient information for USAID to determine that every cost proposed is reasonable and realistic

3. Attachments

a. Biographical Data:

Contractor shall submit a Contractor Employee Biographical Data Sheet (USAID Form 1420-17) to support salary information [for CCN and TCN key personnel only]. The form must be signed by the individual and the contractor (or subcontractor) in the appropriate spaces with all blocks completed, as appropriate;

b. Curriculum Vitae:

A resume or curriculum vitae must be submitted as required.

IV. TYPE OF CONTRACT

The Government contemplates award of a Cost-Plus-Fixed Fee (CPFF) Task Order resulting from this solicitation.

[END OF SECTION II]

SECTION III – EVALUATION CRITERIA

Award will be made to the party whose proposal is most advantageous to the United States Government, cost and technical factors considered. Cost/price will not be scored. The proposed total estimated cost will be carefully evaluated for reasonableness, completeness, credibility and realism. The Government will make a determination of probable cost as provided by the Federal Acquisition Regulation and it reserves the right to adjust the proposed total estimated cost based on its assessment of reasonableness, completeness, credibility and realism. The results of this evaluation shall be carefully considered in determining best value to the Government.

The technical criteria below are presented by major category, in relative order of importance, so that the award will be made to the best value proposal. Best value means the expected outcome of an acquisition that, in the Government's estimation, provides the greatest overall benefit in response to the requirement. All proposals will be evaluated pursuant to the standards below.

1. Personnel *35 points*

The following key personnel are considered by USAID/Peru, based on experience to date, as essential for the overall management and success of the activity:

- Chief of Party **(10 points)**
- Deputy Chief of Party **(10 points)**
- Team Leader for Infectious Diseases **(5 points)**
- Team Leader for Maternal/Child, Reproductive Health & Family Planning **(5 points)**
- Chief Financial Officer **(5 points)**

The evaluation of the proposed Key Personnel will be based on their technical and management background, experience, and demonstrated skills corresponding to the needs of this activity. Demonstrated capacity to work well with the public sector and to implement competently U.S. Government policies and procedures is required for the key personnel team.

In addition, proposed permanent technical personnel will be evaluated based on their experience and expert qualifications in the programmatic areas outlined in the Statement of Work. The proposed permanent technical team will be assessed based on: subject expertise in the program elements and cross-cutting factors described in the SOW; familiarity with Peru's health sector and the Peruvian context, including decentralization, key stakeholders, the situation of Peru's rural poor, and health programs targeting the poor. Offerors may wish to include possible short-term consultants. A matrix indicating proposed staff and their skill areas is recommended.

2. Technical Approach *30 points*

a. Extent to which the proposed approach is clear, logical, well-conceived, and technically sound; is appropriate to the Peru context; reflects understanding and support of USAID/Peru program objectives; exhibits insight and creativity; provides for sustained results beyond the life of the project; and draws from lessons learned nation-wide. **(15 points)**

b. Extent to which the preliminary outline for a Performance Monitoring and Evaluation Plan is clear, appropriate, and sound in terms of achieving major results and monitoring progress of chosen interventions. **(10 points)**

c. The extent to which gender, equity, intercultural dialogue and exclusion issues are identified and addressed. **(5 points)**

3. Institutional Capability/Management Plan ***25 points***

a. Institutional Capability: The extent to which the offering organization has demonstrated the structural and management capacity to organize and implement an activity of this size and complexity. **(5 points)**

b. Management Plan. The extent to which the proposal indicates appropriate use of resources to achieve project objectives. The extent to which the proposal clearly describes the role of managers and technical staff and consultants proposed and the procedures for reporting results. Extent to which illustrative timelines for the effective implementation of project components indicate the offeror's ability to reach stated project objectives within the required time period of performance, including a plan for rapid launch of project activities. **(20 points)**

4. Offeror's Past Performance **10 points**

a. Performance information will be used for both the responsibility determination and best value decision. USAID may use performance information obtained from sources other than those identified by the offeror/subcontractor.

USAID will utilize existing databases of contractor performance information and solicit additional information from the references provided and from other sources if and when the Contracting Officer finds the existing databases to be insufficient for evaluating an offeror's performance.

b. If the performance information contains negative information on which the offeror has not previously been given an opportunity to comment, USAID will provide the offeror an opportunity to comment on it prior to its consideration in the evaluation, and any offeror comment will be considered with the negative performance information.

c. USAID will initially determine the relevance 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 elements below. All elements as listed below are of equal weight for evaluating past performance:

(1) Quality of product or service, including consistency in meeting goals and targets.

(2) Cost control, including forecasting costs as well as accuracy in financial reporting:

(3) Timeliness of performance, including adherence to contract schedules and other time-sensitive project conditions, and effectiveness of home and field office management to make prompt decisions and ensure efficient completion of tasks.

(4) Managing relevant large-scale projects including activities to improve policies and regulation in human resources, pharmaceutical systems, health services quality, information systems, and building in-country capacity to develop and implement sound policies in the health sector.

(5) Business relations, addressing the history of professional behavior and overall business-like concern for the interests of the customer, including coordination among subcontractors and developing country partners, cooperative attitude in remedying problems, maintenance of clear and effective lines of communication between and among clients, and timely completion of all administrative requirements.

(6) Customer satisfaction with performance, including end user or beneficiary wherever possible.

(7) Effectiveness of key personnel, including appropriateness of personnel for the job and prompt and satisfactory changes in personnel when problems with clients where identified.

(8) Prime offerors who are not small business concerns will be evaluated on their performance in using small business concerns as subcontractors, joint venturers, and in other teaming arrangements:

e. In cases where 1) an offeror lacks relevant performance history, 2) information on performance is not available, or 3) an offeror is a member of a class of offerors where there is provision not to rate the class against a sub factor, then the offeror will not be evaluated favorably or unfavorably on performance. The "neutral" rating assigned to any offeror lacking relevant performance history is a score commensurate with the percentage of points received vs. possible points. An exception to this neutral rating provision: the non-small businesses prime with no history of subcontracting with small business concerns. Prior to assigning a "neutral" past performance rating, the contracting officer may take into account a broad range of information related to an offeror's performance

[END OF SECTION III]

SECTION IV - REQUIRED CERTIFICATIONS AND OTHER INFORMATION

I CLAUSES - All FAR, AIDAR and other provisions set forth in the Basic IQC apply shall to this Task Order in full force and are hereby fully incorporated.

II. REQUIRED CERTIFICATIONS AND OTHER INFORMATION

The following certifications must be completed, signed, and attached to the offeror's cost proposal.

1. Biographical Data Sheet (AID Form 1420-17). The contractor shall submit a Contractor Employee Biographical Data Sheet (USAID Form 1420-17) to support salary information The form must be signed by the individual and the contractor (or subcontractor) in the appropriate spaces with all blocks completed, as appropriate;

2. A certification that the proposed personnel were not suggested or requested by USAID;

3. Disclosure of Lobbying Activities, if the proposal exceeds $100,000 in accordance with the contract clause entitled "Limitation in Payments to Influence Certain Federal Transactions" (FAR 52.203-11);

4. Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters (FAR 52.209-5), if the proposal exceeds the Simplified Acquisition Threshold (currently $100,000);

5. Anti-Kickback Procedures (FAR 52.203-7), if the proposal exceeds the Simplified Acquisition Threshold (currently $100,000); and

6. USAID/Washington has acquired EEO Clearances for each prime contractor.

7. Certification Regarding Terrorist Financing.

[END OF SECTION IV]