February 5, 2008

VIA ELECTRONIC MAIL

Subject: RFTOP No. 527-08-009, MCC Immunization Program
Population, Health, and Nutrition Technical Assistance and Support Contract 3 – 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 3 – 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 raise Peru's basic childhood vaccination rates.

A TO will be issued under the basic contract and will be a Cost-Plus-Fixed-Fee (CPFF). The procedures for selection will consist of a Best Value source selection process based upon personnel, technical approach, management capability/plan and past performance.

The USAID estimate for this effort does not exceed $11,465,000. The amount includes $1,869,000 to procure computers.

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 contemplated task order is designed for a two-year implementation period, subject to signature of the bilateral agreement with the Government of Peru (GOP) and continued satisfactory performance. Offerors are further advised that award of a task order is contingent upon normal congressional notification requirements, approval of the annual Operational Plan, and availability of funds for this purpose.

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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 Cecilia Yañez, Senior Acquisition & Assistance Specialist, at cyanez@usaid.gov, and to me at emckee@usaid.gov. We expect to receive your questions related to this RFTOP not later than February 15, 2008. Answers will be provided and distributed within four (04) business days. Please ensure that proposals are received by not later than March 10, 2008, 4:00 p.m. local time at the delivery address listed below.

The Technical and Cost proposals should be addressed by e-mail or mail to Ms. Erin Elizabeth McKee (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 Cecilia Yañez at cyanez@usaid.gov.

The receipt of this RFTOP must be confirmed by written notification (e-mail or fax) 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.

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

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

Sincerely,

Erin Elizabeth McKee
Supervisory Contracting Officer

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

SECTION I - SCOPE OF WORK

1. Purpose and Scope

1.a. Purpose

The purposes of this activity are to raise Peru's basic childhood vaccination rates for measles and DPT3, especially in eight targeted low-coverage areas, and to build capacity to sustain rates above the safety threshold of 95% in all of Peru's regions. This will be accomplished through a set of interventions, detailed below, that were developed by the Government of Peru (GOP) and approved by the Millennium Challenge Corporation (MCC). Working through the Ministry of Health (MOH), this activity will help to boost immunization rates in targeted areas and to strengthen management, supply chain, and information systems at the national, regional, and local levels of the health care system. This activity is Component 2 of Peru's Millennium Challenge Corporation Threshold Program (TP). Successful implementation of this task order will contribute to Peru's efforts to expand and upgrade basic public health services for its population, and thus support Peru's aspiration to qualify for a Millennium Challenge Account compact.

1.b. General Scope

The Millennium Challenge Corporation's TP assistance implemented under this task order will aim to expand coverage of one-year old infants who have received immunization against measles and the full series of three diphtheria, pertussis and tetanus (DPT3) vaccinations so that immunization rates of 95% are reached in each of Peru's regions and, thus, nationally. This assistance will focus intensive efforts on eight regions with dispersed rural populations where coverage rates are significantly below this goal. In addition, this activity will support strengthening of key systems required for the Peru to sustain high vaccination rates throughout the country: training, cold chain management and logistics, and information collection and analysis. The work will be implemented with the government health sector at the national, regional and local levels. The contemplated task order is designed for a two-year implementation period, subject to signature of the bilateral agreement with the GOP and continued satisfactory performance. It will be managed by USAID/Peru.

The work performed under this task order will contribute to the achievement of the Investing in People Objective in U.S. Foreign Assistance Framework, under the Health Area and particularly the specific element of Maternal-Child Health (MCH). The task order will be financed exclusively with MCC funds. It is expected that the TP immunization activity and USAID/Peru's strategy to strengthen child health programs will be mutually complementary and provide opportunities for productive synergy. To that end, Offerors submitting proposals in response to this RFTOP are encouraged to identify targets of opportunity and optimize collaboration under RFTOP 527-08-008 that will be issued on or about February 8, 2008 also under the TASC 3 Basic IQC series.

2. Background

The MCC Threshold Program

Peru was selected as eligible for MCC Threshold Assistance on November 8, 2006. The purpose of the MCC Threshold Program is to help countries make policy and institutional changes to improve their performance on the MCC indicators in order to improve their chances

of qualifying for MCC compact eligibility status in the future. (see indicator scorecards for Peru at: http://www.mcc.gov/countries/peru/index.php). After a Threshold Program is approved by MCC, a Threshold Program Agreement will be entered into between the government of United States and another country to obligate funding for a country's Threshold Program.

The GOP submitted a request to the MCC for Threshold assistance to address the Control of Corruption and Immunization Rate indicators through a two-component plan. The purpose of Component 1 is to reduce corruption in public administration; the purpose of Component 2 is to increase the coverage of basic childhood immunizations. The GOP's plan was approved by MCC on November 30, 2007. The United States Agency for International Development (USAID), working closely with the MCC, will oversee the implementation of both components of the TP.

Component 2 of the Threshold Program, dealing with immunizations, will be managed specifically by USAID/Peru's Office of Health, which will facilitate its coordination with several other health sector activities in Peru that are currently funded by USAID. The TP vaccination-focused activity will not be a stand-alone activity either for the MOH or in relation to other USG efforts in Peru, so coordination with parallel and related activities will be very important. USAID's Health Program, which provides technical support and training related to decentralization, financing, and the strengthening of key sub-systems in the public health sector, is summarized briefly below. Additional information about the Health Program is available at the TASC3 website http://ghiqc.usaid.gov/tasc3/index.html

MCC Immunization Rates Indicator: Fluctuations in Peru's Performance

In general, the supply of health services in Peru has significantly increased during recent decades. Immunization coverage with three doses of the DPT vaccine and measles rose from 16% and 23% respectively in 1980, to 90% and 97% respectively in 1995, and continued at those levels until 2001. Moreover, starting in 1990, the GOP assumed the 99.9% of the total costs of immunization operations (e.g. vaccines, equipment, supplies, and operation costs).

A sharp decline in vaccine coverage began in 2002 due to several factors. First, with the change in government there was high turn-over of health personnel, including those who were in charge of the immunization system (planning, logistics, and service delivery) at different levels of the health system. This caused disruption in the management and planning of the immunization program and undermined investment to sustain the gains of previous years. Second, there was a decline in the acceptance of immunizations among rural populations due to a combination of supply problems and deterioration in health service quality together with misinformation about side effects, particularly for DPT. Third, there was a transition from National Vertical Health Programs to National Sanitary Strategies which required a reorganization within the Ministry of Health (MOH), a change in protocols, and a greater need for coordination efforts among its different offices. Also in 2002, all vertical programs were dismantled in favor of an Integrated Health Services Model, designed to prevent diseases and provide specific health care for every age cohort in the population. Immunization against measles and DPT became part of an integral health package to be delivered to children between 0 and 1 years of age.

In addition to the factors mentioned above, additional problems in terms of a lack of timely access to statistical information regarding coverage, absence of coordination among the different operational units within the MOH, difficulties in delivering health services to rural,

scattered, and hard-to-reach populations, and inadequate funding allocations for basic immunizations have plagued the system. As a consequence, immunization coverage for measles and DPT3 have declined and in 2005 the rates had fallen to 80% and 84%, respectively. This led to Peru's "failing" the MCC Immunization Rates indicator (source: WHO), scoring in the 26th percentile among MCC eligible lower middle income countries.

Peru's current government has committed to increase social investment through improved health, education, and other social sector services to ensure the sustainability of economic growth gains. A major priority, not only for the national government, but also for the regional governments and civil society at large, is to reduce chronic malnutrition by five percent points. Child immunization, particularly in rural areas, is an important element for achieving this objective.

To advance this objective and tackle all components of its immunization problems, the MOH is strengthening the National Strategy of Immunizations. Currently, the MOH is strengthening the cold-chain system at the central and regional levels with funds already available via the "Investment Shock" supplementary budget for FY 2007 and is working in coordination with social assistance programs (including the conditional cash-transfer program *Juntos*) to expand health services in the poorest districts of the country. Registry problems caused by the failure to accurately record the delivery of poly-vaccines encompassing DPT have also been partially solved. New software and data-gathering protocols have been developed and, via a Health Ministry Decree (690-2006/MINSA), DPT3 has been officially included in the poly-vaccine protocols the MOH is now using as part of its new health services model.

Final coverage figures for 2006, as reported by the regional health offices, appear to indicate that these improvements are having an impact. Despite this, underlying weaknesses persist, especially regarding vaccine supply management (including logistics and cold chain systems); health worker training and service quality; and timely access to reliable information on all phases of the immunization program. The MOH is aware that this situation threatens the sustainability of recent improvements, and so proposed to focus Threshold Program assistance for Component 2 on three specific activities: ensure immunization coverage for children in 8 targeted regions; improve vaccine management, cold chain, and logistics systems; and strengthen the information systems vital to operating Peru's vaccination program.

Peru: the Development Context

Peru is a lower-middle income country where nearly 45% of the population of 28 million remains poor despite several years of strong economic growth. Poverty and extreme poverty are highest among indigenous groups. The severe and enduring nature of the socioeconomic disparities in Peru fuels dissatisfaction with the state, its institutions, and political leaders, posing a major threat to Peru's political stability.

Peru'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 inequities, Peru has a long history of cultural and economic discrimination against indigenous peoples.

Peru is committed to reduce poverty by guaranteeing sustainable and inclusive growth. After more than 15 years of economic reform, Peru exhibits strong macroeconomic fundamentals

which, together with a favorable external environment, are fueling a GDP growth rate that now surpasses 7% per year. Though effective in terms of restoring international credibility and getting macroeconomic figures in balance, the various reforms pursued since the 1990s have only recently begun to significantly reduce poverty levels in Peru.

The GOP states that believe further reform aimed at making growth sustainable and inclusive rests on two basic pillars: (i) improving the quality of the State; and (ii) guaranteeing the provision of adequate basic public services. The first of these foundations aims at achieving an efficient and effective public administration that should create strong synergies with private capital to help sustain economic growth. The second pillar aims at delivering and ensuring equitable distribution of those assets that determine household income generation potential and, thus, should guarantee more equitable growth.

Obviously, the two foundations described above are strongly interconnected, since the possibility of introducing reform aimed at enhancing both coverage and quality of basic public services rests on the integrity, efficiency and effectiveness of public administration. Moreover, for growth to be sustainable, it must also be inclusive, since the latter will determine the survival of the economic model expected to deliver growth in the long run. The GOP is strongly committed to this development strategy

Peru: the Health Context

Peru's aggregate national indicators show major advances since the 1980s in prenatal care, skilled attendance at birth, reduction of maternal, infant, under-5 mortality, Total Fertility Rate (TFR), and Contraceptive Prevalence Rate (CPR). Yet, for each of these indicators, large gaps 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. Over half of all births in rural areas still occur at home, and maternal mortality remains high. Immunization rates for DPT3 and measles are estimated at 38.4 and 13.9 in rural areas of 16 regions (See Table 2)

The national chronic childhood malnutrition rate of 31% has remained unchanged for over a decade, 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 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, as mentioned above, Peru is gradually adjusting to 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.

While Peru's public health and clinical norms 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 public MOH system, which provides health services to almost 70% of the population, has made efforts to improve the situation, but 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; a weak logistics system for drugs, contraceptives, and vaccines; an inefficient and non-transparent government procurement system; and low capacity to enforce quality norms and standards in the sector.

Today, major transformations are underway simultaneously on four fronts in Peru's health sector: (1) continued implementation of 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 insurance mechanisms, especially for the poor; and (4) the rapid expansion of national programs targeting the poor: Juntos (a conditional cash transfer program), CRECER (a strategy to combat chronic childhood malnutrition), and SIS (a health insurance system for the poor.) These sea-changes make the sector very dynamic and present many opportunities for system strengthening.

Health sector decentralization is moving toward transferring responsibility for most service functions to the regional level. Maternal and peri-natal services, family planning, reproductive health and child services, and infectious disease control are priorities for regional and local health planning and budgeting. Core functions will remain centralized in the Ministry, including: setting national health policy and global regulations for the health sector; conducting long-term planning; aggregating data from epidemiological surveillance and service delivery and coordinating with international donors.

Health care 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. Note that the TP immunization program will be implemented in this sometimes confusing and disruptive context of decentralization.

USAID/Peru's Health Program: Overview

USAID/Peru works in the following Congressionally-mandated areas: *family planning and reproductive health; maternal and child health; tuberculosis, other public health threats, and HIV/AIDS.* The Mission's health strategy is designed to strengthen the critical health systems and capacities shown in Table 1, below. These systems must function well in order that family planning, MCH, and infectious disease services and programs that are of high quality are accessible to Peru's poor and near-poor population – which is the overriding objective of USAID/Peru's Health Program. The Health Program is represented in condensed form as the matrix on the next page, and brief descriptions of USAID's work in each of the cross-cutting themes follows.

[CONTINUED FOLLOWING PAGE]

A Systems Approach

Table 1. USAID/Peru Health Program Matrix: Cross-Cutting Themes

<table>
<tr><th colspan="2" rowspan="2"></th><th rowspan="2">MAJOR HEALTH SUB-SYSTEMS & CAPACITIES TO BE STRENGTHENED</th><th colspan="3">PROGRAMMING AREAS</th></tr>
<tr><th>Maternal Child Health</th><th>Reproductive Health / Family Planning</th><th>Infectious Diseases (HIV/AIDS, Tuberculosis, Other Public Health Threats)</th></tr>
<tr><td rowspan="8">Decentralization & Strengthening MOH Rector Role</td><td>1</td><td>HUMAN RESOURCES (capacity-building, supervision, management and organization)</td><td colspan="3" rowspan="8">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.</td></tr>
<tr><td>2</td><td>DATA & INFORMATION SYSTEMS (epidemiological, clinical and administrative data collection, analysis and use)</td></tr>
<tr><td>3</td><td>PHARMACEUTICAL REGULATION & LOGISTICS (systems to guarantee the availability of essential medications and contraceptive security)</td></tr>
<tr><td>4</td><td>SERVICE QUALITY IMPROVEMENT (implementation and enforcement of MOH standards at all levels of the health care system)</td></tr>
<tr><td>5</td><td>HEALTH PROMOTION & BEHAVIOR CHANGE (community-organization for public health; health communications via health providers and mass media.)</td></tr>
<tr><td>6</td><td>FINANCING/ BUDGETING (public sector finance in the decentralization context; insurance mechanisms for the poor)</td></tr>
<tr><td>7</td><td>MANAGMENT AND ADMINISTRATION (toward competent and effective executive functioning in the public sector)</td></tr>
<tr><td>8</td><td>POLICY MAKING & REGULATORY CAPACITY (competent design, enforcement, and monitoring of public policies in health by government and other stakeholders)</td></tr>
</table>

HUMAN RESOURCES: USAID is working with universities, professional training institutions, professional organizations, and hospitals to institutionalize pre- and in-service training systems for accreditation of health training institutions and for periodic certification of doctors, nurses, and midwives. USAID is also working with authorities at the national and sub-national level to institute, fund, and implement policies and systems for management, supervision, and training of health system personnel. USAID advocates a "continuous quality improvement" approach to Human Resources (HR) management.

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.

PHARMACEUTICAL REGULATION & LOGISTICS: USAID continues to support the development and modification of the SISMED national logistics system for medication and contraceptive distribution in the public health sector. USAID has recently funded: technical assistance for a major national procurement of medications; analysis of key weaknesses in regulation of Peru's pharmaceutical sector; and analysis of pending legislation, 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 a law 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 norms.

COMMUNITY HEALTH PROMOTION & BEHAVIOR CHANGE: Community-organizing for behavior change and improved public health is underway in 557 communities 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.

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 guaranteeing 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 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.

USAID Program Elements

USAID/Peru's Health Program encompasses five program elements within the Health Area of the U.S. Foreign Assistance Framework: HIV/ AIDS, Tuberculosis, Other Public Health Threats, Maternal-Child Health (MCH), and Family Planning/Reproductive Health. The most direct linkage between USAID's Health Program and the TP Immunization activity will be fall within the program element *Maternal/Child Health.*

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 seven-region focus area through its Healthy Communities and Municipalities 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), strategic planning and budgeting. USAID is collaborating with the MCC to support the GOP's efforts to strengthen the basic childhood vaccination program, the focus of this task order.

3. STATEMENT OF WORK

Introduction

Component 2 of the TP will be carried out by the selected Contractor according to the scope of work delineated herein. The selected Contractor shall carry out this task order under the direction of USAID/Peru, in close collaboration with Peru's health authorities, and in coordination with other USAID implementers. The selected Contractor shall provide technical assistance and purchase equipment as described below in order to achieve sustainable improvements in the country's basic childhood immunization program. The selected Contractor

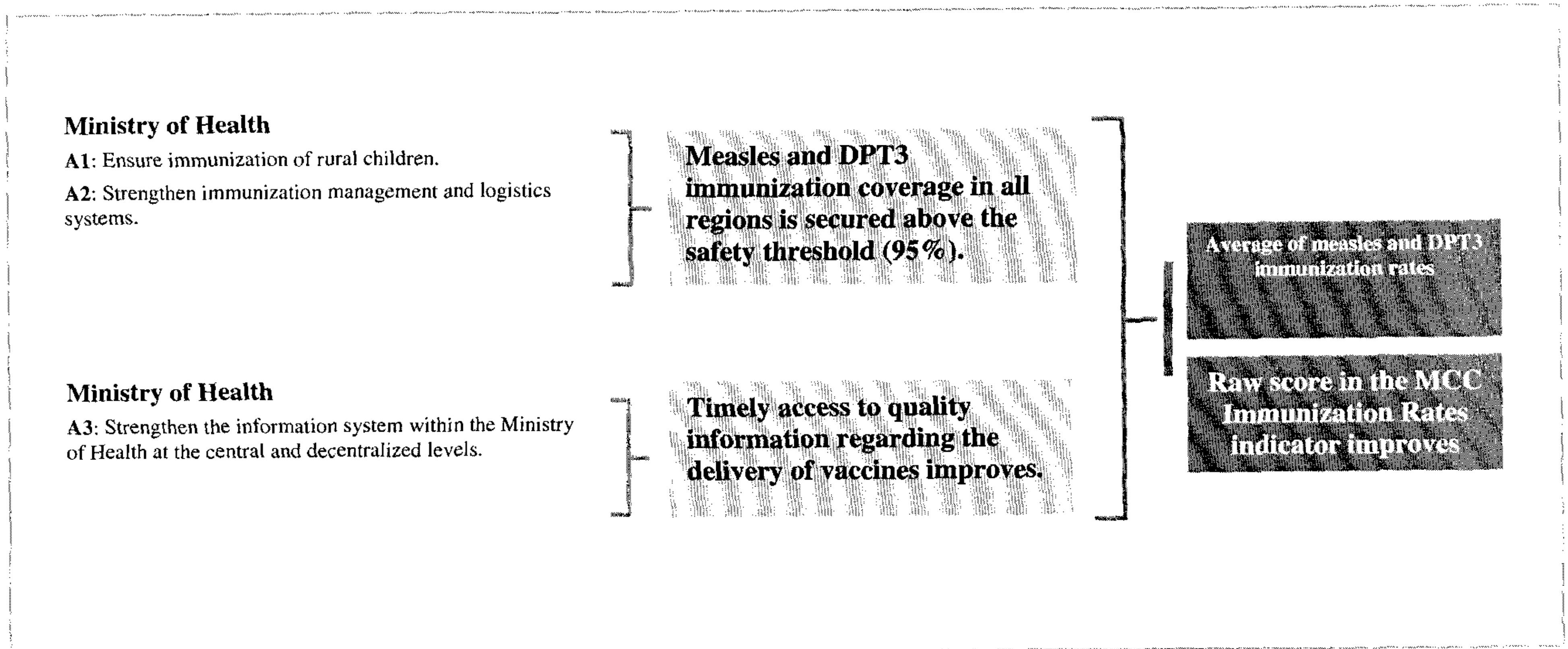
will work with the MOH and regional and local health agencies to boost vaccination rates in eight targeted regions, and to strengthen Peru's national childhood vaccination program, focusing on management; cold chain management and logistics; information collection, compilation, and use; and training systems as they relate to childhood vaccination. This activity will take place in the context of broad efforts by the MOH and the GOP to improve integrated child health and social services for the poor and, as directed by USAID, will be linked to those efforts where possible.

The overall goal of this activity is to increase measles and DPT3 immunization coverage above the safety threshold (95%) in the following regions: Amazonas, Apurimac, Ayacucho, Cusco, Huancavelica, Huanuco, Ica, and Puno, and to strengthen the national immunization program so that basic childhood vaccination coverage will remain at or above the safety threshold in all regions in the future.

The Contractor shall use lessons learned in Peru and internationally, and shall also seek creative and new ideas for addressing cultural and geographical barriers to delivery of quality vaccination and child health services. Figure 1 summarizes our strategy within Component Two and each of these activities is further described below.

[CONTINUED FOLLOWING PAGE]

Figure 1. TCP Immunization Strategy



Coordination with USAID/Peru's Health Program

This task order will complement other components of the USAID/Peru Health Program to advance its central objective: strengthening systems and promoting the effective use of resources in the health sector in order to produce real and lasting improvements in health status for the poor and near-poor population of Peru.

USAID/Peru requires that the selected Contractor coordinate implementation of the TP vaccination activity with other USAID/Peru health activities, as listed here:

(1) A new USAID-funded task order will form an expert technical assistance group ("GATS"), which will provide support to the Government of Peru health agencies in the technical areas of Maternal and Child Health, Family Planning and Reproductive Health and Infectious Diseases. The purpose of GATS is to address operational problems that impair the delivery of effective, quality health services and public health programs in these areas. Both GATS and the TP vaccination activity will involve working closely with the central Ministry of Health and selected regional directorates and municipalities and supplying technical assistance to improve operations. (Implementer TBD)

(2) USAID/Peru is also providing technical assistance to strengthen regulatory policy and implementation in several key health sub-systems that are relevant to the vaccine program, including pharmaceuticals, health information system design and planning, human resources management, and service quality improvement. (Project: Health Policy Initiatives; Implementer: Constella Futures.)

(3) USAID/Peru is also providing technical assistance for health sector decentralization, health financing, and expansion of health insurance coverage, especially for the poor. (Project: PRAES; Implementer: Abt Associates.)

(4) The Peruvian Demographic and Health Survey ("ENDES") provides household data on a range of health indicators including measles and DPT3 immunization rates for one year olds. (Project: Evaluation/DHS; Implementer: MACRO International.)

Gender and Cultural Dimensions

Gender and cultural factors have a major impact on the demand for and use of health services, and they contribute to low vaccine coverage in many areas in Peru. The selected Contractor shall incorporate gender and cultural considerations into this activity, working with both the demand (user) and supply (provider) sides of vaccination services. This will include integrating activities to reduce stigma and discrimination, promote gender and cultural equity, and increase equitable access to health services. Communications strategies, training, data collection, and planning for service delivery will be developed to support these objectives.

Structure of this Task Order

The structure of this task order mirrors the GOP's TP proposal that was approved by the MCC. That proposal has three sub-components that will correspond to the contract line

items (CLINs) for this task order. Objectives, activities, and expected results for each of the three sub-components to be implemented under this task order are explained below.

Sub-Component 2.1 – Ensure immunization of rural children

Objective: To increase the coverage of basic childhood immunizations in rural areas through strengthening itinerant brigades.

Approaches: Expand training; augment basic equipment; build information, communication and education (IEC) strategies; bolster monitoring and evaluation for continuous improvement of service quality.

Overview: The MOH recognizes that securing measles and DPT3 immunization coverage above the safety threshold of 95% in many rural areas of the country poses particular challenges. As shown in Table 2, several regions -- especially those that have a large proportion of poor households in rural areas -- still exhibit coverage significantly below the national average. Low rates of immunization generally signal low access to primary child health services and are often associated with excluded or marginalized populations.

Table 2. Estimated rural immunization coverage in regions with significant rural population

Regions	Total Rural Population (%)	2006 Rural Coverage (%) /1	
		Measles	DPT3
Amazonas	63%	18.87	14.03
Ancash	46%	14.43	11.80
Apurimac	61%	23.34	13.61
Ayacucho	56%	9.32	8.01
Cajamarca	74%	16.28	7.97
Cusco	57%	1.91	3.05
Huancavelica	78%	n.a.	36.46
Huanuco	65%	3.20	3.56
Junín	39%	23.01	19.48
La Libertad	31%	8.54	7.51
Loreto	39%	63.97	56.70
Madre de Dios	36%	31.09	55.56
Pasco	50%	13.63	5.02
Puno	63%	2.37	2.07
San Martin	38%	6.56	6.07
Ucayali	33%	31.35	19.92
Average		**38.37**	**13.89**

/1 177,057 children between 0 and 1 year of age live in rural areas in these 16 regions.

Sources: ENAHO 2006 survey, MOH.

Sub-component 1 will address this challenge by collaborating with the Ministry to increase the reach and effectiveness of the MOH's itinerant brigade program, AISPED (*Atención Integral de Salud a las Poblaciones Excluidas y Dispersas*) in eight regions: Amazonas, Apurimac, Ayacucho, Cusco, Huancavelica, Huánuco, Ica and Puno.

Itinerant brigades have been delivering basic health care services for distant and scattered populations as part of the AISPED program since 1998. However, it was only in 2005 that the AISPED program was officially included as an activity within the MOH National Operational Plan. Since then, the program's basic needs (salaries, vaccine supplies, special clothing and transportation) have been funded from four sources: the Ministry's regular budget, and contributions from the *Programa Salud Basica Para Todos* (PSBPT), the program *Juntos,* and the *Seguro Integral de Salud* (SIS).

As a result, there has been a significant expansion in the numbers of itinerant brigades and of the people served by this program. In particular, in 2004 the AISPED program comprised 61 brigades that served a total population of 224,917. By year 2006, the program had a total of 124 itinerant brigades and was able to provide basic health care services to a total population of 532,801.

To further expand coverage, in 2007, the MOH included 21 additional itinerant brigades into the AISPED program. Recurrent costs, such as salaries and transportation associated with each brigade -- which has an average of 5 members -- are around US$ 5,300 per month. Total program expenditures will exceed US$ 9 million this year. To cover these costs, the MOH has already assigned US$ 4.5 million from its regular budget and secured an additional US$ 4.5 million via a supplementary credit.

Despite these efforts, AISPED still lacks adequate funding to guarantee proper training and the provision of essential equipment such as basic medical supplies and adequate camping gear. In fact, most training activities have had an informal nature and cover only cursory information required to update brigadiers' knowledge regarding basic health care practices. Due to the nature of their work, further training is crucial in order to ensure the effective delivery of vaccines and other basic health care services, especially to communities with significant language and cultural differences. Also, the provision of basic equipment for the brigades remains inadequate and they often have to "borrow" from the jurisdiction's health center, which are themselves frequently under-equipped.

Through this task order, MCC Threshold Program assistance will provide basic equipment for the 145 itinerant brigades that are operational. This equipment will include: (i) basic medical supplies (such as thermometers, blood pressure cuffs, stethoscopes, scales, and portable coolers to carry vaccines); and (ii) camping gear (such as tents, backpacks, and lanterns.)

Threshold Program assistance will also provide five training workshops in each of the 17 Regional Health Offices where the 145 itinerant brigades operate. The goal is to train all 852 members in the first year of the activity, covering five different topics (one in each workshop). The topic areas will be: (i) provision of health services within the Integrated Health Services Model (2 days); (ii) basic health care for children, including basic immunization (3 days); (iii) how to organize the community to foster preventive health practices (2 days); (iv) first-aid techniques (2 days); and (v) basic health care during pregnancy, delivery and the post-partum period (2 days). All training activities will be supervised by a representative of the Ministry's Direccion General de Salud de las Personas (DGSP).

The MOH also recognizes that community participation and political support from local authorities and leaders are essential to ensure the provision of basic health services for children. To increase awareness about the effectiveness of vaccines to prevent many infectious diseases, the MOH has been implementing a promotion and communication strategy which aims to strengthen the linkage between health facilities and communities. This strategy aims to improve the identification of children to be vaccinated and reduce local fears, misconceptions and cultural barriers about immunizations and other health services. Advocacy with local leaders and engagement with local mass media -- especially radio-- are important to leverage resources from local governments, the private sector, and the community. These resources and local participation will facilitate implementation of outreach activities, logistical support to the brigades, and monitoring to ensure that children receive quality vaccination and health services.

The communication and advocacy campaign will be implemented at the district and community levels where the itinerant brigades operate. Threshold assistance will be used to fund advocacy campaigns, fairs, and meetings to increase the demand for immunization and other basic child health services, and engage community leaders, as well as local and regional authorities to promote and oversee the provision of reliable, quality immunization services. Threshold assistance will also fund reprinting of materials and their translation into local languages, media training, posters, and other communications needs.

The above interventions in combination with the Ministry's investments in vaccine supplies and operational expenses will help raise measles and DPT3 immunization coverage above the safety threshold (95%) in eight targeted regions detailed below

Regions	2006 Total Coverage (%)	
	Measles	**DPT3**
Amazonas	94.02	85.76
Apurimac	93.41	90.33
Ayacucho	66.34	65.58
Cusco	91.26	88.26
Huancavelica	90.15	75.10
Huanuco	95.02	76.46
Ica	96.58	91.97
Puno	95.34	88.59
National average	**98.68**	**97.20**
Source: MOH National Strategy for Immunizations		

Activities to increase rural immunization rates must include:

(a) improve training system for itinerant brigades;
(b) ensure timely provision of training for brigade members and mangers;
(c) purchase equipment such as basic medical supplies and adequate camping gear for the brigades;
(d) strengthen inventory control for new and existing equipment;
(e) implement a communication strategy in the targeted rural areas;
(f) improve systems for the supervision and monitoring of the brigades, and
(g) design a sustainability plan for rural populations as part of the national immunization strategy.

Expected results by the end of the Two Year Threshold Program:

- 145 itinerant brigades (852 members) properly equipped.
- 5 training workshops delivered in each of the 17 Regional Health Offices that concentrate all itinerant immunization brigades.
- An IEC and advocacy campaign is implemented at the district and community levels where the itinerant brigades operate.
- Regional vaccine rates for DPT3 and Measles are 95% in all eight target regions.

Sub-component 2.2 – Strengthen immunization management and logistics systems

Objective: to strengthen Peru's national management and logistics systems for basic childhood immunization.

Approaches: conduct baseline survey and analysis of immunization system; implement software program for a national cold chain inventory; implement training programs for cold chain and logistics managers at the national and regional levels.

Overview
Although it constitutes an important element for increasing coverage rates, strengthening itinerant rural brigades will not suffice to sustain coverage of basic childhood vaccinations above the recommended safety threshold in all regions over time. The MOH recognizes, for example, that an intact cold chain system to protect vaccine efficacy is a critical component in any immunization strategy, and that Peru currently has significant deficits in cold chain equipment. Management of cold chain operations and of vaccine logistics and distribution are also areas that require strengthening.

A baseline study conducted in year 2004 (with the technical assistance of the United Nations Children's Fund - UNICEF and PAHO) revealed that, of the 6,730 health establishments[1] inventoried, 6,694 were operative and 71% of these had cold-chain equipment. However, 35% of the equipment was more than 10 years old and only 30% of the equipment acquired after 1995 met standard criteria for vaccine conservation. Moreover, 24% of all inventoried health establishments had no access to any type of energy. Many establishments lacked other basic equipment used when administering vaccines. In fact, in over 30% of these establishments there was not even a thermometer. With respect to human resources, this same study revealed that only 22% of the 6,214 employees in charge of managing cold-chain resources had received proper training.

To tackle these weaknesses, the MOH has already started to expand three cold chains at the regional level and to implement up to four properly equipped new health centers in Lima. For this, nearly 15 US$ million (from the GOP's 2007 "Investment Shock" budget redistribution) have been devoted to the acquisition of: four cold chambers for central health vaccines warehouses; six cold chambers for regional warehouses; and seven power generators for areas were electrical supply is unreliable. The MOH has committed to direct a portion of the "Investment Shock" resources to sustain these efforts and provide proper maintenance for all existing and new equipment.

[1] Hospitals, health centers, health posts and warehouses.

Under this sub-component, MCC Threshold Program assistance will complement MOH efforts with major training activities for personnel in charge of managing and maintaining these resources.

For practical purposes, the cold chain system for physical handling of vaccines can be treated as a separate system from that for other drugs and contraceptives. However, procurement planning, ordering, and tracking of vaccine inventories is included in the MOH's integrated system for medical drugs and supplies, SISMED *(Sistema Integrado de Suministro de Medicamentos y Material o Insumos Médicos Quirúrgicos del Ministerio del Salud.)* The selected Contractor shall coordinate with the MOH to identify features of SISMED that could be modified to help strengthen the vaccine supply system.

Activities to improve cold chain, logistics, and program management for Peru's basic childhood immunization program must:

(a) conduct a baseline/diagnostic study of the immunization system, including:
- overall processes
- a cold chain inventory
- human resources management
- data and information management
- equipment and materials management
- logistics and distribution of vaccines nationally.

(b) report results and recommendations to USAID and MOH.
(c) update and implement a software program for a national cold chain inventory
(d) train regional cold chain technicians
(e) purchase license for Visual Fox Pro
(f) design and implement a six-month virtual training course in immunization, cold chain, and logistic management for 750 health workers (conferring an specialization diploma.)
(e) coordinate with MOH and other USAID implementers to improve SISMED performance related to the childhood immunization program.

<u>Expected results by the end of the Two Year Threshold Program:</u>

- A detailed diagnostic study of Peru's immunization program has been conducted and presented to USAID and the MOH. (Note: this study should be completed as quickly as possible to inform implementation of activities under this task order.)

- Findings and recommendations have been considered in the execution of this task order.

- Cold chain system management is reinforced nationally in all of the regions.

- A six-month virtual course in immunization and cold-chain management has been delivered to at least 750 health workers.

- SISMED's functionality for the vaccine program has been improved and appropriate training has been provided to users.

Note that sub component 2.2 will provide important support for sub-component 2.1, and therefore, performance for this sub-component will also be assessed in terms of measles and DPT3 immunization coverage in the regions.

Sub-component 2.3 – Strengthen the immunization information system within the Ministry of Health at the central and decentralized levels

Objective: to improve the accuracy and speed of information flows for the monitoring and management of regular and supplemental vaccination schemes in Peru in support of improved coverage rates.

Approaches: assess current information problems; provide technical assistance to the MOH for upgrading its information system on immunization coverage; provide basic computer equipment for health centers and radios for itinerant brigades to improve data collection and transmission; implement a geo-referenced system in the eight targeted regions; provide training in the use of these new instruments; audit the resulting information system for accuracy and timeliness.

Overview

Accurate and timely information is essential for operating an effective immunization program, knowing its successes and failures, and assessing its strengths and weaknesses. Through this task order, MCC Threshold Program assistance will help the MOH address a range of issues related to information for the basic childhood immunization program.

Regarding immunization coverage rates *per se*, one signal indicating that information about vaccinations is not accurate is that some reports have stated that the population effectively vaccinated exceeded the estimated population. Several factors complicate the calculation of immunization rates. Migration from mono to poly-vaccines required adaptations in information registry mechanisms. These were delayed, which resulted in less timely and reliable information regarding the administration of vaccines. Also, the Ministry of Health staff believes that statistical errors in the 2005 Census bias estimates of population in each region, province and district.

Another complicating factor is registry errors that arise from the difficulty of verifying if the data in vaccination registries corresponds to the district where the targeted individual actually lives. In fact, temporary migration affects the reliability of this information (especially in rural areas) and, in some cases, the same individual appears as vaccinated in more than one health establishment. This causes a discrepancy between the number of vaccines delivered and the number of individuals targeted for coverage.

In addition, the Ministry's current information technology does not allow a fluid communication between peripheral points of the vaccine delivery system and the central MOH where data are compiled. Reporting is slow for the vaccines administered by rural brigades, as well as the distribution and use of vaccines in all health centers. Moreover, the lack of reliable geographical information prevents an adequate planning of the distribution of vaccines to decentralized offices and the prioritization of itinerant brigades' duties.

The MOH has already moved to address some of these challenges. The Ministry signed an agreement with the National Institute of Statistics and Informatics (INEI) which guarantees that, beginning 2008, based on the 2007 census, INEI will provide the MOH

with updated information about population by age group not only at the district but also at the community level. In addition, the Ministry has already designed an information system covering supplementary processes, such as special vaccination campaigns, and has updated registry mechanisms to consider the target population's place of residence down to the district level, new age cohorts, and the prevalence of poly-vaccines. These new mechanisms were tested during 2006 rubella vaccination campaign, resulting in a significant acceleration in the transmission of information from health centers and immunization brigades to regional directorates and the central MOH.

MOH leadership is aware that an efficient immunization information system should combine data from routine and supplementary vaccination processes, and include the timely collection, processing and reporting of information from all of the dispersed points of the immunization system. To support the MOH in achieving this goal, the MCC Threshold Program will support multiple interventions that will ensure timely access to reliable information generated at the point of origin, supply needed equipment, strengthen human resource capacity, and improve the decision-making process for planning distribution of vaccines and itinerant brigades' duties. In addition, this sub-component will effectively support the entire Component Two of the TP, and provide reliable information to monitor its performance.

Note that other "upstream" data is also crucial for effective operation of the immunization system, including detailed information about logistics and cold chain systems, which is addressed in sub-component 2.2; and, information tracking for health worker training, which is addressed in 2.1 and 2.2.

Activities to strengthen the immunization coverage information system within the Ministry of Health at the central and decentralized levels must include:

(a) based on the diagnostic analysis (sub-component 2.2), and in coordination with the MOH and DIRESAs, and USAID/Peru's Health Program, upgrade a flexible Integrated National Immunization Information System that provides timely information about Peru's immunization program to decision makers and the public.

(b) implement the National Immunization Information System through an efficient, sustainable, and accurate informatics system for collecting child health and vaccination data in Peru's 1,246 health centers.

(c) purchase personal computers and small USB storage devices for 1,246 health centers

(d) develop appropriate training of trainers for at least 3 representatives from all regions, focused on integrated child health and vaccination information systems and facilitate propagation of this training to 1,246 health centers. (Suggestion: provide 5 workshops to train at least 3 people in each region who will in turn ensure appropriate training for the staff of all health establishments.)

(e) purchase radios for 145 itinerant brigades and facilitate appropriate training.

(f) purchase equipment for implementation of a geo-referenced system in the eight health regions targeted under sub-component 2.1, and provide appropriate training.

(g) conduct an external audit of the immunization information system

(h) utilize information generated through these interventions to report on the status of the TP vaccination activity.

(i) with local health authorities, evaluate functioning of integrated vaccination and child health data management system in the 1,246 health centers.

(j) sub-contract for an external audit of the information system, which will enhance confidence in the reliability of the data provided, which will serve to monitor the performance of the three activities comprised in this component of our Threshold Plan.

Expected results by the end of the Two Year Threshold Program:

- Integrated Immunization Information System improved and implemented in the MOH and 1,246 Health Centers.
- 1,246 Health Centers properly equipped to record and transmit vaccination and child health information
- 145 itinerant brigades have radio equipment and are 90% of brigades are using it appropriately.
- A geographic information system is implemented in 8 Regional Health Offices.
- A reduction in the time required to process and receive information from the decentralized health establishments to the MOH, from 2 months to 30 days or less.
- A reduction in the time required for the reception (by Health Centers) of the information produced by itinerant brigades from 30 days to 1 week or less.
- A reduction of, at least, 50% in the occurrence of registry errors.
- 5 training workshops covering 3 representatives from each of the Regional Health Offices;
- Appropriate materials and training developed for personnel in all 7,000 service delivery facilities providing child vaccinations.
- An external audit of this information system is implemented.

Note: for each of the three sub-components above, 2-year results are indicated. The Offeror's implementation plan should show the rate and sequence of implementation via a timeline and benchmarks.

3. MEASURING RESULTS: MONITORING AND EVALUATION

The selected Contractor shall adhere to regular reporting requirements set forth by USAID/Peru and the MCC, and will be expected to respond to intermittent requests from USAID for information needed for management and reporting purposes. Also an independent evaluation firm(s) may be charged with assessing program impact, and the

Contractor must coordinate with this firm(s) and MCC in this effort, including on data collection. The following are the key indicators and final targets agreed through the TP.

- Immunization coverage of measles and DPT3 above the safety threshold (95%) in the following regions: Amazonas, Apurimac, Ayacucho, Cusco, Huancavelica, Huanuco, Ica, Puno.
- A reduction in the time required for regional health centers to receive immunization information from itinerant brigades to one week. (Baseline: 30 days)
- A significant decrease in data entry errors by regional health centers.

To respond to MCC requirements, the selected Contractor will be responsible for developing additional interim indicators and quarterly benchmarks/milestones. Expected program results with illustrative indicators, quarterly and annual milestones/ benchmarks, and 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. **A preliminary M&E reflecting the Offeror's technical approach should be submitted as part of the proposal.**

The selected Contractor will be responsible for finalizing and executing a Monitoring and Evaluation (M&E) plan, in consultation with the USAID M&E team, MCC and any independent evaluation firm(s). During the initial implementation period, the selected Contractor shall work closely with USAID/Peru's Health Program to confirm interim and 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 30 days of the award of the Task Order. USAID/Peru and the selected Contractor will conduct periodic performance reviews to monitor the progress of work and the achievement of results, 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.

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

4. 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. Any independent evaluation firm(s) shall also be included in coordination with M&E.

5. Reports and Performance Requirements

Reports shall be submitted in both electronic form (Word or PDF) and in hard copy form.

5. a. <u>Work Plans</u>: The selected Contractor will develop work plans in collaboration with the CTO and other appropriate partners for the two years of the contract. As part of the technical proposal, the Contractor shall provide an illustrative initial work plan for the first 3 months of the task order, which will be finalized in consultation with USAID during the first 30 days following the award. Subsequently, a draft 21month work plan through the end of the task order will be prepared and submitted to the USAID/Peru CTO no later than 15 days before the close of the initial work plan.

The 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

5.b. <u>Quarterly progress reports</u>: The selected Contractor shall prepare and submit to the USAID/Peru CTO a quarterly report **within 7 days** after the end of each Fiscal Year Quarter. These reports will be used by USAID/Peru to fulfill electronic reporting requirements to the MCC; 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
2. Results reporting table, based on M&E the indicators and benchmarks
3. Planned activities for the next quarter
4. Problems encountered and whether they were solved or are still outstanding
5. Proposed solutions to new or ongoing problems
6. Success stories (if available)
7. Documentation of best practices that can be taken to scale
8. List of upcoming events with dates
9. Environmental compliance

5.c. <u>Quarterly financial reports</u> 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.

5.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.

5.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 in order to deliver effectively the message that assistance provided under this task order is from the American people.

Program Name: MCC - USAID – Threshold Immunization Program (TIP)

Positioning: The Threshold Immunization Program (TIP) is a new activity, aimed to raise Peru's basic childhood vaccination rates, especially in targeted low-coverage areas, and to build capacity to sustain Peru's rates above the safety threshold of 95%. This will be accomplished by a set of interventions developed by the Government of Peru (GOP) and approved by the Millennium Challenge Corporation (MCC). Working through the Ministry of Health (MOH), this activity will boost immunization rates in excluded areas and will strengthen management, supply chain, and information systems at the national, regional, and local levels of the health care system. The audiences of the program will be central, regional and local decision makers, including public sector, civil society, and public opinion at large. The main message will be that the MCC and USAID are contributing to Peru's efforts to invest in its people by expanding and upgrading basic public health services for its children.

Public Outreach: The TIP will promote the visibility of the partnership of MCC - USAID with the GOP to strengthen key systems required for the Peru to sustain high vaccination rates throughout the country: training, management, cold chain and logistics, and information collection and analysis.

Counterparts: Government of Peru counterparts including the Ministry of Health and/or Regional and local Governments will be acknowledged on similar standing as USAID, strictly following MCC and USAID marking regulations.(See Section V – Annexes, Attachment 2, MCC Marking Regulations)

Partners: USAID partners' identities will be acknowledged adhering to USAID's regulations. Activities currently implemented by USAID/Peru health partners include Healthy Communities and Municipalities, Health Policy Initiatives, MACRO, and GATS, the names of which will be used as appropriate in the public outreach for the program and according to MCC - USAID regulations.

Level of visibility: For the TIP activity, the MCC and USAID identities 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 appropriately marked. These include 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 MCC - USAID is funding but not fully supporting in terms of contents, and should read: MCC - 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 and MCC's web page contains the electronic version of the Graphic Standards Manual that is compulsory for all contractors.

5.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.

5.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 be submitted one week prior to the end of the contract.

6. Staffing

6.a. Technical Direction and Coordination: The USAID/Peru MCC-Immunizations CTO will be responsible for all day-to-day management, oversight, and technical direction of the selected Contractor. 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.

6.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 3 – Statement of Work.

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.

6.c. Key Personnel

A. The key personnel which the Contractor shall furnish for the performance of this contract are as follows:

Title/Position

1. Chief of Party/Senior Manager, Public Health Specialist
2. Deputy Chief of Party/Senior Analyst, Public Health Specialist
3. Monitoring and Evaluation (M&E) Specialist
4. Administration and logistics (A&L) Specialist
5. Accounting and Finance (A&F) Specialist

B. The personnel specified above are considered to be essential to the work being performed hereunder. Prior to replacing any of the specified individuals, the Contractor shall immediately notify both the Contracting Officer and USAID Cognizant Technical Officer reasonably in advance (e.g. within ten (10) working days) 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. Environmental Requirements

The Contractor shall ensure that all activities and services provided under the MCCTP Contract are consistent with the environmental requirements and procedures for the Activity. Specifically, for vaccination of rural children through itinerant brigades that will produce medical waste the Contractor will a) comply with Peruvian, international and USAID accepted guidelines for their management, including relevant portions of Chapter 5, sub-section "B" of the "Environmental Guidelines for Development Activities in Latin America and the Caribbean", which address medical waste; b) ensure incorporation of best practices for solid medical waste management in the design and implementation of training activities for itinerant brigades; c) work with the MOH at the central and local levels to implement an environmental monitoring plan to ensure that recommended mitigation measures are being adopted during vaccination interventions; and d) include a section on environmental compliance (monitoring/evaluation) in its regular quarterly/annual/final reports.

MCC-TP RFTOP - ACRONYMS & ABBREVIATIONS

AMI	Amazon Malaria Initiative: Regional USAID program
CDC	U.S. Center for Disease Control
CDCs	Centros para el Desarrollo de Capacidades
CLIN	Contract Line Item
CRECER	"GROW": Government of Peru's strategy against childhood malnutrition
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
ENDES	Encuesta Demográfica y de Salud Familiar
ESSALUD	El Seguro Social de Salud
FAF	U.S. Foreign Assistance Framework (U.S. Department of State, 2006.)
FP	Family Planning
GDP	Gross Domestic Product
GOP	Government of Peru
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
MCC	Millennium Challenge Corporation
MCH	Maternal-Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-Governmental Organization
OPHT	Other Public Health Threats
PAHO	Pan American Health Organization
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
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USG	Government of the United States
WHO	World Health Organization

[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 Close of Business 4:00 p.m., local time in Lima, on Monday March 10, 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. <u>Delivery by Mail</u>
   Ms. Erin Elizabeth McKee
   Sup. Regional Contracting Officer
   USAID/Peru
   Av. La Encalada S/N
   Cdra. 17 Monterrico - Surco
   Lima, Peru
   Phone No.: (511) 618-1200
   Re: RFTOP No. 527-08-009
   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 Application must have text in Microsoft Word format and with budgets/spreadsheets in Microsoft Excel format. Electronic document size should not exceed 15MB and shall be delivered to the following addresses:

Ms. Erin Elizabeth McKee (Technical and Cost Proposal)
Internet Address: emckee@usaid.gov

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

Ms. Cecilia Yanez (Technical and Cost Proposa)
Internet Address: cyanez@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 applicant's lack of cost consciousness. Elaborate art work, expensive paper and bindings, and expensive visual and other presentation aids are neither necessary nor wanted.

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

Contractor personnel and/or consultants shall have English and Spanish proficiency as needed to perform technical services.

b. Six-Day Work Week

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

c. 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.

d. Duration

All proposals should be prepared based on the expectation that the task order will have an estimated period of performance of two (02) years.

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 15 pages excluding attachments and resumes) – *THE TECHNICAL PROPOSAL BODY SHALL NOT EXCEED FIFTEEN 8.5 x 11 INCH SINGLE SPACED PAGES USING BETWEEN 10 AND 12 POINT SIZE USAID APPROVED FONT TYPE.*

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 Peruvian partner institutions and their proposed roles shall also be included as an attachment.
- 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 for the two years of the program.
- An implementation plan with measurable key performance standards, benchmarks and suggested results indicators, and target dates to each specific benchmark proposed for the initial three-month period.
- Describe its strategy, tactics, coverage (geographically and frequency) and timing of activities to be undertaken.

b) Technical Approach: This section shall describe:

- Understanding of the technical, institutional, and political issues facing the National Strategy of Immunization in Peru and what is needed to expand

immunization coverage rates and build the central, regional and local capacity to sustain rates above the safety threshold level.

- Understanding of root problems of the National Strategy of Immunization in Peru and discussion of solutions.

c) Personnel

- **Chief of Party (COP) : Senior Manager, Public Health Specialist**

The COP will be responsible for the overall technical and managerial leadership of the program. The COP will have high level training at a PhD or Master's level in the area of Public Health, Public Policy, or Management. COP will have a minimum of 10 years of relevant experience working in building institutional capacity efforts with solid demonstrated experience working with high level officials and experience or work in child basic health services, immunizations, health information or health logistic systems. A minimum of ten years of supervisory experience is required. The COP should have experience in results management, coordination, obtaining support for program changes, and carrying out health programs. COP must be fluent in English (FSI Level 4 minimum) with a demonstrated ability to work with cooperating partners in implementing a complex program in the field. He/she should have considerable autonomy and the authority to commit funds and resources during the implementation of the contract.

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

The DCOP must have demonstrated professional excellence in the health field. He/she will have high level training at a PhD or Master's Level in the area of Public Health, health information and logistics systems, basic child health care, or health systems management. The DCOP should have extensive recent experience in evaluating, designing, and promoting health services and health programs, and in addressing constraints to progress in program implementation in rural areas. The DCOP should have excellent writing ability and strong interpersonal skills. The DCOP must be fluent in English (FSI Level 4 minimum).

- **Monitoring and Evaluation (M&E) Specialist**

The M&E Specialist must have specialized professional training in project monitoring and evaluation, with more than 5 years of work experience in monitoring and evaluating health activities and/or similar complex development projects. He/she must have good to excellent Spanish and English (FSI level S4/R4.) The M&E Specialist must be familiar with USAID Performance Management requirements, Data Quality Assessments, and must quickly become familiar with MCC performance measures and reporting requirements. He/she will have excellent communication and interpersonal skills to facilitate collection and sharing of information about the project with the team and stakeholders.

- **Administration and logistics (A&L) Specialist**

  Administrative and logistical support will be required to procure equipment for the GOP, and to manage workshops, trainings, and other outreach or communication events. The A&L Specialist should have 5 years of relevant work experience in implementing similar activities and good to excellent English S3/R3 and Spanish S4/R4. (Note: that beyond basic facilitation, the contractor will not be able to rely upon USAID to assist the successful offeror with required logistics as USAID/Peru is a Tier One consolidated service post.)

- **Accounting and Finance (A&F) Specialist**

  The A&F Specialist must be familiar with USAID accounting and financial procedures, including those related to sub-grants and contracts. The A&F Specialist qualifications include excellent professional performance with more than 5 years of work experience in accounting and finance and good to excellent English S3/R3 and Spanish S4/R4.

d) Mobilization Plan: The offeror shall include a mobilization plan with a detail of the timeframe for implementing the various elements of their technical plan, deadlines for deliverables, and periods of employment for local staff.

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.

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 and approved Operational Plan Program Elements. Cost data must be summarized into DFB/OP 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. (See Section V - Annex)

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 & Labor Category	Number of Work Days	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 (a)

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. Authorized Attachments

a. Biographical Data:

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 [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.

c. Branding Implementation and Marking Plans.

IV. TYPE OF CONTRACT

The Government contemplates award of a Cost-Plus-Fixed-Fee (CPFF) completion type 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 40 points

The demonstrated professional and technical quality of the proposed Chief of Party and key personnel. The Contractor's team must have thorough knowledge of Peru's health sector and Peru's context, including the decentralization process, health sector resources, and technical issues related to child immunization and health. The team must have subject expertise in all the components of the TO, including reaching rural populations, improving logistics and management systems, and upgrading health information systems. In addition, the team must include competence in purchasing large amounts of equipment, distributing it, and training for its appropriate use. The team must have experience in capacity building, training, and provision of expert technical advice to public sector counterparts. The team must have strong interpersonal and collaborative skills. The COP and DCOP must have demonstrated capacity to implement competently USAID policies and procedures. *(40 points)*

a. Chief of Party (15 points)
b. Deputy Chief of Party (10 points)
c. Monitoring and Evaluation (5 points)
d. Administration and logistics (5 points)
e. Accounting and Finance (5 points)

2. Technical Approach 30 points

a. Extent to which the proposed approach is clear, logical, well-conceived, and technically sound; is appropriate to Peru context; reflects understanding and support of TCP program objectives; demonstrates feasibility for achieving results within the expected two-year frame and addresses possible risks; provides for sustained results beyond the life of the project; and draws from lessons learned nationally, and in similar contexts in other countries. *(20 points)*
b. Extent to which the Performance Monitoring and Evaluation Plan is clear, appropriate and sound in terms of identification of expected interim and final

results of the program and extent to which the plan will reliably quantify program progress and impact, demonstrates accountability for adherence to and achievement of goals within timeframe and will support building local capacity to gather and analyze data for decision making. *(5 points)*

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

3. Implementation Plan. 15 points

The extent to which the proposal indicates fast deployment and appropriate use of resources to achieve project objectives, including a plan for procurement and deployment of equipment. The extent to which the proposal describes the role of managers and technical staff and consultants proposed and the procedures for reporting results, and the demonstrated access to appropriate technical personnel with technical experience and expert qualifications in the programmatic areas outlined in the Statement of Work. Extent to which the initial 3 month workplan and the overall illustrative timelines for the effective implementation of project components, demonstrate 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.

4. Contractor Past Performance 15 points

a. The prime and major subcontractor's demonstrated experience in the geographic and program areas identified in the Statement of Work and organizational experience in managing relevant large-scale projects including activities to improve Immunizations, basic child health, information systems, surveillance, and logistics based on the information provided in Section II, II, 2 of this RFTOP. (15 *points)*

Total Points Possible 100 points

[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]

SECTION V – ANNEXES

ATTACHMENT 1

	Program Element 3.1.6 Maternal Immunization Program				
	Component	**Year 1**	**Year 2**	**Total**	
1	Ensure Immunization of Rural Children				
2	Strengthen Immunization Management and Logistics Systems				
3	Strengthen the Immunization Information System within the Ministry of Health at the Central Decentralized Levels				

	Input Categories*	**Component 1** Ensure Immunization of Rural Children	**Component 2** Strengthen Immunization Management and Logistics Systems	**Component 3** Strengthen the Immunization Information System within the Ministry of Health at the Central Decentralized Levels	**Total**
a	Labor (Long Term & Short Term)				
b	Fringe Benefits				
c	Travel & Transportation				
d	Equipment & Software				
e	Subawards				
f.	Monitoring				
g	Other Direct Costs				
	Workshops, Seminars & Conferences				
	Training Events				
	Supplies				
h	Administrative Costs				
	Rent & Utilities				
	Total				

*Each input category must include a breakdown of all input costs

ATTACHMENT 2

MCC Marking Regulations

These guidelines provide specific instructions on the appropriate use and placement of the Millennium Challenge Corporation logo. They also provide broad guidelines for Accountable Entities in creating their logo and specific marking guidelines for Millennium Challenge Corporation Threshold Program agreements.

Living Document

The Millennium Challenge Corporation reserves the right to revise, update, and change this document from time to time as necessary.

Exemptions

Accountable Entities created prior to October 31, 2006 and having already established a name and a logo and whose logo is already widely distributed are not required to follow the naming and logo standards outlined herein. All other guidelines shall be followed, as appropriate.

Authority

Specific language in the legal agreements for Millennium Challenge Corporation Compacts requires compliance with the standards outlined in this document. Language in the legal agreements for Threshold Program Agreements provides specifics on how these standards shall be applied.

Branding and Marking with Others

With U.S. Government Departments and Agencies

Other United States government departments or agencies may display its seal, logo or signature on any material purchased or paid for with funds disbursed pursuant to a Millennium Challenge Corporation Compact or Millennium Challenge Corporation Threshold Program Agreement when the department or agency provides goods or services while partnering with the Millennium Challenge Corporation, an accountable entity established by a Millennium Challenge Corporation Compact, or as part of a Threshold Program Agreement.

All seals, logos, or signatures shall be the same size, though the Millennium Challenge Corporation reserves the right to have dominant placement for its logo or for an accountable entity's logo.

With Foreign Governments

Foreign governments may display its seal, logo, signature, or other national insignia on any material purchased or paid for with funds disbursed pursuant to a Millennium Challenge Corporation Compact or Millennium Challenge Corporation Threshold Program Agreement when the government provides goods or services while partnering with the Millennium Challenge Corporation, an accountable entity established by a Millennium Challenge Corporation Compact, or as part of a Threshold Program Agreement.

All seals, logos, signatures, or national insignia shall be the same size, though the Millennium Challenge Corporation reserves dominant placement for its logo or for an accountable entity's logo.

With Non-Governmental Organizations, Non-Profit Institutions, and Other Partners

An organization may display its seal, logo, or signature on any material purchased or paid for with funds disbursed pursuant to a Millennium Challenge Corporation Compact or Millennium Challenge Corporation Threshold Program Agreement when the organization provides goods or services while partnering with the Millennium Challenge Corporation, an accountable entity established by a Millennium Challenge Corporation Compact, or as part of a Millennium Challenge Corporation Threshold Program Agreement.
All seals, logos, or signatures shall be the same size, though the Millennium Challenge Corporation reserves the right to have dominant placement for its logo or for an accountable entity's logo.

With Contractors

Contractors may not include their logo, brand mark, signature, company name or provide any other representation of their company on any material purchased or paid for with funds disbursed pursuant to a Millennium Challenge Corporation Compact or Millennium Challenge Corporation Threshold Program Agreement.

Identity Elements

Official Names

Millennium Challenge Corporation

The official name of this United States agency is the "Millennium Challenge Corporation" and shall be referred to as such. Any reference using the official name shall always be done so first in English but may then be translated as required by law or custom.

Accountable Entity

All accountable entities shall be known as "Millennium Challenge Account – Countryname" where *countryname* is the most commonly recognized name of the country by its citizens. Use the accountable entity's formal name – Millennium Challenge Account - Countryname – when first referenced. Thereafter, it may be referred to as "MCA - Countryname."

"Millennium Challenge Account – Countryname" may be translated where appropriate, but shall be done so consistently. The entire phrase, "Millennium Challenge Account – Countryname" shall be translated and may be re-arranged to ensure that it appears grammatically correct in the translation.

Threshold Program Agreements

No formal name is identified with a threshold agreement as different U.S. government agencies and other organizations may administer the program.

Logo

A logo is recognizable in many different instances: from a glance at a letter printed on your letterhead to noticing it as you're driving by a sign posted next to a roadway. Be

aware that the less intricate the logo's design, the more likely people will recognize it quickly.

Millennium Challenge Corporation Logo

The MCC logo shall be used in both Millennium Challenge Account and Millennium Challenge Threshold countries to represent both the MCC and the United States of America.

Accountable Entity Logo

Accountable entities shall create a logo which serves as an element of its signature. The accountable entity logo shall conform to the following guidelines:

1. The logo must be a circle.
2. The logo must include "Millennium Challenge Account," which may be translated.
3. The logo must include the most commonly recognized country name by its citizens, which may be translated.
4. The logo must acknowledge the generosity of the people of the United States of America.

The Millennium Challenge Corporation reserves approval authority, which will not be unreasonably withheld, for the accountable entity's logo.

Logos for Threshold Program Agreements

Threshold Program countries shall not create a unique logo to represent the relationship and efforts created out of the Threshold agreement. Threshold countries shall use the Millennium Challenge Corporation logo (shown above) or the flag of the United States of America. Threshold Program countries may use their own flag or national insignia *in conjunction with* either the Millennium Challenge Corporation logo or the flag of the United States of America to create a signature for their Threshold Program agreement. See the "Signature" section for more detail.

Signature

A *signature* is the compilation of multiple pieces of branding to create one unified, recognizable symbol.

Accountable Entity Signature

The accountable entity logo combined with any tagline serves as the signature. See the "Logo" section for specific requirements for accountable entity logos. See the "Tagline" section for specific requirements for accountable entity taglines.
For accountable entities whose logo was created prior to October 31, 2006 and whose logo does not conform to the guidelines outlined in the "Logo" section, either the MCC logo or the flag of the United States of America must appear with the logo as part of the signature.

The signature shall be used on all material promoting the accountable entity's partnership with the Millennium Challenge Corporation and shall be used for the duration of the Compact agreement.

Signature for Threshold Program Agreements

Threshold Program countries shall use either the Millennium Challenge Corporation logo or the flag of the United States of America as their signature. Threshold Program countries may use their flag or other national insignia in conjunction with either the Millennium Challenge Corporation logo or the flag of the United States of America to

create a signature unique to the country. The flag or other national insignia of the Threshold Program country must be the same size as either the Millennium Challenge Corporation logo or the flag of the United States of America.

Tagline

The tagline is a "catch phrase" that embodies the purpose of an organization. The Millennium Challenge Corporation's tagline is "Reducing Poverty Through Growth."

Accountable Entity Tagline

The accountable entity may choose to create a tagline. The tagline shall never be used without the accountable entity's logo.

Taglines for Threshold Program Agreements

Threshold countries shall not create a unique tagline, but may use the MCC tagline in specific instances.

Color

Accountable entities may not adopt the official colors of the Millennium Challenge Corporation.

Color Usage Consistency

Color usage shall be consistent. If the accountable entity's signature or logo or Threshold Program signature appears in full color, the MCC logo or flag of the United States must appear in full color; conversely, if the accountable entity's logo or Threshold Program signature appears in black and white (or one color), the MCC logo or flag of the United States must appear in black and white (or one color).

Usage and Placement

The accountable entity signature or Threshold Program agreement signature shall be placed on any material purchased or paid for with funds disbursed pursuant to an MCC Compact or Threshold Program agreement that is visible to a significant portion of the population where the item is placed. Location, size, and frequency of placement of the signature shall be determined by the accountable entity or Threshold Program agreement implementer, but shall be placed prominently and sized proportionally to the material or object.

Miscellaneous

Accountable Entity Marking Manual

Accountable entities may, but are not required to, use the Millennium Challenge Corporation *Standards for Corporate Branding and Marking* as a model for establishing rules and guidelines for appropriate usage of its logo, signature, and colors.

Whom to Contact with Questions

Address any questions to:
Brett A. Bearce
Director of Branding and Web Projects
Millennium Challenge Corporation
Department of Congressional and Public Affairs
875 Fifteenth Street NW
Washington, D.C. 20005

202-521-4076
bearceb@mcc.gov

Clearance Process
In most instances, clearance for branded items is at the discretion of the accountable entity's chief executive or at the discretion of the implementer of a Threshold Agreement. Address questions to:

Brett A. Bearce
Director of Branding and Web Projects
Millennium Challenge Corporation
Department of Congressional and Public Affairs
875 Fifteenth Street NW
Washington, D.C. 20005
202-521-4076
bearceb@mcc.gov

[END OF SECTION V - ANNEX]

[END OF RFTOP NO.527-08-009]