



USAID
FROM THE AMERICAN PEOPLE

July 24, 2009

VIA ELECTRONIC MAIL

Subject: RFTOP No. 527-09-002, Health Policy Reform
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 the “New Enhanced Competition” requirements mandated by recent legislation.

Enclosed please find the scope of work for the provision of technical assistance to improve health sector performance in the context of decentralization by strengthening policies and policy related capacities at all levels of government.

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

The USAID estimate for this effort ranges between \$18.5 Million - \$20 Million.

Under a best value source selection, non-price evaluation factors, when combined, are significantly more important than price. 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 an implementation period of approximately five-year, subject to 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.

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 Liliana C. Murguia, Acquisition & Assistance Specialist, at lmurguia@usaid.gov, and to me at dvan@usaid.gov. We expect to receive your questions related to this RFTOP not later than August 7, 2009. Answers will be provided and distributed within four (04) business days. Please ensure that proposals are received by not later than August 28, 2009, 4:00 p.m. local time at the delivery address listed below.

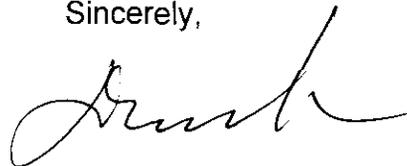
The Technical and Cost proposals should be addressed by e-mail or mail to Ms. Doanh Van (Av. La Encalada S/N, Cdra. 17 Monterrico-Surco, Lima, Peru, care of Ms. Veronica Leo, RCO/Lima) E-mail address, vleo@usaid.gov and to Liliana C. Murguia at lmurguia@usaid.gov.

The receipt of this RFTOP must be confirmed by written notification (e-mail or fax) to Ms. Veronica Leo at the email 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,



Doanh Van
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

The Office of Health in USAID/Peru works at different levels of the Peruvian health system through multiple projects: one to improve local capacity, community participation and behavior change; and another to improve the quality of public health programs and services, primarily by working with regional authorities. This Task Order procures a third project, the purpose of which is to improve health sector performance in the context of decentralization by strengthening policies and policy-related capacities at all levels of government.

Peru has made great strides in decentralizing its health sector, and most management, financing, and operational functions previously carried out by the central Ministry of Health (MOH) have been successfully delegated to regional authorities. The challenge today is to ensure that the MOH is prepared to perform its role of steward of the health system, and that the regions, including regional and local public entities, are able to assume their new responsibilities effectively. The goal of this Task Order is to increase capacities of the MOH and regional and local public entities to ensure the delivery of quality health programs and services, and the improvement and effective use of key health system inputs. This will be accomplished by providing expert technical support to public sector institutions. The work will be carried out in Peru, at the national, regional, and local levels. The Task Order will focus on capacity building and systems strengthening in these key areas: (1) Health Governance; (2) Health Financing; (3) Health Information; (4) Health Workforce; and (5) Medical Products, Vaccines and Technologies.

The design of this Task Order reflects the central emphasis of USAID/Peru's health portfolio: supporting policies and systems in the health sector that will lead to real improvements in health status for the poor and near-poor populations of Peru. While current laws and regulations reflect the desire for equity in health services (meaning that regardless of income or population group, persons with similar health needs are able to receive the same quality care), institutional capacity of the health system to carry out their functions in compliance with these laws and regulations remains weak. Under this award, national-, regional- and local-level public entities will be strengthened to respond to challenges and opportunities created by a changing health sector, while maintaining focus on equitable access for all. This Task Order seeks to mobilize Peru's own considerable human and financial resources to improve the organization and financing of Peru's public health sector, as well as the equity, effectiveness and efficiency in its operations.

USAID/Peru intends this award to be the final award for assistance to Peruvian health policy reform and contemplates that in five years, local institutions in the health sector will fill any gaps in providing technical assistance for ongoing reforms in Peru's public health sector. In general, this award focuses on the key

factors associated with the structures and functions of the sector, with specific attention to certain health systems building blocks¹. It builds on previous achievements, uses lessons learned, and complements other activities in the USAID/Peru health portfolio.

The work performed under this Task Order will contribute to the achievement of the Investing in People Objective in the U.S. Foreign Assistance Framework and the Health Program Area (see www.state.gov/documents/organization/88433.pdf). The award will be financed with and include activities related to Maternal and Child Health (MCH), Family Planning and Reproductive Health (FP/RH), HIV/AIDS, and Tuberculosis (TB) Program Elements.

2. Background

Development Context

Peru is a dynamic lower middle-income country, with a population of almost 28 million. For several years the country has had one of the highest growths in gross domestic product (GDP) and one of the lowest inflation rates in Latin America. Notable economic growth has not translated into poverty reduction, however, and Peru's recent success has not eliminated the structural factors that keep indigent more than one of every three people (36.2%).

Rural Peru, with about a quarter of the total population, had poverty levels as high as 88% in some regions in 2006. There is a strong correlation between poverty and ethnicity in Peru, where almost half of the population is indigenous. Those most impacted by structural poverty are those living in jungle and highland communities, and in urban slums. These marginalized populations are difficult to reach with current health and education initiatives, generating severe and enduring socioeconomic disparities that fuel dissatisfaction with the state, its institutions and political leaders, and posing a major threat to the country's political stability.

Peru is undergoing a process of decentralization; the government is promoting regional planning in development and is increasing direct provision of financial resources to local governments, encouraging local solutions. National strategies to overcome poverty have been considered in the Multi-Annual Macroeconomic Plan of the Ministry of Economics and Finance (MEF). However, regional and local elections will take place in 2010, and national elections in 2011, posing challenges for continuation of these programs and policies.

In an effort to decrease poverty, Peru is modernizing its state institutions. The impact of the global economic crisis on Peru, unknown at this point, could impede this effort. The challenge for Peru's government is to sustain high

¹ The World Health Organization identifies the six building blocks of health systems as: (1) health governance; (2) health financing; (3) health information; (4) health workforce, (5) medical products, vaccines and technologies, and (6) service delivery. Service delivery strengthening is supported by other USAID/Peru health projects. For more information, see Table 2.

economic growth, improve health and education, and ensure that all Peruvians benefit from the country's economic success thereby acquiring a stake in continued democratic stability. In broad terms, the government must modernize government institutions, improve the state's service delivery capacity, tackle narcotics production, and promote social inclusion by providing public services where previously they have been absent or inadequate.

Thus, to help Peru address critical issues on its development agenda, USAID/Peru's overall assistance program is aimed at reducing poverty through broad-based economic growth, modernizing key institutions, improving state-run services, and strengthening civil society. In addition to working at the national level, USAID/Peru has generally concentrated its field presence in a seven-region area where coca is grown for cocaine, and narcotrafficking activity is common. USAID/Peru has a multisectoral Alternative Development strategy that aims to promote licit and secure lifestyles through its activities in economic growth, democracy and governance, basic education, and environmental protection, as well as health. In USAID/Peru's latest strategy, assistance to regional governments may be provided outside of the coca-growing regions, with prior consent and approval of USAID/Peru.

Peru is implementing a Millennium Challenge Corporation (MCC) Threshold Program, begun in 2008, which focuses on reducing government corruption and boosting childhood immunization rates.

Health Context

Peru's aggregate national indicators show major advances since the 1980s in prenatal care, skilled attendance at birth, Total Fertility Rate (TFR), Contraceptive Prevalence Rate (CPR), and reduction of maternal, infant, and young child mortality. Still, large gaps persist between upper and lower income groups for each of these indicators, owing to vast disparities in standards of living, access to health care services, and the quality of services received. Rural populations, including poor indigenous groups, continue to have high unmet needs for basic health services, and are the most difficult to reach. For instance, in 2008 use of modern contraceptives in urban areas was 49%, but in rural areas was 38%, with an unsatisfied need for contraceptives of more than 10%. Over half of all births in rural areas still occur at home without skilled medical attendance, and maternal mortality remains high.

Peru's chronic childhood malnutrition rate of 28% has remained essentially unchanged for over a decade and is mostly concentrated in rural areas where the condition affects nearly 70% of children in some communities. In fact, despite overall economic growth, between 2005 and 2007 undernourishment in children actually increased in the poorest populations (ENDES, 2005, 2007). Contributing to malnutrition, childhood illness goes untreated in many areas due to the inaccessibility of health care and basic drugs, coupled with poor understanding of effective home management. Without strong public health programs, in many rural and urban settlements, there is low awareness of the importance of clean

water, good sanitation practices, and adequate diet in preventing chronic malnutrition.

The central MOH oversees the provision of public health programs and individual health services to the country's poor and near-poor population (almost 70% of Peru's 28 million inhabitants). According to Peru's decentralization plan, certain core functions will remain in the MOH, including: setting of national health policy and global regulation for the health sector; conducting long-term planning; aggregating and analyzing national epidemiological data; responding to public health threats; and coordinating with international donors. The MOH has begun many interventions to improve the public health care system. Peru's clinical and public health and clinical standards and guidelines are generally rigorous, however the actual quality of state-provided health services remains low and the quality of professional practice among health care providers varies greatly. In addition, the public health system faces challenges as a result of many factors, including: budgetary deficiencies; historic centralization of health sector resources in Lima leading to inefficiencies and poor response to needs in the rest of the country; frequent turnover of personnel in both management and clinical cadres; inadequate training and supervision for managers and healthcare providers; vulnerability to political change in upper management of the MOH; inadequate information available for epidemiological surveillance, technical decisions, and clinical and management functions; weak logistics and regulatory systems for drugs, contraceptives, and vaccines; an inefficient and non-transparent procurement system; and low capacity to enforce quality standards in the sector.

Decentralization of Peru's health system is prudent, given the long-run 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 and participation. Decentralization is also risky, in that service provision may falter where sub-national entities are inadequately prepared to perform their new functions. The process of transferring many health functions and responsibilities to the regions concluded in June 2008. However, regional and local levels recognize that they lack the capacity for planning and budgeting of health functions and face challenges in operating the public health system effectively. HIV/AIDS, tuberculosis, and childhood vaccination programs, which had been highly effective as vertical programs, declined markedly due to resource and management problems after the reorganization. Maternal and perinatal services, family planning and reproductive health programs, child health services, and infectious disease prevention and control are all stated priorities for regional and local health authorities, but their ability to effectively address these issues is lacking. Both increasing stewardship capacities at the central and regional levels and preparing regional and municipal institutions for their new responsibilities will be critical to the success of Peru's decentralized health system.

Today, major transformations are underway simultaneously on four fronts of Peru's health sector: (1) the adjustment of the MOH to its new role of steward;

(2) the adaptation of regional- and municipal-level entities to newly-delegated responsibilities; (3) a push to expand health financing and insurance mechanisms, especially for the poor, including the new universal health insurance law; and (4) the rapid expansion of national programs, such as *Juntos* and CRECER (described below), targeting the poor. These changes create significant and unique opportunities for lasting health reform.

Other Donor Efforts. In addition to the activities under this Task Order and other USAID/Peru projects, international donor support to the health sector in Peru includes assistance from bilateral and multilateral projects working under the coordination of the MOH. The largest such undertaking, the Program for the Support of Health Reform (PARSALUD II), is the second phase of a health reform project financed by the Government of Peru (GOP), in part through loans from the World Bank. The GOP is contributing US\$132 million to the five-year project, and the World Bank is loaning an additional US\$30 million. The goals of PARSALUD II, scheduled to begin by the end of 2009, are to: improve family care practices for women and young children; strengthen health services networks with capacity to solve obstetric, neonatal and infant emergencies and to provide comprehensive health services to women and young children; and support the MOH's governance functions of regulation, quality, efficiency and equity for improving maternal and child care in a decentralized environment. A large percentage of the budget is for upgrading and equipping health facilities. In addition to the World Bank and MCC, the Inter-American Development Bank, Pan American Health Organization, UNICEF, the United Nations Population Fund, and the Belgian Technical Cooperation agency are all supporting health reform and universal insurance with a focus on primary health care for women and children.

Government of Peru Initiatives. Three important cross-cutting issues define the context for health reform under the direction of the MOH. First, the MOH operates in the larger context of government decentralization, an effort which began in 2002 by creating 26 regional governments (25 regions and the capital, Lima) and that involves devolving national-level functions to regions and local municipalities. In the health sector, some functions are specific to one level, while others are shared among all three levels of government. For example, the national (or central) level has the mandate to set national health policies, and all three levels are responsible for the implementation of these policies. When setting policies, the central MOH does not always recognize community needs or coordinate with regional and local authorities, and, therefore, the policies are not always applicable or fully implemented at local levels.

Second, Peru endeavors to achieve universal health coverage. Almost half of the Peruvian population is uninsured, and the MOH seeks an alternative to the existing health financing structure in order to reach more of the uncovered population. A universal health insurance law providing state insurance to the poor was approved in March 2009, and was welcomed by political leadership and the population. It is not clear, however, how the law will guarantee the quality of health care provided or address the barriers that have historically prevented a

significant portion of the population from benefiting from healthcare services. Implementation of the law will be piloted in seven regions before it is employed nationwide.

Third, the MOH aims to support populations' access to integrated provision and delivery of health services. Peru's public health financing and health service delivery structures are fragmented. There are three principal public providers of health services in Peru: (1) the MOH (which will continue to operate national hospitals, even under decentralization); (2) EsSalud, the social security provider for public employees; and (3) the hospitals and services for the National Police and Armed Forces. The MOH strives to integrate these three principal health service providers into a single, modern organization for emergency care services, blood banks, and other services that are currently provided separately.

In support of the three main themes mentioned above -- decentralization, universal health insurance, and access to integrated health services -- current initiatives promoted by the GOP include social programs and strategies, as well as financing mechanisms to deliver funds to local governments so that they may implement activities more effectively. The capacity of local authorities to effectively gain access to these funding sources or implement these programs varies greatly, and is generally low. These initiatives include:

- *CRECER* – An umbrella initiative comprised of several multi-sectoral components: *Juntos* (a conditional cash transfer program to increase participation of the poorest families in social programs by offering to household mothers monetary incentives to participate in certain health, education and nutrition activities); an integrated care package for mothers and children; support from regional and local governments; and programs for nutrition, water safety, food security, employment generation, and civil participation. CRECER includes an MOH coordinating body for Peru's social investment projects whose main goal is to reduce chronic malnutrition in children under five years of age.
- *Sistema Nacional de Inversion Publica* (SNIP) – a MEF administrative system that certifies the quality of public investment projects, based on efficiency, sustainability, and socio-economic impact.
- *Fondo de Promocion a la Inversion Publica Regional y Local* (FONIPREL) – a MEF competitive fund, aimed at poverty reduction, whose objective is to co-finance public investment projects and pre-investment studies aimed to reduce gaps in provision of basic services (such as health) and infrastructure.
- *Fondo Nacional de Compensacion y Desarrollo Social* (FONCODES) – a MEF fund aimed to reduce poverty by fostering job promotion while investing in rural infrastructure (water, sanitation, health, and education).
- *Presupuesto por Resultados* – a national law approved in 2007 mandating

results-based financing in the entire public sector.

3. CURRENT USAID/PERU EFFORTS

USAID/Peru's Health Program: Overview

The overriding objective of USAID/Peru's health program is to improve the health of high-risk populations, including poor and marginalized groups. USAID/Peru aims to ensure equity in clinical services and public health programs by increasing access to and utilization of quality services, promoting healthier behaviors, and strengthening responsive policies and programs for poor and near-poor populations. The USG provides funding for such activities through the Global Health and Child Survival account in the following areas or elements: FP/RH, MCH, HIV/AIDS, TB, and other public health threats (OPHT). By partnering with host country institutions to strengthen the critical health systems and capacities shown in Table 1, below, USAID/Peru's health strategy is designed to prepare Peru for graduation from USAID support in the medium term.

Peru's health system operates at the national, regional, municipal and community levels and involves government, civil society, non-governmental organizations and the private sector. To improve the health of high risk populations, it is imperative that the health system functions well from the national-level policies down to local-level implementation. USAID/Peru's health program supports improved performance of Peru's health sector at each level and within all six building blocks (as outlined by the World Health Organization and detailed in Table 2) of the health system. It currently encompasses four major instruments: USAID/Health Systems 20/20, USAID/Health Policy Initiatives (USAID/HPI), USAID/Quality Healthcare, and USAID/Healthy Communities and Municipalities (USAID/HCM). Together these instruments address work in all segments of the health system, each confronting a specific part of the health sector improvement agenda (see Table 1). USAID/Peru is also implementing the Millennium Challenge Corporation (MCC) Threshold Program in Peru, which has Control of Corruption and Immunizations components.

Table 1: Current USAID/Peru Health Sector Improvement Agenda

Approach	USAID/Peru Project(s)
<p>Support for macro-structural reform through technical assistance for the overall design and implementation of the sector’s decentralization process, sector financing, sector-wide regulatory structures and insurance for the poor.</p>	<p>USAID/Health Systems 20/20 and USAID/HPI (<i>to be continued by this Task Order</i>); and the MCC- Immunizations Threshold Program²</p>
<p>Development of effective regulatory systems to strengthen human resources, pharmaceutical logistics and supply chain management, service delivery, and information systems. This approach focuses primarily on activities within regions, including coordination with higher and lower levels of government.</p>	<p>USAID/Health Systems 20/20 and USAID/HPI (<i>to be continued by this Task Order</i>); and the MCC-Immunizations Threshold Program</p>
<p>Strengthening key operations at the functional level of the health sector. This approach addresses problems related to poor implementation of existing technical procedures and practices, focusing on technical capacity of health providers.</p>	<p>USAID/Quality Healthcare and the MCC- Immunizations Threshold Program</p>
<p>Community health promotion through a multi-sectoral method to address basic determinants of health at the community level. This approach empowers community members and increases utilization of improved health care services.</p>	<p>USAID/HCM</p>

Current and Recent Health Systems Strengthening Efforts

The strengthening of Peru’s health system is an essential component of USAID/Peru’s agenda to improve health sector performance. USAID/Peru’s health programs are improving the six health system building blocks (detailed in Table 2) and increasing Peru’s capacity to manage the interactions of these building blocks to achieve equitable and sustained improvements across health outcomes. USAID/Peru’s assistance includes the advancement of both technical and political knowledge.

² A Millennium Challenge Corporation project, implemented by USAID/Peru.

Table 2: Health System Building Blocks

- 1. Health Governance:** The leadership and governance of health systems, also called *stewardship*, is arguably the most complex but critical building block of any health system. It involves overseeing and guiding the whole health system, private as well as public, in order to protect the public interest. Health Governance requires both political and technical action, because it involves reconciling competing demands for limited resources, in changing circumstances, for example, with rising expectations, more pluralistic societies, decentralization or a growing private sector.
- 2. Health Financing:** A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them. Health financing systems that achieve universal coverage in this way also encourage the provision and use of an effective and efficient mix of services. Three interrelated functions are involved in order to achieve this: the collection of revenues; the pooling of revenues; and purchasing. The interaction between all three functions determines the effectiveness, efficiency and equity of health financing systems.
- 3. Health Information:** A well functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely health information by decision-makers at different levels of the health system, both on a regular basis and in emergencies. It involves three domains of health information: on health determinants; on health systems performance; and on health status.
- 4. Health Workforce:** Health workers include all people engaged in actions whose primary intent is to protect and improve health. A country's health workforce consists broadly of health service providers and health management and support workers. Overall, there is a strong positive correlation between health workforce density and service coverage and health outcomes. In any country, a well-performing health workforce is one which is available, competent, responsive and productive.
- 5. Medical Products, Vaccines and Technologies:** A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. To achieve these objectives, the following are needed: national policies, standards, guidelines and regulations that support policy; information on prices, and capacity to set and negotiate prices; reliable manufacturing practices and quality assessment of priority products; procurement, supply, storage and distribution systems that minimize leakage and other waste; and support for rational use of essential medicines, commodities and equipment, through guidelines, strategies to assure adherence, reduce resistance, maximize patient safety and training.
- 6. Health Service Delivery:** Good health services are those which deliver effective, safe, good quality care to those that need it, when needed, with minimum waste. Services – be they prevention, treatment or rehabilitation – may be delivered in the home, the community, the workplace or in health facilities. Some well established requirements of a good health service delivery includes: trained staff working with the right medicines and equipment, and with adequate financing; an organizational environment that provides the right incentives to providers and users; organization and management of inputs and services to ensure access, quality, safety and continuity of care across health conditions, across different locations and over time.

USAID/Peru has made significant advances in each of the health systems building blocks. Achievements to date, as well as outstanding needs, are described below:

Health Governance. USAID/Peru activities in Health Governance include technical assistance provided to the MOH and regional governments in management and administration. Citizens, civil society, and the private sector are empowered to provide input and to assume new health sector roles and responsibilities. Health Governance activities also include assistance to strengthen policy-making and regulatory capacities, and to ensure competent design, enforcement, and monitoring of public policies related to health.

Since Peru's decentralization law was adopted in 2002, USAID/Peru has provided extensive support to the MOH and the GOP in designing an orderly approach to the transfer of functions from the central MOH to the regions and municipalities. Support included mapping those functions, analyzing the competencies required, and helping the MOH establish criteria for accrediting regions receiving new responsibilities. USAID/Peru provided extensive support to nine regions in developing their own integrated health plans, as well as anti-corruption plans for health in four regions. USAID/Peru also funded a decentralization monitoring and evaluation system designed to track the impacts of decentralization on the health sector. In addition, USAID/Peru has, over the years, supported the development of formal agreements between national and regional health authorities, and between regional and municipal authorities ("*acuerdos de gestion*") through which health programming is coordinated.

Recent USAID/Peru programs provided technical assistance and studies that provided a basis for the universal health insurance law, the reorganization of the MOH, and agreements among political parties to advocate for increased health budgets. Current activities are improving communication of essential information between local and upper levels of regional health systems.

Much of the health sector has been decentralized from the central MOH to regions, however future success of the health system relies on further developing roles and capacities within the health sector and continued commitment to decentralization by citizens and political parties. The MOH needs the capacity to operate as the steward of the health system, with oversight and accountability responsibility. The regions (at the regional government and local levels) need the capacity to plan, manage, and operate their own health programs. Each of these capacities must be developed in the context of the universal health insurance.

Health Financing. USAID/Peru's support in Health Financing includes support to the central and regional governments for improved financing in the context of decentralization, as well as increased financing of health services for the poor. USAID/Peru-provided technical assistance gave rise to the framework for the new universal health insurance which guarantees health service coverage to poor populations, and to agreements among political parties to increase health

budgets. USAID/Peru also provided support to nine regions in developing their own participatory budgets.

Now that a universal health insurance law has been passed, continued advocacy is needed to ensure further political support and legislation to secure the planned expansion of coverage and financing of health services to the poor and those afflicted with catastrophic disease. Furthermore, additional health regions need to develop participatory budgets and criteria need to be developed for the allocation of resources among and within regions.

Health Information. USAID/Peru programs strengthen Health Information by improving the collection, analysis and use of epidemiological, clinical and administrative data. Recent USAID/Peru support includes a completed diagnosis of Peru's health information system. The USAID/Peru-implemented MCC-Immunizations Threshold Program is improving the immunization information system within central and decentralized levels. Support provided includes technical assistance for upgrading the existing information system on immunizations coverage, and providing basic computer equipment for health facilities.

Effective governance and planning of the decentralized health sector depends on the availability and use of timely, relevant, and reliable information. Despite efforts over a several-year period, health information systems are fragmented and much of the data that is collected is not used well for decision-making. A national policy needs to be developed and implemented for an improved integrated health information system that provides data for local, regional and central use.

Health Workforce. USAID/Peru activities in Health Workforce strengthening include technical assistance for increased capacities to plan and ensure competencies of human resources in the health sector.

The frequent turnover of public health sector personnel (at all levels, from policy-makers to practitioners) and the scarcity of qualified workers in rural areas (an issue of distribution) pose significant challenges to the strengthening of Peru's Health Workforce. USAID/Peru has re-directed its program from training of health care workers to increased technical assistance to establish self-sustaining quality training systems. The health sector, by its nature, is characterized by very high training needs, and building capacity in human resources is a prerequisite for the critical improvements needed in the sector. Pre-service training is required at some level for virtually all health workers, and the initial training requirements for physicians, midwives, and nurses are considerable. Moreover, the knowledge and skills of all health workers must be refreshed and updated regularly to maintain required competencies. Recent USAID/Peru support has led to the inclusion of priority health topics in university curriculums, and periodic certification of health professionals.

Additional Health Workforce strengthening is critical for a successful Peruvian health system. Technical assistance is needed to develop capacities at the central and regional levels regarding strategic planning and management of human resources in the health sector. A National Civil Service Authority was created by law in Peru in 2008. Together with accompanying legislation, this new set of laws is a first step at civil service reform over the long-term, and allows for the Ministry of Health to proceed immediately with reforms to improve the organization and functioning of its human resources. The MOH will require continued technical support for workforce management under this new authority in order to successfully implement ongoing sector reforms.

Medical Products, Vaccines and Technologies. USAID/Peru activities to strengthen Peru's Medical Products, Vaccines and Technologies focus on improvements to the logistics systems (forecasting, purchase, transport and storage) designed to guarantee the availability of essential drugs and medical supplies, including family planning commodities. Recent USAID/Peru support has led to the training of key health personnel in logistics management. Additionally, the USAID/Peru-implemented MCC-Immunizations Threshold Program performed a study of the vaccine supply chain and is providing technical assistance to improve the logistics of immunizations in Peru.

Additional support is needed in Medical Products, Vaccines and Technologies to increase capacities of workers at all levels of the health system to forecast needs for medical consumables, and to ensure the availability of quality pharmaceuticals and other supplies when needed.

Health Service Delivery. USAID/Peru has been a main sponsor of efforts to develop and enact MOH policies setting explicit quality standards for health facilities. Continuous quality improvement approaches are used to help apply the standards for facilities and for human resources management. USAID/Peru promotes quality assurance systems by providing technical assistance and training to local government officials, community groups, and community leaders. USAID/Peru continues to support upgrading of family planning and reproductive health services in particular, and monitoring for compliance with a range of MOH quality standards.

The MCC-Immunizations Threshold Program, implemented by USAID/Peru, is strengthening service delivery to dispersed populations in 17 regions. Support provided includes training and augmentation of basic equipment needed by traveling medical teams.

The USAID/HCM and USAID/Quality Healthcare projects are USAID/Peru's primary tools for strengthening of health service delivery. Although this Task Order is not designed to directly address Health Service Delivery development, the Task Order's Health Workforce line of activity will ensure availability and competencies of health workforce, thereby supporting delivery of quality services. Furthermore, the Contractor will coordinate with USAID/Quality Healthcare and

HMC activities under this Task Order, not only to avoid duplication, but to ensure they complement activities of those projects.

Other USAID/Peru Health Activities

In addition to the health systems strengthening activities described above, USAID/Peru's health program includes significant work in community health promotion and behavior change through the USAID/HCM project. Community-organizing for behavior change and improved public health is underway in over 500 communities. 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, perinatal, and child health services.

Other USAID/Peru Activities

Over the last four years, USAID/Peru has provided critical support to the Peruvian decentralization process. Current activities supporting decentralization and strengthening regional and local governments include:

USAID/ProDecentralization is a new activity with two main components: (1) improving legal and policy framework, and (2) strengthening capacities of target local and regional governments. Because civil society participation is an integral part of the decentralization process, especially at the local level of government, targeted support to civil society members or organizations are woven into these two major components when required. This activity works in four regions (Junin, San Martin, Ucayali and Ayacucho) and builds on previous USAID/Peru efforts in the sector to support the GOP's commitment to improving the decentralization process and the quality of services provided to citizens at the local level.

USAID/Comun@s is an activity that supports targeted local governments' abilities to receive and respond to demands with increased civil society capacity to present and advocate their interests. This activity is directly linked to USAID/ProDecentralization, such that interventions of each project are synchronized. USAID/Commun@s interventions include the use of local media and other communication strategies for greater information dissemination among citizens, formal and informal training activities to improve key skills of local leaders, community authorities, and key civil society representatives, and support for the development of stronger internal management systems within these organizations.

USAID/Extractive Industries Transparency Initiative (USAID/EITI) is an activity that aims to increase the capacity of local officials to effectively and transparently invest revenues from the extractive industries; promote greater citizen participation in the identification of extractive industry revenue investments; strengthen civic oversight of government performance; increase confidence in local government management of resources to create a more conducive investment environment; establish linkages with the national-level EITI Working Group; and share best practices for replication of activities through the Working Group's regional pilot activities. The activity is being implemented in

approximately 30 municipalities from five selected regions where revenues from extractive industries are most significant. USAID/Peru implements this activity through a grant agreement with the International Finance Corporation, a member of the World Bank Group.

USAID/Support Reforms to Improve Basic Education Quality in Disadvantaged Areas is a new education activity that aims to support critical education reform initiatives that will lead to the improvement of basic education quality in disadvantaged areas in Peru. Support will be provided through expert technical assistance and training to public sector institutions and to civil society organizations, at the national, regional, and local levels. The contract will focus on supporting systems reforms and capacity building in the key areas of (1) education management and decentralization, and (2) teaching quality. Regions receiving considerable USAID/Peru assistance, such as San Martín, Ucayali, Amazonas, Lambayeque and Junín, will be prioritized by the activity.

MCC Threshold Program with Peru seeks to improve the country's performance on MCC's *Control of Corruption* and *Immunization Rate* indicators. The Control of Corruption Threshold Program will help the Government of Peru combat corruption nationwide by improving internal controls within the public sector, including the MOH; simplifying processes to reduce opportunities for corruption; strengthening enforcement in the judiciary and the police, increasing public awareness about corruption, and increasing the capacity of citizens to use public information to effectively assess and monitor the government's transparency and accountability. The Immunization Threshold Program will focus on increasing immunization rates by strengthening immunization management and logistics systems and strengthening the information system within the MOH, and will prioritize work in 17 regions. The MCC Threshold Program with Peru is implemented by USAID/Peru.

4. GENERAL APPROACHES/GUIDING PRINCIPLES

Sustainability

Sustainability of achievements under this Task Order is of high importance. The Offeror is encouraged to identify specific activities within each Activity that are considered essential actions toward continued health system strengthening and reform. One effort to ensure sustainability is the continuation of political consensus measures discussed under the Health Governance Outcome in the Statement of Work section below.

Additionally, it will be important to anticipate future technical assistance requirements, and coordinate with the GOP to develop their plans to meet those needs. For each Activity, the Offeror should propose interventions to address issues related to sustainability and to ensure that gaps in capacity development and/or policy expertise can be addressed beyond the end of this program through means other than U.S. assistance. For example, if there is an ongoing need for the GOP to procure targeted technical assistance for specific actions,

the GOP will need to have the ability to effectively and efficiently mobilize public sector resources to acquire needed technical assistance.

Furthermore, upcoming regional and national elections will likely bring government staffing changes during the performance period of this Task Order. The need to focus on strengthening systems, rather than individuals, is critical in Peru. How to ensure that the capacities developed lie in the institutions, rather than in individuals, should be foremost in the design of all activities. The contractor may want to consider developing a formal sustainability plan with GOP or regional counterparts to ensure activities being implemented have the necessary buy-in (commitment of staff, resources, etc.) needed to continue after the end of this Task Order.

Coordination

USAID/Peru is committed to the proactive coordination of the donor community and alignment with the GOP's health strategy. USAID/Peru continues to play a lead role in ensuring donor efforts are not duplicative but complementary and fully aligned. In all areas of the project, close coordination with GOP counterpart institutions is vitally important and a requirement of USAID/Peru. 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 USAID/Peru Office of Health.

The Contractor must demonstrate effective collaboration with other projects within USAID/Peru's Health Program and with USAID/Peru projects in other sectors, as appropriate. For example, USAID/ProDecentralization is working directly on furthering decentralization beyond regional levels for all sectors of the GOP, and on improvements to increase the flow of funds between different levels of the government. The Contractor will collaborate with USAID/ProDecentralization on its Health Governance and Health Finance interventions, and will be expected to adopt the governance and finance tools already developed by USAID/ProDecentralization for use in the health sector.

Similarly, the Contractor will be expected to collaborate with relevant civil society groups and donor programs. The Contractor will formulate a quick diagnosis of all key actors working in health systems strengthening and establish an effective coordination plan. This could include ongoing round-tables on specific cross-cutting topics or regularly scheduled meetings to understand other related programs.

Coordination activities will also include identifying GOP contributions to the objectives of the Task Order. Such contributions, which are required under USAID/Peru's bilateral agreement with the GOP, may take the form of cost-sharing of funds, goods, or in-kind contributions, and must be tracked for each GOP counterpart institution.

Mitigating Threats/Flexibility

The Offeror's proposal is expected to identify and mitigate threats to ongoing reform. Currently the biggest threats are those posed by the current worldwide financial crisis and the uncertainty of continuing political agendas. Elections will take place in Peru during the course of this award and have the potential of changing government priorities with respect to the health sector. Delayed implementation of civil service reform could also pose a challenge to the success of this activity. Unforeseen changes in security conditions or political stability may necessitate adjustments to where or how activities will take place. Proposed programs should be flexible and able to adapt to changing circumstances while simultaneously minimizing the likelihood that changing external circumstances will negatively influence the health reform process in Peru.

Civil Society Participation

The Offeror should not underestimate the valuable role civil society plays in furthering the fight against corruption and improving social services at the local level. Throughout the performance of this Task Order, there will be multiple opportunities to integrate civil society organizations and leaders at the local, regional, and national levels into discussions of policy development and implementation. Leading non-governmental organization experts and members of professional groups – health professional associations, universities, academics, think tanks, etc. – might be drawn upon for technical guidance. Furthermore, as described in specific Activities below, strengthening of Peru's health system should include encouraging public sector entities to develop mechanisms that invite citizen participation in policy-making.

Citizen participation is also necessary and desired in the monitoring and evaluation of the quality of health services and programs. As noted above, the universal health insurance law declares guaranteed quality in the provision of services. The Contractor will work with facilities and local, regional and national government authorities on ways to measure quality as part of the ongoing management of the health system. This is an area that will require close coordination with the USAID/Peru projects USAID/Quality Healthcare and USAID/HCM projects.

Anticorruption

Control of corruption is a cross-cutting theme to be considered in each line of this project. Transparency, accountability, and discretion in decision-making are imperative in every building block of a successful health system. The Contractor will coordinate with other USAID/Peru activities focusing on anticorruption, such as the MCC Control of Corruption Threshold Program.

Private Sector Alliances

USAID/Peru is committed to pursuing alliances with private-sector partners to enhance the development impact of its foreign assistance. Often, commercial interests and philanthropic efforts are operating in the same areas and addressing many of the same challenges as USAID/Peru. By partnering,

USAID/Peru has the opportunity to expand the reach, effectiveness, and sustainability of its development interventions by combining its strengths with those of other private sector and philanthropic actors. Contributions from these partners include not only funding, but expertise, networks, access to markets, technology, etc. It is important to clarify that this approach is not to pursue partnerships as an end unto themselves, but rather as a means to improve development impact.

The Contractor will be expected to be watchful for potential private-sector alliances that could further the sustainability goals of this award, increase private flows of resources to the health sector, expand the reach and functionality of Peruvian health systems, enhance the role of the private sector in the distribution of medicines and medical supplies, or otherwise benefit the Peruvian health sector. The Contractor must notify USAID/Peru of any potential partnerships identified by the Contractor during the performance period of this Task Order, and will be expected to work with USAID/Peru in pursuing such partnership(s) as appropriate.

Monitoring Performance

The Offeror should propose a Performance Monitoring Plan (PMP) for collecting, evaluating, and validating data which will be used to measure overall progress and compare status over time. The Contractor must adhere to regular reporting requirements set forth by USAID/Peru, and will be expected to respond to intermittent requests from USAID/Peru for information needed for management and reporting purposes. The PMP should include performance indicators and targets, and show how baseline measurements can be established to assess the impact of proposed interventions. Required indicators are set forth below, and in the Statement of Work section additional illustrative indicators are provided for each Activity. The Contractor will be expected to define indicator baselines and targets. The PMP will be finalized by the Contractor within 90 days of the contract awarded under this Task Order.

The proposed PMP should demonstrate how it will clarify and focus project objectives, serve as a forecasting and reporting tool, promote on-going discussions pertaining to project scope and direction, and aid in effective management decision-making. The proposed PMP should also include an explanation of how data and information will be collected, analyzed, used, and verified, and the cost effectiveness of such activities.

Gender and Cultural Issues

Gender and cultural factors have a major impact on the demand for and use of health services. Women are critical to the care, feeding and education of children; and play a critical role in the development of a country's social and economic infrastructure. Rural, indigenous populations live under cultural structures distinct from those in urban Peru. Proposals should reflect vigilance of and sensitivity to issues of stigma and discrimination, as well as the pursuit of gender and cultural equity within broader efforts to increase equitable access to health services. The Offeror should incorporate gender and cultural

considerations into interventions to increase equity in health services. Support to national health authorities to increase capacities to adopt policies and programs addressing gender and culture is encouraged.

Technical proposals should address the following key issues: (1) how gender relations will affect the achievement of sustainable results, and (2) how proposed results will affect the relative status of men and women. Gender is included in the Evaluation Criteria as well.

Note also that USAID requires that the contractor not discriminate against people with disabilities in the implementation of USAID programs and that it make every effort to comply with the objectives of the USAID Disability Policy in performing this contract. To that end and within the scope of the contract, the contractor's actions must demonstrate a comprehensive and consistent approach for including men, women and children with disabilities.

Activity Distribution

An estimate of the program activity distribution by Outcome is provided below, and it is anticipated that interventions (resources and activities) will be undertaken annually in the suggested percentages. If an Offeror believes this estimate is not optimal to achieve the objectives of this project, the Offeror is encouraged to propose, with clear rationale, an alternative program activity distribution.

Table 3: Activity Distribution by Outcome

Outcome/Objective	Percent
1. Health Governance	35%
2. Health Financing	25%
3. Health Information	15%
4. Health Workforce	15%
5. Medical Products, Vaccines and Technologies	10%
TOTAL	100%

Geographic Focus

To best build on investments and activities to date, and to align with MOH priorities, the geographical scope of this activity will include twelve "priority" regions where the universal health insurance program will be piloted, and/or where USAID/Peru has provided previous health policy support (see Table 4 below). This activity may work beyond these twelve priority regions as needed in order to reach those most in need and achieve the greatest impact (taking into account poverty levels, political will, GOP priorities, universal health insurance priority regions, USAID/Peru target areas, and health indicators).

Table 4: Geographic Focus

Description	Regions	Notes
Universal health insurance pilot regions	Ayacucho, Apurimac, Huancavelica, San Martin, Lambayeque, La Libertad, and Piura	Priority regions where insurance is being piloted. Success in these regions is critical, as these regions will not only serve as models for future insurance implementation, but success in these regions will also provide incentives for increased GOP health investments
Regions traditionally supported by USAID/Peru	Ayacucho, Cuzco, Huanuco, Junin, Pasco, San Martin and Ucayali	Priority Regions of USAID/Peru from the Alternative Development strategy. This Task Order will build on previous achievements and investments in health policy reform in these regions.
Private Sector Alliances	To be determined	Support to additional regions <i>may</i> be warranted as opportunities for Private Sector Alliances in other regions arise
Others	To be determined	Support to additional regions <i>may</i> be warranted, and any such inclusion will be based on analysis of information related to the epidemiological profile (poverty and health statistics), political will, and opportunity for impact in the region

The suggested work distribution under this Task Order (resources and activities) is divided as follows: 33% central level, 67% regional and sub-regional levels. If an Offeror believes this work distribution is not optimal to achieve the objectives of this project, the Offeror is encouraged to propose, with clear rationale, an alternative work distribution.

Indicators

The following Foreign Assistance Framework (FAF) indicators will be used by USAID/Peru for monitoring program. The Contractor will be held responsible for collecting data showing results under each of these indicators.

Table 5. Required Indicators

1	Number of local organizations provided with technical assistance for HIV-related institutional capacity building
2	Number of local organizations provided with technical assistance for HIV-related policy development
3	Number of improvements to laws, policies, regulations or guidelines related to improve access to and use of health services drafted with USG support (TB, MCH, FP/RH)
4	Number of people covered by USG-supported health financing arrangements (TB, MCH, FP/RH)
5	Number of people trained in TB sub-elements with USG funding
6	Number of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs (TB, MCH, FP/RH)
7	Value of pharmaceuticals and health commodities purchased by USG-assisted governmental entities through competitive tenders (TB, FP/RH)
8	USG-assisted facilities' provider staff with a written performance appraisal (MCH, RH/FR)

Additional project indicators and national- and regional-level context indicators also will be required. The Offeror should propose such additional indicators taking into account the Outcomes, Activities, Deliverables, and Illustrative Indicators specified in the Statement of Work section below. Both the required indicators above and the additional indicators must be included in the PMP. Targets for all indicators will be finalized 90 days after the contract is awarded.

5. STATEMENT OF WORK

By improving policies and capacities to strengthen Peru's health system, this Task Order will improve the quality and coverage of health services for all Peruvians, and particularly for poor and rural populations. Under this award, national, regional and local level public entities will be strengthened to respond to challenges and opportunities created by a changing health sector, while focusing on equitable access for all.

The Contractor will advance policies and build policy-making capacity toward each Outcome, set forth below, to strengthen Peru's health systems and improve health indicators. The Contractor will use lessons learned in Peru and internationally, and will seek creative and new ideas to address barriers to policy adoption and implementation.

Specific Outcomes, corresponding to the five of the six building blocks of health systems strengthening covered by this project, are set forth below. In addition to those delineated for each Outcome, deliverables and indicators for the project overall are listed at the end of this section.

OUTCOME 1: Health Governance. The MOH, regional and local authorities are operating in coordination under the decentralized health system by developing, implementing, and enforcing sound policies and regulations that are effectively implemented.

Achievement of this Outcome will require the design and implementation of an approach to health sector leadership that supports sound policies and regulations that are effectively implemented throughout the health sector. Support provided will build on previous achievements in Health Governance. This support will include advancing health sector decentralization using good governance principles such that in conjunction national, regional and local health authorities have the capacity to effectively plan, budget, finance, and implement health services and respond to citizen demands with transparency and accountability.

Activity 1.1: Strengthen and expand decentralization of the health sector.

This activity will assist the MOH in adapting to its stewardship role under a decentralized health sector. This activity also will continue to expand the decentralization process in Peru by extending responsibilities to even lower levels of the government and will include provision of assistance to improve organizational capacity at regional and local levels. It will reduce fragmentation of the health system across different providers and promote the role of civil society in oversight and the decision-making process by encouraging public sector entities to develop mechanisms through which citizen participation is invited.³ Furthermore, this activity will continue work at the national and regional levels to catalyze political consensus around health plans, elevating health policy decisions to become ongoing priorities of the state rather than transient priorities of political parties in power, and contributing to the sustainability of achievements in the health agenda. In performance of this activity, the Contractor will provide technical assistance to:

- Support the MOH and regions in adapting to their new roles under a decentralized health sector;
- Develop a regulatory framework for MOH's new stewardship role;
- Improve capacity of regional and local authorities to effectively and efficiently manage their health systems and programs;
- Continue the decentralization process by extending responsibilities to even lower levels of the political structure;
- Improve monitoring and reporting of how the health system addresses gender, culture, and stigma and discrimination issues in health;
- Coordinate within regions the various health providers and user groups to reduce gaps in coverage;
- Create mechanisms through which local or regional authorities encourage and receive civil society input into the processes of health care planning, budgeting, management, service provision and oversight; and
- Build consensus among political parties around health agendas.

³ Civil society plays a valuable role in any decentralized system. Other USAID/Peru health projects, such as Healthy Communities and Municipalities, are working to increase the involvement and strengthen the capacity of civil society and community leaders in the decision-making process and oversight roles.

Expected Results:

By the end of the first year:

- The MOH and regional governments have plans to further decentralize health functions down to local levels.
- Health sector issues have been debated publicly in the political transition at the subnational level.
- Regional Health Directorates (DIREASs) and Social Development Managers from three macro-regions have agreed on mechanisms to exchange experiences and coordinate activities, particularly on health issues.
- DIREASs in at least three priority regions have been reorganized to carry out their new functions under decentralization.
- DIREASs in at least three priority regions plan and implement programs using results-based budgets.

By the end of the fifth year:

- The MOH is exercising its stewardship and oversight authorities.
- DIREASs in at least the 12 priority regions are reorganized and functioning according to their new roles and responsibilities.
- DIREASs in at least the 12 priority regions plan and implement programs using results-based budgets.
- At least 30% of local governments within the 12 priority regions have been delegated authority to and are actively managing the operations of the primary health care system within their geographic area of responsibility.
- At least one macro-regional government health project in each of the three macro-regions is designed and implemented and is achieving agreed upon results.

Deliverables:

By the end of the first year:

- Technical report on progress made regarding macro-regional health agreements.
- Technical report on the systematization of local decentralization pilots.
- Technical report on the progress made regarding reorganization and revised functioning of the DIREASs (including draft handbooks, as available).
- Technical report on the results of dialogues with political parties regarding the health agenda.

By the end of the fifth year:

- Technical report evaluating the reorganization of the DIREASs.
- Technical report evaluating use of results-based budgets by the DIREASs.
- Technical report on macro-regional plans.
- Technical report on the systemization of DIREASs' monitoring of local compliance with norms and standards within the 12 priority regions.

- Assessment of local government operations, including a summary of best practices and lessons learned.

Illustrative Indicators:

- Number of health authorities who received information and policy advice.
- Number of local health boards made up of community representatives.
- Number of DIRESAs using results-based budgets.
- Number of macro-regional health meetings.
- Number of macro-regional governmental health projects implemented.
- Number and percent of local governments that have been delegated authority to manage primary health care.

Activity 1.2: Develop and implement national and regional anticorruption plans for the health sector.

This activity will support the development, implementation and monitoring of national and regional plans to control corruption in the health sector. In performance of this activity, the Contractor will provide technical assistance to develop and implement national and regional policies related to this goal.

Expected Results:

By the end of the first year:

- A national anticorruption plan has been developed by the MOH.

By the end of the fifth year:

- Corruption levels in the 12 priority regions have decreased by 50% in three critical areas as identified in the regional health anticorruption plans: pharmaceuticals, human resources, and preferential treatment of patients.

Deliverables:

By the end of the first year:

- Copy of final MOH anticorruption plan.

By the end of the fifth year:

- Technical report on corruption levels, addressing selected critical areas and covering the 12 priority regions.

Illustrative Indicators:

- Number of DIRESAs with anti-corruption plans.
- Number of people trained in anti-corruption.
- Percentage of public health insurance beneficiaries in a sampling of clinics whom report having been directed to a private pharmacy to purchase medication.
- Percentage of staff positions filled without wide publication of a vacancy announcement.
- Percentage of public health insurance beneficiaries in a sampling of clinics whom report having paid for childbirth or outpatient pediatric services provided in these public health facilities.

Activity 1.3: Develop and implement national and regional plans to monitor compliance with regulations and standards governing the health sector.

This activity will support the development and implementation of mechanisms to monitor and evaluate compliance with regulations, policies and standards governing the health sector.

In performance of this activity, the Contractor will provide technical assistance to:

- Strengthen the role of the national oversight body for the health sector, the Superintendancy of Health; and
- Increase monitoring and enforcement of governing regulations and standards in the health sector.

Expected Results:

By the end of the fifth year:

- Superintendancy of Health is organized, staffed, funded, and operating under established policies.
- DIRESAs have a functioning monitoring and evaluation system to monitor local compliance with norms and standards.
- MOH has a functioning monitoring and evaluation system to monitor DIRESA compliance with norms and standards.

Deliverables:

By the end of the fifth year:

- Technical report regarding the systemization of MOH's monitoring of DIRESA compliance with norms and standards within the 12 priority regions.
- Technical report on the Superintendancy of Health functioning.
- Technical report of the systemization of DIRESAs' monitoring of local compliance with regulations, policies and standards within the 12 priority regions.

Illustrative Indicators:

- Number of investigations performed by the Superintendancy of Health
- Number of DIRESAs monitoring local compliance with regulations, policies and standards.

OUTCOME 2: Health Financing. Peru has increased its public spending on health to achieve its health insurance coverage goals, and is funding health services to ensure efficiency and equity in the public health system.

Achievement of this Outcome will require improving the system for financing Peru's health sector, including the new universal health insurance law, such that budgeting for health prioritizes and reaches the poorest and most vulnerable citizens in Peru with the services that are most needed by them. Technical assistance will include ensuring that payments for health services to decentralized entities are based on performance and transferred efficiently in order to eliminate gaps in service delivery. Health Financing activities will build

on previous achievements and continue to strengthen Peru's health finance systems and ensure effective use of health finance data.

Activity 2.1: Improve health coverage of poor and vulnerable populations.

This activity will improve coverage to poor and vulnerable populations through provision of a basic package of health care insurance benefits (e.g. through the implementation of the universal health insurance pilots), the development and implementation of the mechanisms necessary for financing the insurance, developing a system for financing assistance to those affected by catastrophic disease, and long-term planning for resources needed in the health sector.

In the performance of this activity, the Contractor will provide technical assistance to:

- Ensure health sector resources (regardless of source) are complementary to promote equitable access to health services;
- Enhance financing and health insurance coverage through implementation and scale up of pilot programs for providing universal access to a basic health care package;
- Design and implement the policies and mechanisms required for insurance coverage of populations employed in small and micro enterprises;
- Design and implement a system for financing assistance to those affected by catastrophic disease; and
- Develop long-term plans for resources needed based on estimations of costs as insurance coverage expands and based on the changing disease profile of the country (i.e. burden of disease).

Expected Results:

By the end of the first year:

- Proposal for mechanisms required to extend universal health insurance coverage to populations employed by small and micro-enterprises.

By the end of the fifth year:

- Guaranteed full financing of the health sector as required by the universal health insurance.
- Guaranteed full financing of the health sector for catastrophic diseases.
- Universal health insurance implemented in the 12 priority regions, covering a minimum of 85% of the disease burden with guaranteed quality of service (as currently planned by the GOP).

Deliverables:

By the end of the first year:

- Project strategy to ensure health financing laws is developed with broad participation and gain wide public support.
- Report on policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding health financing.

- Report on financing analysis and recommendations.

By the end of the fifth year:

- Analysis of the current burden of disease.
- Long-term plans for health financing.

Illustrative Indicators:

- Percentage of income spent on health expenditures by households in the poorest quintile.
- Per capita health investments for primary health care.
- Mean public sector per capita expenditure.

Activity 2.2: Ensure efficiency and equity in health resource allocation.

This activity will require the development and implementation of the mechanisms necessary to finance the health coverage developed in Activity 2.1, as well as the creation of mechanisms for effective allocation of resources to lower levels of government.

In the performance of this activity, the Contractor will provide technical assistance to:

- Design and implement a system for results-based budgeting, to be utilized by national and sub-national health authorities;
- Assess the current system for financing health service provision under decentralization and universal health insurance; and
- Develop payment methods and resource allocation models based on the health needs in different regions, corresponding to healthcare provided (in terms of the nature, quantity and quality of care), and to appropriate improvements to and maintenance of infrastructure and equipment.

Expected Results:

By the end of the first year:

- MOH and at least three priority regions have developed criteria for resource allocation designed to ensure equity.
- At least three priority regions have developed plans to ensure that payments to local health providers are timely and based on performance.
- Analysis of health financing in Peru with recommendations for streamlining planning and budgeting processes.

By the end of the fifth year:

- Public resources for collective and individual health care are allocated to, and within, regions according to established criteria designed to ensure equity in health care.
- Implementation of universal health insurance in each of the 12 priority regions includes a plan to ensure that payments to local health providers are timely and based on performance.

Deliverables:

By the end of the first year:

- Project strategy to ensure national health financing policies are developed with broad participation and gain wide public support.
- Report on policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding health financing.
- Technical report on analysis of health financing in Peru, with recommendations.

By the end of the fifth year:

- Technical report on criteria used to allocate public health resources.
- Technical report on the methods and criteria for payments to local providers under the universal health insurance in each of the 12 priority regions.

Illustrative Indicators:

- Number of regions allocating public resources in accordance with established criteria to ensure equity in health care.
- Number of health networks and micro networks that received late payment from the DIRESA or the network.

OUTCOME 3: Health Information. The MOH, regions, and local authorities are generating and using accurate and timely information to manage the health system.

Activity 3.1: Strengthen the capacity to collect, analyze, and use data in the health sector.

This activity will strengthen the capacity at all levels of government to collect, analyze, and use data for making informed decisions in the health sector, including decisions related to design, implementation, monitoring, and evaluation of health policies, strategies, programs, and activities. The activity will encourage collection of information that is relevant, reliable, accurate and complete. Health Information activities under this program are expected to build on past advances in the development of information systems, including norms and standards relating to these and improved performance of the existing systems; and to ensure that the implementation of new systems is in accordance with established action plans and the principals of effective information systems outlined above. This activity will also develop capacity for the analysis of information gathered, including the appropriate exchange of information at all levels for optimal monitoring and evaluation of programs and policies. New information systems and processes may be required to provide improved information, and existing systems may need modification to guarantee effectiveness and efficiency overall. The activity should ensure compatibility among various information systems in use.

The universal health insurance law guarantees quality in the provision of services to covered beneficiaries. Quality is understood by patients as not just the resolution of their illness, but the manner in which services are provided (*i.e.*, respectful treatment), wait times, the availability of prescribed medicines, etc. Thus, user satisfaction is an important measure of quality. In order to monitor and evaluate quality, a system for gathering patient input at the facility or household level that is culturally appropriate is required. The Contractor will have to work with authorities at all levels to institute measures to gather information on the quality of services through such instruments as patient satisfaction surveys or other qualitative studies that may involve local universities, governments and communities.

In the performance of this activity, the Contractor will provide technical assistance to:

- Promote the use of information in decision-making at national, regional, and local levels, especially with respect to policy-making and oversight of new initiatives;
- Improve data collection methods;
- Monitor and evaluate the quality of health services and programs as guaranteed under universal health insurance law;
- Streamline and improve the health information system as a whole so that needed information at all levels is cohesive, avoids duplication and is produced efficiently;
- Support the implementation of regional action plans for the improvement of the performance of the regional health information system;
- Ensure compliance with appropriate national data quality standards, developed with USAID/Peru support, at regional and local levels; and
- Ensure public availability of timely, accurate data.

Expected Results:

By the end of the first year:

- Regional plans for (1) improved collection, analysis, dissemination, and use of information by health micronetworks; and (2) enhanced coordination between regional and local governments implemented.
- A strategy to improve information-based decision-making in local governments to help monitor progress of programs of MCH and FP/RH policies is designed and implemented.
- National data quality standards are established or improved.

By the end of the fifth year:

- A national policy, with standards, is implemented for an improved integrated health information system at all levels (national, regional and local) that efficiently provides information needed for planning programs, assigning resources, and informing the overall functioning, efficiency and quality of health services and programs.

- An electronic patient registry, using unique patient identifiers and containing patient medical histories, is established and operating in at least three regions.
- National, regional and local governments and health authorities are using reliable data, including vital statistics and health determinants, for decision-making.

Deliverables:

By the end of the first year:

- A report of policies, regulations and programmatic actions taken by local, regional and national government and health authorities regarding registry, use and dissemination of reliable data for decision making related to integrated health and to MCH, FP/RH, HIV/AIDS, and TB.

By the end of the fifth year:

- Report on and assessment of the health information system, including activities undertaken to strengthen the system and recommendations for future activities.

Illustrative Indicators:

- Number of regions using timely information for decision-making.
- Performance score of the integrated health information system using the WHO Health Metrics Network assessment tool.
- Number of press articles or independent publications citing health information produced by the integrated health information system.
- Number of regions using electronic patient registry.
- Number of regions meeting national data quality standards.
- Number of regions that have implemented health information system improvement plans.

OUTCOME 4: Health Workforce. Policies for improved human resources management in the public health sector are implemented.

Achievement of the Health Workforce Outcome will require strengthening the policy and regulatory framework for human resources in the public health sector, and its application in practice to achieve sustained health objectives while advancing workforce development in the sector. Technical assistance will be provided to the MOH, regions, and local authorities, as well as national health professional associations and training institutions, to develop and implement policies for human resources management in the public health sector, including long-term planning and strategies for ensured human resource quality and availability. Health Workforce activities under this Task Order are expected to enhance the delivery of quality health services by providing technical assistance in the long-term planning of human resources and the development of certification standards for health service providers.

Activity 4.1: Support the design and implementation of a broad-based system for planning and managing the health workforce.

This activity will include implementation of a broad-based system for planning and managing human resources throughout the health sector. Such a system will allocate human resources based on specific and identified needs. The system should be able to forecast and plan human resources needs into the future and will provide the appropriate incentives to reduce turnover in health sector staff and to increase quality in health services.

In addition, the activity will include support for the implementation of the reform processes developed by the National Civil Service Authority. Such support will include assistance to strengthen the overall management of health workforces and with developing incentives and salary guidelines for health providers, in order to combat corruption and decrease health staff turnover, especially in health networks that are remote and provide services to excluded populations. The activity will include planning for the full range of health workforce functions necessary for the effective functioning of a decentralized health system in which the MOH acts as a steward of the health system and the national Superintendent of Health is developed as a public health oversight body for the health sector. This activity will also develop and implement formal national strategies for recruitment and retention of personnel.

In the performance of this activity, the Contractor will provide technical assistance to:

- Develop long-term plans in human resources, including development of the appropriate set of job functions at different professional levels and responsibilities in the health system and forecasting needs with respect to these functions;
- Develop, implement and monitor national, regional and local strategies for human resources recruitment and retention;
- Develop policies and tools for ensuring continued staffing of health services; and
- Develop and implement workforce management policies with incentives and salary guidelines in collaboration with the civil service reform process.

Expected Results:

By the end of the first year:

- Health authorities received technical assistance to design specific regulations for the health workers according to processes established by the National Civil Service Authority.
- Teams from 100% of undergraduate health training institutions trained in issues of Human Resource Management in the health professions.

By the end of the fifth year:

- A system for planning and managing human resources, including long-term needs and strategies for recruitment and retention, throughout the health

sector is implemented at the national, regional and local levels in the 12 priority regions.

- Civil service policies implemented and enforced in the health sector, with incentives and salary guidelines.

Deliverables:

By the end of the first year:

- Report of policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding human resources for health.

By the end of the fifth year:

- Report on and assessment of the human resources management system, including activities undertaken to strengthen the system and recommendations for future activities.

Illustrative Indicators:

- Percentage of staff positions vacated in DIRESAs, health networks, micro networks and health facilities.
- Percentage of health facility staff positions that are filled.
- Number of regions with an established human resource management system that addresses long-term needs.
- Number of regions with established civil service policies with standards for recruitment, management, training, monitoring and incentives and compensation of civil servants in the health sector.

Activity 4.2: Ensure competency of workers in the health sector.

This activity will build on previous work of USAID/Peru that includes tools for managing health facilities' workforce needs according to levels of care offered and the actual competencies required of each level of service provider. Standards of care and the training and accreditation of a competency-based workforce allow for better monitoring and evaluation of personnel performance at the level of facilities and networks. The activity will build on efforts to develop policies and programs to strengthen health centers that can become training institutions within their networks, where workers can receive continuous education to meet quality of care and competency-based standards. This work will be coordinated closely with the USAID/Quality Healthcare project to improve services and programs.

In the performance of this activity, the Contractor will provide technical assistance to:

- Strengthen policies for continuous education and on-the-job training to improve quality of care;
- Assess current staffing patterns at health facilities and work with local and regional authorities to develop policies, as appropriate, to organize and build capacities of the health workforce in collaboration with professional associations and training institutions; and

- Establish and ensure compliance with minimum competency requirements for meeting quality standards.

Expected Results:

By the end of the first year:

- System implemented for evaluation of competencies of health care providers in health centers and regional hospitals.
- Periodic health professional certification enforced nationwide by the National Council of Deans of Professional Associations.
- Supervisory policies at the regional level for health care workers designed and implemented.
- The national law for Evaluation, Accreditation and Certification of Superior Education in Health enforced by the Ministry of Education and MOH.
- Senior managers trained in leadership and in the design, planning, implementation, and monitoring of evidence-based policy-making.

By the end of the fifth year:

- Policies for human resource management, including minimum qualification and competency requirements for meeting established quality standards, are implemented in the 12 priority regions.

Deliverables:

By the end of the first year:

- Report of policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding human resources for health.

By the end of the fifth year:

- Report on and assessment of the human resources management system, including activities undertaken to strengthen the system and recommendations for future activities.

Illustrative Indicators:

- Percentage of positions where incumbent possesses specific qualifications required by the position.
- Number of USG-assisted facility provider staff with a written performance appraisal
- Number of regions with human resource management policies that include minimum qualification and competency requirements.

OUTCOME 5: Medical Products, Vaccines and Technologies. The Peruvian health system appropriately procures and manages the pharmaceuticals and supplies needed for all public health services and programs.

Decentralization and the new law for universal health insurance have dramatically changed the environment and needs of Peru's logistic systems. This activity will help Peru adapt from a push- to a pull-system of commodities

distribution. Building on previous USAID/Peru achievements, including new regulations for regional procurement, upgrades to electronic systems for quality control and extensive training of health personnel in logistics management, this activity will provide assistance in the assessment and improvement of existing logistics systems to best meet the new demands, and to improve the availability, quality assurance and quality control of commodities in the supply chain. At the regional and local levels, the activity will include additional capacity-building in logistics management, including forecasting, order placement, transportation and storage of commodities.

This activity will improve government abilities at the national and regional levels to develop policies to ensure that medical products, vaccines, contraceptives and supplies are procured, stored, transported and in stock at facilities according to logistics standards. This includes the ability to forecast needs and procure medical supplies at both the central and regional levels and to address remaining weaknesses in the logistics systems. This activity will provide support for policies and capacities to meet the demands of the population for medicines and family planning methods. This activity also will involve collaboration and coordination with different stakeholders, including international cooperation agencies such as the United Nations Population Fund, in order to achieve systemic and sustainable improvements.

Activity 5.1: Improve capacities and policies at the national and regional levels to ensure that medical products, vaccines, contraceptives and supplies are procured, stored, transported and in stock at facilities according to established logistics standards.

The Contractor will provide technical assistance to ensure that the Peruvian health system appropriately procures and manages pharmaceuticals and supplies needed for individual and collective health services. Such support will include developing quality assurance and quality control processes, to ensure that reasonably-priced products are available in the right quantities and in good condition. This activity will strengthen monitoring of drug quality and improve policy and regulatory frameworks to enable improvements in drug quality and reduced reliance on name brand pharmaceuticals. All of these efforts will ensure that the products are available to support the delivery of health services to the poor and most vulnerable, and it is expected that these actions will help to reduce per capita expenditures on pharmaceuticals. The activity will promote clear policy-making and help generate evidence for increased commitment by GOP officials for the adequate financing and implementation of all supply chain requirements in the health sector.

In the performance of this activity, the Contractor will provide technical assistance to:

- Improve the logistics system to ensure quality and availability of pharmaceuticals and supplies;
- Strengthen capacities of national, regional and local authorities to plan and forecast needs for pharmaceuticals and other healthcare supplies;

- Develop and implement systems to enforce regulation of quality control and the use of transparent mechanisms of purchase and inventory at national and sub-national levels;
- Monitor the availability and quality of drugs by enforcing the use of tracer products from the list of essential medicines; and
- Support increased capacity of workers at all levels within the health system to track consumption, project needs, request, purchase and store pharmaceuticals and supplies.

Expected Results:

By the end of the first year:

- Systems functioning, at the national level and in at least one priority region, to enforce regulations regarding quality control and the use of transparency mechanisms in the purchase and registry of goods.
- Systems functioning, at the national level and in at least one priority region, to increase the capacity of workers at all levels of the health care system in all regions to track consumption, project needs, request, purchase, and store pharmaceuticals and supplies.

By the end of the fifth year:

- Logistics system ensures the quality and availability of pharmaceuticals and equipment.
- National, regional and local authorities have capacities to plan and forecast needs for pharmaceuticals and supplies.
- Systems are in place to enforce regulations for quality control and use of transparent mechanisms of registry and purchase in national and subnational levels.
- Systems are in place to increase the capacity of workers at all levels of the health care system in all regions to track consumption, project needs, request, purchase, and store pharmaceuticals and supplies.

Deliverables:

By the end of the first year:

- Report on policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding pharmaceutical and supply chain management systems.

By the end of the fifth year:

- Report on and assessment of pharmaceutical and supply chain management, including activities undertaken to strengthen the system and recommendations for future activities.

Illustrative Indicators:

- Number of service delivery points experiencing stock-outs of specific tracer drugs within the 12 priority regions.
- Number of regions that have implemented processes for the efficient procurement of pharmaceutical and supplies.

- Number of regions and health networks certified in best storage practices.
- Value of pharmaceuticals and health commodities purchased by USG-assisted governmental entities through competitive tenders.
- Evidence of increased enforcement of existing pharmaceutical regulations.

OVERALL PROJECT DELIVERABLES/INDICATORS:

Overall Deliverables:

By the end of the first year:

- Technical report of policies, regulations, and programmatic actions taken by regional and national governments and health authorities regarding the universal health insurance pilots.
- Overall report on activities under the five Outcomes of the Task Order (Health Governance, Health Financing, Health Information, Health Workforce, and Medical Products, Vaccines and Technologies) during the period, addressing their effect on the improvement of maternal - perinatal and child health and proposing benchmarks and strategies for future interventions.
- Overall report on activities under the five Outcomes of the Task Order during the period, addressing their effect on the improvement of FP/RH and proposing benchmarks and strategies for future interventions.

By the end of the fifth year:

- Overall report of the main processes and activities under the five Outcomes that supported with an analysis of the results and impact in the 12 priority regions, related to MCH, FP/RH, HIV/AIDS and TB.

Overall Illustrative Indicators:

- Use of essential health services by socio-economic quintile.
- Proportion of poorest quintile covered by health insurance.
- Proportion of poor exempted from paying fees for pharmaceuticals.

6. Reports and Performance Requirements

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

6. a. Work Plans: As part of the technical proposal, the Contractor shall provide an illustrative initial work plan for the first year of the task order, which will be finalized in consultation with USAID during the first 30 days following the award. The selected Contractor will develop work plans in collaboration with the COTR and other appropriate partners for the subsequent four years of the contract. A draft of these work plans will be prepared and submitted to the USAID/Peru COTR for approval 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. Any sub-contracts anticipated
8. Any equipment or commodities to be procured
9. Adjustments required and justification

6.b. Quarterly progress reports: The selected Contractor shall prepare and submit to the USAID/Peru COTR 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 of the activity; 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

6.c. Quarterly financial reports will be submitted to USAID/Peru. They should be disaggregated by component 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.

6.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.

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

6.f. 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 COTR will provide the Contractor with comments. The Final Report will be submitted one week prior to the end of the contract.

7. 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: USAID – Health Policy Reform

Positioning: The Health Policy Reform program is a new USAID health activity, aimed to strengthen Peru's health systems; with the purpose to improve health sector performance in the context of decentralization by strengthening policies and policy-related capacities at all the levels of the government. The work will be carried out at the national, regional and local levels of the health sector in Peru this activity will focus on capacity building and systems strengthening in key areas: health governance; health financing; health information; health workforce; and medical products, vaccines and technologies. The audiences of the program will be central, regional and local decision makers, including public sector, civil society, and public opinion at large.

Public Outreach: Public Outreach: The Health Policy Reform activity will promote health decentralization and the universal health insurance and communicate the success histories at the national, regional and local levels, highlighting its impact in the population at high risk and the assistance provided to the program by USAID.

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

Partners: USAID partners' identities will be acknowledged adhering to USAID's regulations. Activities currently implemented by USAID/Peru health partners include Healthy Communities and Municipalities, Demographic Health Survey, Millennium Challenge Account and Health Quality, the names of which will be used as appropriate in the public outreach for the program and according to USAID regulations.

Level of visibility: In the Health Policy Reform activity, USAID identity will have a high level of visibility in cases in which its audience needs to grasp the extent of the aid provided by the American people; in cases in which its audience needs to perceive the ownership of the program by the GOP, the visibility will be at a medium level; and in cases in which its audience would react negatively to USAID identity visibility it will be kept at a low profile 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 USAID is funding but not fully supporting in terms of contents, and should read: USAID will not be held responsible for any or the whole of the contents of this publication. Threats and restrictions to the security of the program need to be identified and assessed in order to request any necessary exception from the marking requirement in accordance with ADS 320.3.2. USAID's web page contains the electronic version of the Graphic Standards Manual that is compulsory for all contractors.

Sub-brand:

No logo is permitted for the project. Instead, the project should be identified with a sub-brand. The sub-brand should be developed by adding the name of the project to the USAID identity. Design guidance for development of sub-brands can be found in the GSM.

8. Staffing

8.a. Technical Direction and Coordination: The USAID/Peru COTR will be responsible for all day-to-day management, oversight, and technical direction of the selected Contractor. The COTR 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 COTR or his/her designee to review the status of activities, and shall provide periodic oral and written briefings to USAID as appropriate.

8.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.

8.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
2. Deputy Chief of Party
3. Team Leader for Governance
4. Team Leader for Financing
5. Chief Financial Officer

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 Contracting Officer Technical Representative 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.

9. Environmental Requirements

The Contractor shall ensure that all activities and services provided under the TO are consistent with the environmental requirements and procedures for the Activity.

[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 Friday August 28, 2009. **Late proposals will not be considered.**

D. Delivery

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

1. Delivery by Mail
Ms. Doanh Van
Contracting Officer
USAID/Peru
Av. La Encalada S/N
Cdra. 17 Monterrico - Surco
Lima, Peru
Phone No.: (511) 618-1435
Re: RFTOP No. 527-09-002
c/o Ms. Veronica Leo
RCO/Lima

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.

1. 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. Doanh Van (Technical and Cost Proposal)
Internet Address: dvan@usaid.gov

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

Ms. Liliana C. Murguia (Technical and Cost Proposal)
Internet Address: lmurguia@usaid.gov

E. Unnecessarily Elaborate Proposals

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

F. Authority to Obligate the Government

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

G. Task Order Clauses

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

a. Language Requirements

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

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

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 five (05) 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 **20** 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

1. Technical Proposal:

This section provides a clear description of the offerors understanding and general approach to achieve the objectives described in the Scope of Work:

The description of the technical approach to be undertaken by the offeror shall include:

1.1 Technical Approach.

- The proposal should 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.
- It needs to show innovation, feasibility, and synergies of stakeholders while focused towards generating sustainability beyond the task order completion date.
- Should describe the steps to be taken to work toward the sustainability of health reform processes in Peru including actions deemed critical to ensuring an ongoing process of further reforms or system strengthening measures. It also needs to identify critical gaps with respect to potential for sustainability and proposed means for the health sector to continue to address those gaps once the program ends.
- Additionally, the technical approach should recognize external factors which may threaten the ongoing health reform process and propose actions to mitigate these threats.
- The technical approach should be developed such that the Peruvian health sector is assisted in its efforts to extend quality healthcare services to the poor and/or most vulnerable populations.
- At the same time, the technical approach will serve to reinforce and expand the decentralization process in Peru and ensure that the health system reforms provide a sector wide orientation toward primary health care.
- The technical approach must address the role of gender.
- Finally, the technical approach should outline key activities in each of the five health systems building blocks covered by this SOW.

1.2 Performance Monitoring Plan

- A draft of the Performance Monitoring Plan, which includes measurable performance standards and benchmarks against which the program will be evaluated.

1.3 Time Schedule

- A proposed time schedule for the five years of the program.

1.4 Implementation Plan and Logframe

- An implementation plan with measurable key performance standards, benchmarks and suggested results indicators, and target dates to each specific benchmark proposed for the entire estimated period of performance
- The technical proposal should be supported by a Logframe which should summarize the full approach and demonstrate how the activities will achieve the goals of this award and further will delineate measurement factors as well as key assumptions regarding the proposed approaches.

1.5 Draft Annual Workplan:

- The offeror shall include as an attachment a work plan for the first year of implementation as a concrete example of the translation of the logframe and technical approach into an initial plan of action. The plan must explain the methodologies and activities to be undertaken to achieve the specific targets proposed as per section 1.5 *Statement of Work*. The plan shall describe the specific steps that will be taken to achieve the proposed results, by month for the first year. The first three months of the annual workplan will consist of a Start Up and Mobilization section describing how the staff and resources will be quickly mobilized and the activities that will be accomplished,

The workplan shall also discuss how specific implementation activities under the control of the contractor will be monitored and reported, projected expenditures by month, and identify major issues to be addressed;

2. Organizational Capability and Management Plan:

2.1 Organizational Capability

Offerors shall provide a narrative section that demonstrates the offeror's successful management and technical experience and expertise.

As part of their technical proposal, offerors shall discuss their organization's proven capability and capacity to move quickly and effectively to establish a presence in country and move to tackling implementation issues. This should include an organizational strategy for delivering cost-effective technical assistance and training in the regions, while balancing requirements for national-level activities, discussion of ability to coordinate with other projects, relevant civil society groups and donor programs, subcontractors and partners in order to successfully work with host country counterparts. The technical proposal must also present a clear plan to transfer capacity to Peruvians and Peruvian institutions over time and assist the Ministry of Health in identifying mechanisms for accessing local technical assistance as needed after the project ends.

2.2 Management Plan

As part of the technical proposal attachment, offerors shall submit a comprehensive management plan. The management plan shall include:

- A proposed organizational chart and organizational structure as part of the submission package. All staff proposed is required to dedicate 100% of their time to this project. The suggested role and qualifications for key personnel are described below;
- A staffing plan that fits the organizational chart with position descriptions for all key personnel plus any professional-level positions that the offeror proposes. Position descriptions will include specific tasks to be accomplished, roles and responsibilities and required skills and experience;
- A description of the systems and procedures required for successful contract administration;
- Offerors will designate the anticipated level of effort for the proposed life of the Task Order of long-term U.S. and local professionals, short term U.S. and local professionals and all support staff and home office staff, required to implement the technical proposal. This level of effort will be presented in matrix format with any necessary supporting text, in person days; and

3. Personnel

Provide a brief summary of qualifications for the key positions listed below describing their technical capabilities, interpersonal relations, ability to work under difficult circumstances, and the ability to form productive relationships with host country counterparts at the national and local levels. Brief resumes shall be included in the attachment (and will not be counted against the page limit), in addition a list of three references for each, including at least one current or former supervisor with the name, title, organization, nature of professional relationship with the candidate, telephone number and e-mail.

The proposed quality and mix of staffing plan (including provision of short term technical assistance) must possess expertise in planning, managing and evaluating complex health programs in a decentralized context.

The key personnel and other project staff must have collective expert knowledge of: Peru's health sector and the Peruvian context; pending policy issues; Peruvian law and policy affecting the health sector; relevant trends in Peru's regions; and key actors in the sector (e.g., government agencies, universities, health professions associations, relevant civil society organizations).

Specific qualifications for key personnel are:

Chief of Party (COP)

Suggested Role:

- Responsible for the overall technical and managerial leadership of the program.

Qualifications:

- PhD or Master's level education in the area of Public Health, Public Policy, Health Economics, or Management.
- Minimum 10 years of relevant experience working in key health policy efforts, demonstrated experience working with high-level government officials, and experience in at least three of the five Outcomes.
- Minimum 10 years of program management experience.
- Experience in agenda setting, coordination, obtaining support for policy design and carrying-out policy implementation.
- Previous experience as a COP in health-related projects, preferably in health systems strengthening and/or health reform.
- A proven, successful record of achieving results, preferably in a difficult working environment.
- Considerable autonomy and the authority to commit funds and resources during the implementation of the Task Order contract.
- Fluent in both English and Spanish (level 4).

Deputy Chief of Party (DCOP)

Suggested Role:

- Lead analyst in field investigation and responsible for the bulk of the analysis and preparation of the synthesis reports that will be presented to MOH and USAID. Will ensure that these and other program components are results-oriented.
- Primary focus on achieving results in all areas assuring that subcontractors and consultants are poised to deliver services on schedule.
- Establish productive and positive relationships with GOP officials, alliance partners, and implementing partners.

Qualifications:

- PhD or Master's level education in the area of Public Health, Public Policy, Health Economics or Management.
- Minimum of 5 years of relevant experience working in key policy efforts with solid demonstrated experience working with high level officials and experience or work in at least two of the five Outcomes.
- Extensive experience in evaluating, designing and promoting health services and health programs, and in addressing constraints to progress in public health policy implementation.
- Demonstrated ability to create and maintain effective working relations with senior government personnel, non-governmental partners, host country citizens, U.S. and foreign government organizations, donor partners, and the private sector.
- Fluent in Spanish and high level of proficiency in English (level 3).

Team Leader for Governance

Suggested Role:

- Promoting the integration of governance, health financing and health systems operations.

Qualifications:

- PhD or Master's level education in the area of Public Health, Public Policy, Health Economics or Management.
- Minimum five years of relevant experience working in key policy efforts with solid demonstrated experience working with high level officials in the area of health governance, policy and advocacy.
- Experience in the following:
 - At least two (and preferably more) of the following areas: health insurance, public private partnerships, information systems, human resources, and/or decentralization.
 - Strategy-development and policy dialogue in the health sector and in translating such strategies into actions and operations.
 - Conducting special studies, evaluations, comparative analyses, and other research tasks in support of the MOH and other projects.
 - Promoting active engagement of partners and representatives of interest groups (such as professions and service users) in policy debates and developing regulation, building on the existing mechanisms.
- Broad knowledge of health policy social, economic policy issues and health systems issues in Peru.
- Fluent in Spanish and high level of proficiency in English (level 3).

Team Leader for Financing

Suggested Role:

Define alternative health policies to reduce health care costs, to increase access, to enhance quality, and improve health care sustainability and equity.

Qualifications:

- PhD or Master's level education in the area of Health financing or Health Economics.
- Minimum five years of experience in health economics, health financing, applied research, and project monitoring and evaluation for projects.
- Experience in the following:
 - At least two (and preferably more) of the following areas: health insurance, public private partnerships, information systems, and/or decentralization.
 - Working in Peru or other Latin American countries on health economics issues, as well as applied research and project monitoring and evaluation.
- Specific technical expertise in health economics and health sector reforms.
- The TLF should have knowledge of the Peruvian public health care system, including SIS, Essalud and the private health sector.

- Extensive computer and analytical skills, particularly in issues related to monitoring and evaluation.
- Fluent in Spanish and high level of proficiency in English (level 3).

Chief Financial Officer

Suggested Role:

Guarantee the financial management of the activity

Qualifications:

- Post-graduate degree in Accounting or Financial Management and Administration.
- Preferably Chartered Accountant or Certified Public Accountant.
- Minimum five years of experience in financial management, planning, development, management, and administration.
- Minimum five years of experience in accounting and finance.
- Familiar with USAID accounting and financial procedures, including those related to sub-grants and contracts.
- Demonstrated excellence in professional performance.
- Fluent in Spanish and high level of proficiency in English (level 3).

4. Past Performance

The offeror must demonstrated recent and relevant technical and field experience and quality of performance in programs of similar technical content and scope in developing countries, preferably in Latin America. Past performance information must speak to both the timeliness with which the contractor accomplished program objectives and the business relations cultivated to facilitate coordination and problem solving.

Performance information will be used for both, the responsibility determination and best value decision. Information on past performance must be provided in accordance with the following table. USAID may use performance information obtained from other than the sources identified by the offeror/subcontractor. USAID will utilize existing databases of contractor performance information and solicit additional information from the references provided herein and contact the individual(s) indicated as well as others. If the performance information contains negative information on which the offeror has not previously been given an opportunity to comment, USAID will provide the offeror an opportunity to comment on it prior to its consideration in the evaluation.

In cases where an offeror lacks relevant performance history, information on performance is not available, and then the offeror will not be evaluated favorably or unfavorably on performance.

Scope of work summary	Primary location of work	Term of performance	Dollar Value	Contract type & Number	COTR name	COTR e-mail address and Tel. No.

NOTE: USAID relies on the prime organization’s review of partner/subcontractor institutions. However, if deemed necessary to ensure prudent use of USG funds, USAID may conduct its own past performance review of proposed partners/subcontractor institutions.

(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. Briefly summarize in a list format 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, with a minimum total dollar value of \$5 million. 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.

5. The Annex:

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

a) Curriculum Vitae:

The offeror shall provide a resume copy for each Key Personnel. Include at least three work references for each Key Staff.

b) Past Performance:

In *the Annex*, the offeror shall provide the information required in section 4 above. This includes the list of the 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.

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

- a. Resumes/CVs.
- b. Biographical Data
- c. Past Performance information.
- d. Timelines/Chronograms.
- e. Commitment letters
- f. Branding and Marking Plan

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.

Development Focused Budget Table

COMPONENT #	Health System Building Blocks	Year 1	Year 2	Year 3	Year 4	Year 5	Total
0001	HEALTH GOVERNANCE						
0002	HEALTH FINANCING						
0003	HEALTH INFORMATION						
0004	HUMAN RESOURCES						
0005	MEDICAL PRODUCTS, VACCINES AND TECHNOLOGIES MANAGEMENT & LOGISTICS						
Total							

B. Detailed Budget

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

For each health system building Block identified above, offerors are required to include an itemized budget for all input costs in support of those CLINs in accordance with Agency policy. A format sample is provided below.

COMPONENT 001 – HEALTH GOVERNANCE

Total Direct Labor	Year 1	Year 2	Year 3	Year 4	Year 5	Total
1. Salary and Wages						
2. Fringe Benefits						
3. Consultants						
4. Travel, Transp., Per Diem						
5. Equipment and Supplies						
6. Allowances						
7. Other Direct Cost						
8. Overhead						
9. G&A						
10. Material Overhead						
11. Total Estimated Cost						
12 Fixed Fee						
Total						

Additional information for completing the itemized budget:

1. If proposing U.S. staff who shall perform directly under the Task Order, the following information shall be required in the following format:

<u>Name & Proposed Position Title</u>	<u>Number of Work Days</u>	<u>Proposed Daily Rate</u>	<u>Total</u>
Total			_____

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

<u>Name & Proposed Position Title</u>	<u>Number of Work Days</u>	<u>Proposed Base Daily Rate</u>	<u>Total</u>
Total			_____

3. *Other Direct Costs:* A complete breakdown of costs is required, 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 Plan.

IV. INSTRUCTIONS FOR THE PREPARATION OF THE BRANDING IMPLEMENTATION PLAN (BIP) and MARKING PLAN

In accordance with ADS 320.3.2.1, Offerors must prepare a Branding Implementation Plan (BIP) and Marking Plan (MP) to address the Branding Strategy described under Section I.7, and the matrix affixed under Attachment I, Section V of this RFTOP. This is to ensure that the successful offeror's Branding Strategy Implementation Plan and Marking Plan under this task order are in compliance with the "USAID Graphics Standard Manual" available at www.usaid.gov/branding and any successor branding policy, as detailed in ADS Chapter 320.

USAID policy is to require exclusive branding and marking in USAID direct acquisitions. "Exclusive Branding" means that the program is positioned as USAID's, as showcased by the program name (e.g., the USAID Basic Education Program). "Exclusive marking" means contractors may only mark USAID-funded programs, projects, activities, public communications, and commodities with the USAID Standard Graphic Identity and, where applicable, the host-country government or ministry symbol or logo. It is USAID's policy that contractors' and subcontractors' corporate identities or logos may not be used on USAID-funded program and communications materials.

Communications Plan

A Communications Plan shall be developed by the contractor to describe how the Health Policy Reform-Peru (HPR) program will be communicated to beneficiaries and promoted to GOP host-country citizens. It must outline the events and materials the contractor will use to deliver the message that the assistance is from the American people.

In order to be acceptable for award, the contractor's Communications Plan must specifically address the following:

- How to incorporate the message, "This assistance is from the American people," in communications and materials directed to beneficiaries, and an explanation if this is not appropriate or possible.
- How to publicize the program, project or activity in the host-country and a description of the communications tools to be used including press conferences, press releases, site visits, success stories, photographs, etc. and the key milestones

anticipated to generate awareness and an explanation if this is not appropriate or possible.

Marking Plan

The contractor must also include a Marking Plan that details the public communications, commodities, and program materials and other items that visibly bear or will be marked with the USAID Identity. USAID policy is that programs, projects, activities, public communications, or commodities implemented or delivered under contracts and subcontracts exclusively funded by USAID are marked exclusively with the USAID Identity, and, where applicable, with the host-country symbol or ministry logo. Except for the manufacturer's trade mark on a commercial item, the corporate identities or logos of contractors or subcontractors are not permitted on USAID-funded program materials and communications, unless specified in the [USAID Graphic Standards Manual](#) or approved in advance by the COTR. The COTR must obtain clearance from the Senior Advisor for Brand Management before approving the use of the contractor's logo

To ensure that all items are appropriately marked in accordance with this policy, all USAID direct contracts must incorporate a Marking Plan that details the public communications, commodities, and program materials and other items that will bear visibly the USAID Identity.

Marking Requirements for Specific Contract Deliverables

The contractor must list the contract deliverables to be marked with the USAID Identity. These deliverables must follow design guidance for color, type, and layout in the [Graphic Standards Manual](#). Specifically, the contractor must address the following as applicable:

- a.** Commodities or equipment provided under humanitarian assistance, disaster relief or development programs, and all other commodities and equipment funded by USAID contracts, and their export packaging, must prominently display the USAID Identity.
- b.** Program, project, or activity sites financed by USAID contracts, including visible infrastructure projects (roads, bridges, buildings, etc.) or other programs, projects, and activities that are physical in nature (agriculture, forestry, water management, etc.), must prominently display the USAID Identity. Temporary signs must be erected early in the construction or implementation phase. When construction or implementation is complete, a permanent, durable sign, plaque, or other marking must be installed.
- c.** Public communications, letterhead, websites, studies, reports, publications, informational and promotional products such as brochures, audiovisual productions, and public service announcements provided or produced under the USAID contract, whether program or operating expense-funded, must be marked with, or carry, the

USAID Identity. Radio spots must include an audio tag, such as, “made possible by USAID: From the American people.”

d. Studies, reports, publications, websites, and all informational and promotional products not authored, reviewed, or edited by USAID must contain a provision substantially as follows:

This study/report/website (specify) is made possible by the generous support of the American People through the United States Agency for International Development (USAID.) The contents of this (specify) are the sole responsibility of <name of organization> and do not necessarily reflect the views of USAID or the United States Government.

e. Training courses, conferences, seminars, briefings, exhibitions, fairs, workshops, press conferences, and other public activities, and invitations, press releases, publicity and media materials associated with these events, that are produced under a USAID direct contract must be marked with the USAID Identity. Unless directly prohibited and as appropriate to the surroundings, contractors must display additional materials such as signs and banners with the USAID Identity.

f. USAID reserves the right to request preproduction review of USAID-funded public communications and program materials for compliance with USAID graphic standards and the approved Marking Plan.

V. 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 Government of the United States (the “Government”), cost and technical factors considered. The Government will make a determination of probable cost as provided by the Federal Acquisition Regulation. The Offeror’s proposed total estimated cost will be carefully evaluated for reasonableness, completeness, credibility and realism, and the Government reserves the right to adjust the proposed total estimated cost based on this assessment. Although cost and price will not be scored, the results of the cost evaluation shall be carefully considered in determining best value to the Government.

Technical factors will be scored. 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 requirements of the Request for Task Order Proposals (RFTOP). All proposals will be evaluated pursuant to the criteria below.

1. TECHNICAL PROPOSAL

A. Technical Approach

(45 points total)

Subfactor A-1: The technical approach is comprehensive, prioritized, and technically sound and includes program activities in each of the five health systems building blocks covered in this RFTOP. The technical approach reflects an understanding of U.S. Foreign Assistance priorities and health reform processes in Peru, including specific recognition of: the steps necessary to further the sustainability of health reform processes in Peru, with a focus on specific actions critical to ensuring continuing reform; identified threats, including any external factors, to sustainability and a strategy for the health sector to continue to address these threats during Task Order implementation and once the program ends. (20 points)

Subfactor A-2: The technical approach, Annual Work Plan, Logframe and PMP are logical and show clear linkages between proposed program activities and the achievement of the Expected Results within the timeframe of the Task Order. The Workplan shall clearly demonstrate an ability to mobilize quickly while coordinating an efficient structure between offices through clearly defined roles and responsibilities. (15 points)

Subfactor A-3: The technical approach reinforces and strengthens the decentralization process in Peru and ensures that primary health care is at the center of health system reforms, including a focus on the poor and most vulnerable populations. The proposal allows flexibility to adapt to changing circumstances. (5 points)

Subfactor A-4: Technical proposal demonstrates how gender considerations are

factored into the program, how gender relations affect the achievement of sustainable results, and how the results affect the relative status of men and women. (5 points)

B. Organizational Capability and Management Plan (25 points total)

Subfactor B-1: The proposal presents a clear and efficient management plan and organizational structure for accomplishing all aspects of the Task Order implementation; one that clearly demonstrates an ability to mobilize quickly while coordinating an efficient structure between offices through clearly defined roles and responsibilities; clarity and appropriateness of overall structure and staffing plan, including all long-term, short-term, local and headquarters personnel. (15 points)

Subfactor B-2: Proposed sub-contractors and local partners possess complementary skills; the proposal demonstrates that those skills will be fully utilized in the implementation of the Task Order; and the management structure allows for efficient oversight of partner institutions. (5 points)

Subfactor B-3: The proposed management approach promotes the progressive transfer of skills and responsibilities to Peruvian individuals and institutions; and demonstrates capacity to implement competently USAID policies and procedures. (5 points)

C. Key Personnel (20 points total)

Subfactor C-1: The Chief of Party and other key personnel have demonstrated expertise in health reform processes and influencing health policy and program decisions among senior-level officials; and have the required competencies to effectively and efficiently manage the program. (10 points)

Subfactor C-2: The quality and mix of staffing plan (including provision of short term technical assistance) represents an appropriate mix of staff to successfully undertake the proposed technical approach; key project personnel demonstrate expertise in planning, managing and evaluating complex health programs in a decentralized context. (5 points)

Subfactor C-3: The key personnel and other project staff have collective expert knowledge of: Peru's health sector and the Peruvian context; pending policy issues; Peruvian law and policy affecting the health sector; relevant trends in Peru's regions; and key actors in the sector (e.g., government agencies, universities, health professions associations, relevant civil society organizations). (5 points)

D. Past Performance (10 points total)

Subfactor D-1: Relevant Experience: Demonstrated recent and relevant technical and field experience and quality of performance in programs of similar technical content and scope in developing countries, preferably in Latin America. (4 points)

Subfactor D-2: Timeliness: Timeliness of performance, including adherence to contracting schedules and other time-sensitive project conditions, and effectiveness of home office field management to make prompt decisions and ensure efficient operation of tasks. (3 points)

Subfactor D-3: Business Relations: Customer satisfaction, including satisfactory business relationship with clients, coordination among partners, and prompt and satisfactory correction of problems if and when they arose. (3 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);
6. USAID/Washington has acquired EEO Clearances for each prime contractor; and
7. Certification Regarding Terrorist Financing.

[END OF SECTION IV]

SECTION V – ATTACHMENTS

**ATTACHMENT 1
 MATRIX – BRANDING/MARKING PLAN FOR CONTRACTS**

BRANDING / MARKING PLAN for CONTRACTS

Contract #XXX-X-XX-XXXXX-00 (Activity Name, Contract Partner)

ATTACHMENT #1

Table #1: Synopsis of Items Affected by USAID Marking/Branding Regulations (ADS 320)

Complete the following chart with all items in this plan that will be affected by the USAID/Marking/Branding Regulations (ADS 320) and provide appropriate code. In some cases, multiple codes may apply:

Marking Codes: M = Marked U=Unmarked E = Exception W=Waiver

Important note: Marking Codes U Marking Codes PE need further explanation in Table 2.
 Marking Codes with W requires a Waiver from the Principal Officer (i.e. Mission Director in the field, Policy in Washington)

<i>Item</i>	<i>Type of USAID marking</i>	<i>Current Status of Marking</i>	<i>Marking Code</i>	<i>Locations affected/ Explanation for any 'U'</i>

* ADS 320.3.1.5 states: USAID contractors and recipients must not use the USAID Identity on any communications that are strictly administrative, rather than programmatic, in nature. Examples of administrative communications include, but are not limited to, correspondence with the cooperating government concerning contractor compliance with local law, such as the administration of tax, customs, or other provisions. The USAID Identity is also prohibited on contractor and recipient communications related to award administration, such as hiring/firing staff or renting office space and/or equipment. USAID COTRs, COs/AOs and RLAs are available to advise **partners** about USAID’s implementation of USAID framework bilateral and other agreements with the cooperating country government.

** ADS 320.3.1.6 states: It is USAID policy to prohibit the use of the USAID Identity on contractor and recipient business cards. At their option, contractors and recipients may include wording on their employees’ business cards (“USAID Contractor” or “USAID Grantee” as appropriate) to identify that the employee is working on a USAID-funded activity. In addition, if the contractor or grantee elects to identify the employee as stated above, they may also, at their option, include the USAID program name (see **320.3.2** or **22 CFR 226.91 (f)**). However, business cards must not use the USAID Identity and designs and layouts used must make it clear that the employee is not a USAID employee.

BRANDING / MARKING PLAN for CONTRACTS
Contract #XXX-X-XX-XXXXX-00 (Activity Name, Contract Partner)

Table #2: REQUEST FOR EXCEPTIONS

Determine the correct exception that you wish to request in the chart below and complete the country(ies) listing and explanation for approval by the Contract Officer.

Exception 320.3.2.5 (a)		Guidelines for addressing exception
Compromise the intrinsic independence or neutrality of a program or materials where independence or neutrality is an inherent aspect of the program and materials. This includes, but is not limited, the following: 1) election monitoring or ballots, and voter information literature; 2) political party support or public policy advocacy or reform; 3) independent media, such as television and radio broadcasts and newspaper articles and editorials; and, PSAs or public opinion polls and surveys.		Identify the USAID Strategic Objective, Interim Result, or program goal furthered by an appearance of neutrality, or state why the program, project, activity, commodity, or communication is 'intrinsically neutral.' Identify, by category or deliverable item, examples of program materials funded under the award for which you are seeking the exception.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (b)		Guidelines for addressing exception
Diminish the credibility of audits, reports, analyses, studies and policy recommendations whose data or findings must be seen as independent		State what data, studies, or other deliverables will be produced under the USAID funded award, and explain why the data, studies, or deliverables must be seen as credible.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (c)		Guidelines for addressing exception
Undercut host-country government "ownership" of constitutions, laws regulations,, policies, studies, assessments, reports, publications, surveys or audits, PSAs, or other communications better positioned as "by" or "from" a cooperating country ministry, organization or government official.		Identify the item or media product produced under the USAID funded award, and explain why each item or product, or category of item and product, is better positioned as an item or product produced by the cooperating country government.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (d)		Guidelines for addressing exception
Impair the functionality of an item, such as sterilized equipment or spare parts.		Identify the item or commodity to be marked, or categories of items or commodities, and explain how marking

		would impair the item's or commodity's functionality.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (e)		Guidelines for addressing exception
Incur substantial costs or be impractical, such as items too small or other otherwise unsuited for individual marking, such as food in bulk.		Explain why marking would not be cost beneficial or practical.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (f)		Guidelines for addressing exception
Offend local cultural or social norms,, or be considered inappropriate on such items as condoms, toilets, bed pans, or similar commodities		Identify the relevant cultural or social norm, and explain why marking would violate that norm or otherwise be inappropriate
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (g)		Guidelines for addressing exception
Conflict with international law, such as the international recognized neutrality of the International Red Cross (IRC) or other organizations.		Identify the applicable international law that is conflicted by marking.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

Exception 320.3.2.5 (h)		Guidelines for addressing exception
Deter achievement of program goals, such as cooperating with other donors or ensuring repayment of loans		Identify the applicable program goals and identify other donors or explain how marking will deter achievement.
<i>Country(ies):</i>	<i>Item: Description</i>	<i>Explanation:</i>

REQUEST FOR WAIVERS FOR CONTRACTS

ADS 320.3.2.6 Waivers are approved by the Principal Officer. Waivers are determined on the following criteria:

“The USAID Principal Officer has this authority to waive, in whole or in part, USAID marking requirements. The Principal Officer may only exercise this authority if he/she determines that USAID-required markings would pose compelling political, safety, or security concerns, or that marking has had or will have an adverse reaction in the cooperating country. In exception circumstances, the Principal Officer may approve a blanket waiver by region or country.” Please see ADS 320.3.2.6 for more information on waivers.

Contract Officers (CO) do not make waivers. However, only the CO has the authority to inform the contractor of a waiver decision and to direct the contractor to comply with it. A waiver decision may constitute a change to the contract terms and conditions, and only the CO has the authority to issue a change order to the contract. USAID contractors may request waivers of the Marking Plan, in whole or in part, through the CO, with the COTR then assisting in processing a waiver request to the Principal Officer.

[END OF SECTION V - ANNEX]

[END OF RFTOP NO.527-09-002]