ATTACHMENT 1

DESCRIPTION/SPECIFICATIONS/STATEMENT OF WORK

I. PROJECT SUMMARY

The purpose of this Project is to assist the Department of Health (DOH), the Department of Labor and Employment (DOLE) and the Local Government Units (LGUs) engage and mobilize private sector resources in the delivery of family planning and maternal and child health services and products. The implementation of PRISM II will focus on three major areas: 1) increasing and sustaining private sector provision of quality family planning and maternal and child health services and products through the workplace, private midwives and other health providers as appropriate; 2) increasing utilization of quality FP and MCH services and products in and from the private sector by providing health information to communities and marketing products and services; and 3) improving the policy environment for the private sector by providing technical assistance on licensing and accreditation and strengthening the government's capacity for engaging the private sector in the provision of health services and products. PRISM II will also support cross-cutting efforts such as alliance building, advocacy and institutional development. PRISM II will be implemented in all U.S. Government (USG) assisted sites listed in Section V herein.

II. BACKGROUND AND OVERVIEW

A. Demographic Profile

The 2007 Philippine population, according to the National Statistics Office, was 88.5 million. The projected annual population growth rate for the period 2005 to 2007 was 1.95 percent based on the 2000 Census of Population and Housing. The 2007 and 2000 census figures, however, are translated into an average annual population growth rate of 2.04 percent for the period 2000 to 2007. [Population Census 2007].

B. Maternal and Child Health Status in the Philippines

1. Fertility Trends - The current fertility rate, according to the National Demographic Health Survey (NDHS) 2008 preliminary results, is at 3.3. The NDHS 2008 also reports that fertility levels in the Philippines declined gradually in the last 15 years. The declines in the fertility rates of women 25 to 34 years have continued to be more noticeable. The fertility rates of women 15-19 and 45-49 have remained almost unchanged in the last 15 years while the rate of birth remains higher among women aged 25 to 29.

2. Maternal Mortality Trends - According to the 2006 FPS, the maternal mortality ratio for the seven-year period prior to the survey was 162 deaths per 100,000 births. This implies a slight decline from the level of about 172 estimated from the 1998 NDHS. However, because of the 95 percent confidence intervals around the point estimates of the two surveys, the apparent decline cannot be considered statistically significant. The 2008 NDHS did not collect maternal mortality data.

3. Infant and Child Mortality Trends - Preliminary results of the NDHS 2008 show that there has been a decline in under-five mortality rate in 15 years, from 54 deaths per 1,000 live births during the period 1988-1992 to 34 deaths per 1,000 live births in the period 2003-2007. The infant mortality rate has declined, from 34 deaths per 1,000 live births to 25 deaths per 1,000 live births.

4. Immunization of Children - The 2008 NDHS preliminary report shows that overall, 80 percent of children ages 12-23 months have received all of the recommended vaccinations. Immunization coverage is generally high for each type of vaccine: 94 percent of children have received the BCG vaccination, 93 percent have received the first DPT dose, and 92 percent have received the first polio

dose. Coverage against measles is 84 percent. Only 6 percent of children have not received any immunization, a decrease from 8 percent of children not immunized in 2003.

5. Nutritional Status of Infant and Children - The 6th National Nutrition Survey 2008 initial results show that among children under age five, 27.6 percent are underweight and 1.4 percent are overweight. Among pregnant and lactating women, 26.6 percent and 11.7 percent, respectively, are underweight. The prevalence of anemia among 6 months to below 1 year and 1 year and 11 months old children is at 66 percent and 53 percent, respectively. The prevalence of anemia among pregnant and lactating women is at 43.9 percent and 42.2 percent, respectively.

The 2008 NDHS results show that 8 percent of infants under two months old are not breastfed. Furthermore, only 34 percent of infants under 6 months old are being exclusively breastfed, most are mixed fed with other milk or plain water or given complementary feeding. By age 6-9 months, only 63 percent of infants are being breastfed with 58 percent receiving complementary food. The 6th National Nutrition Survey initial results show that 99 percent of households consume foods with the Sangkap Pinoy Seal. Eighty percent of households (mothers) claim they are aware of iodized salt, but only 38 percent actually use iodized salt. The proportion of households whose salt tested positive for iodine is 56.4 percent.

6. Childhood Illness - Acute respiratory illness (ARI), malaria and dehydration from diarrhea are the major causes of childhood mortality. In the 2008 NDHS, mothers were asked whether each child under age five had experienced cough with short, rapid breathing (symptoms of ARI), fever (symptom of malaria), or diarrhea in the two weeks prior to the survey and the treatment given to those who experienced the symptom. The survey results show that treatment was sought from a health facility or health provider for 50 percent of children with symptoms of ARI in the two weeks before the survey. The survey results also show that treatment was sought for 34 percent of children under age five who are reported to have had diarrhea in the two weeks prior to the survey, and 47 percent were given solutions prepared from packets of oral rehydration salts (ORS). Fifty-nine percent of children with diarrhea were given oral rehydration therapy (ORT), which includes solution prepared from ORS and recommended homemade fluids.

C. The Philippine Health Care System - The health care system in the Philippines consists of two sectors: the public and the private.

1. *The Public Sector -* The public sector consists of the Department of Health (DOH), the local government units (LGUs) and other national government agencies providing health services, such as the Department of Labor and Employment (DOLE) and the Department of Education (DepEd). As the lead agency in health, the DOH provides national policy directions and develops national plans, technical standards and guidelines on health. It has a network of 17 regional offices, called the Centers for Health Development (CHDs). (The Autonomous Region in Muslim Mindanao or ARMM has its own DOH, which is autonomous from the national DOH.) The DOH maintains specialty hospitals, regional hospitals and medical centers. It also maintains provincial health teams made up of DOH representatives assigned to LGUs.

   The LGUs are responsible for the delivery of basic health services at the primary and secondary levels of health care. The provincial governments manage provincial and district hospitals, city governments manage city hospitals, main health centers and barangay health stations (BHSs), and municipal governments manage the rural health units (RHUs) and the BHSs.

2. *The Private Sector -* The National Objectives for Health (NOH) 2005-2010 defines the contribution of private sector from both for-profit and non-profit providers, focusing on those who are market-oriented and where health care is paid through user fees at the point of service.

3. *The Philippine Health Insurance -* The Philippine Health Insurance Corporation (PHIC) is the government agency responsible for managing the national health insurance program (PhilHealth). As such, it is a major source of financing health services through its various benefit packages including the maternal care package for normal deliveries and the new born screening package.

D. FOURmula One for Health - Formulated in 2005, FOURmula One for Health is the guiding implementation framework for health sector reforms. Health interventions are implemented as a consolidated package, supported by effective management infrastructure and financing arrangements. The entire health sector (public and private, national and local, the donor community and civil society) are engaged in the implementation of health reforms.

FOURmula One for Health aims to achieve the following goals:

- Better health outcomes;
- More responsive health system; and
- More equitable health care financing.

It has four critical components:

- **financing**, intended to secure more, better and sustained investment in health;
- **regulation**, intended to assure access to quality and affordable health goods and services;
- **service delivery**, intended to improve the accessibility to and availability of basic and essential health packages; and
- **governance in health**, intended to adopt a sector-wide development in order to improve performance of the health system at national and local levels.

E. Overview of USAID/Philippines Assistance

USAID has been providing development assistance in the health sector since 1970. To date the US and the Philippine governments have signed a total of seven bilateral agreements and one Memorandum of Understanding for the health sector. The current bilateral agreement was signed in 2006 for the achievement of the Health Program Area of "Improved Family Health Sustainably Achieved".

USAID's assistance in the health sector had been used to support implementation of such public health programs as reproductive health, maternal and child health, TB treatment, and HIV-AIDS prevention and control; training of thousands of health workers and community volunteers; development and production of communication materials; procurement and distribution of health commodities and supplies; conduct of demographic and health surveys; and upgrading of management information system.

In response to devolution, USAID assistance was used to enhance the capacity of local governments in managing devolved and integrated health services, and to strengthen key management and logistics systems at the LGUs.

In support to the Philippine Government's contraceptive self-reliance initiative, in October 2002, USAID developed its phase-out plan which included the gradual reduction of donated contraceptives (condoms, pills, injectables, and IUDs), and supporting the development of the private sector as a major player in the provision of health services and commodities. The phase-out timeline was developed to ensure that enough supplies remained available to provide a safety net for the poor and that both public and the private sectors had adequate time to make necessary policy changes and to put systems in place to achieve contraceptive self-reliance. In February 2003, the USAID phase-out began with the last shipment of condoms. The last shipment of pills and injectables were in June 2006 and June 2007, respectively. The USAID contraceptive donation phase-out will be completed this year with the last shipment of IUDs.

F. USAID Private Initiatives on Family Planning and Maternal and Child Health.

In several of the Philippine Health Department's family planning and maternal and child health programs, USAID has supported private sector involvement as part of its package of assistance. Past and current initiatives at expanding private sector involvement in family planning and maternal and child health have mainly been in the areas of social marketing, workplace health programs and establishing midwife clinics and birthing homes. USAID support to social marketing began in early 1993 with the Social Marketing for Change (SOMARC) program that assisted three pill manufacturers, Schering, Wyeth and Organon, sell their products with retail price ceilings. Under the SOMARC program, the participating manufacturing companies marketed their products under a common brand name called "Couples Choice".

Later in 2002, USAID started to develop its plans for phasing-out of its contraceptive donations to support the government's Contraceptive Self-Reliance Initiative. USAID provided funds to DKT Philippines to introduce low-priced pills and injectables into the market to provide affordable alternatives to the donated supplies which started to be phased-out in 2003. Earlier support to expanding accessibility of family planning and maternal and child health services through the private sector included assistance through the Philippine Council for Population and Development (PCPD) in establishing family planning programs in selected companies, support to the establishment of a network of midwife clinics branded as Well Family Midwife Clinics and support to FriendlyCare Foundation Inc. in establishing family health clinics. USAID also supported initiatives through the Commercial Markets Strategies (CMS) program to test the viability of implementing a broader private sector program that addresses policy and financing issues and the need for increasing private sector investment for health, in addition to the technical aspect of delivering services and products.

In 2004, USAID launched a five-year Private Sector Mobilization Project for Family Health Project (PRISM) to mobilize the private sector in the delivery of health services. The initial focus of the PRISM Project was family planning. On the third year of implementation, maternal and child health was integrated into the PRISM scope of work. PRISM has three main project components, that is, workplace initiatives, market development, and private practice initiatives. The workplace initiatives component aims to increase support for FP and MCH services within the formal employment sector by developing models for workplace-based FP and MCH services and implementing them in companies of different kinds and at different locations. The market development component aims to establish viable mass market brands of oral and injectable contraceptives, intra-uterine devices (IUD), and selected MCH products in the commercial sector by supporting the introduction and marketing of new low cost contraceptives and selected MCH products by pharmaceutical companies. The objective of the private practice initiatives component is to increase the business value of FP and MCH services in private providers' practice by increasing the number of midwives with self-sustaining private birthing homes and Philhealth accreditation.

G. Challenges and Opportunities

1. *The Sectoral Context -* The DOH recognizes the importance of private sector contributions in pursuing the National Objectives for Health (NOH) 2005-2010. In the NOH document, the DOH characterizes the cooperation between the public and private sector as poor or not present. The DOH F1 framework includes private sector as a cross cutting theme in the four pillars of F1. Several administrative orders and other policy instruments have been issued that are relevant to private sector delivery of services and products. Some of these are:
   - DOH AO 29 s2008, signed in September 2008, on implementing health reforms for rapid reduction of maternal and neonatal mortality (or the MNCHN AO).
   - DOH Memorandum 2008-62, signed in March 2008, which reiterates support to expand private midwives functions in maternal child health delivery.

- DOH AO 2006-08, signed in May 2006, which describes the guidelines on public-private collaboration in delivery of health services including family planning for women of reproductive age.
- DOH AO 2007-0045, signed in December 2007, mandating zinc supplementation and reformulated oral rehydration salt in the management of diarrhea among children.
- DOH AO 158 s2004, signed in July 2004, which describes the guidelines on the management of donated commodities under the CSR strategy.
- DOH AO 50-A s2001, signed in September 2001, which describes the National Family Planning Policy that includes market segmentation.

In addition, in 2007, the DOH signed a joint Memorandum of Understanding with the Department of Labor and Employment (DOLE) and later issued DOH AO No. 12, s2008 describing the DOH Partnership with DOLE for strengthening support for workplace health programs. The DOLE, likewise, issued an equivalent department memorandum for expanding workplace health programs. However, despite all these issuances, improving the policy environment for private sector provision of family planning and maternal and child health still remains a challenge. DOH's strategy for a conscious and systematic effort of mobilizing the private sector is not yet clear and the operating mechanisms and structures to implement these administrative orders and other policy instruments have yet to be developed.

The DOH budget for family planning and maternal and child health has significantly increased in the last two years. While the DOH does not have a specific line item for procurement of contraceptives, the General Appropriations Act of 2008 has an earmark in the DOH budget of US$43,478,260 (PhP2 Billion) for contraceptives and related training, promotional and other costs. US$26,087,000 (PhP1.2 Billion) of this earmark is for contraceptives and downloaded to the LGUs to facilitate LGU procurement of contraceptives. The guidelines for operationalizing this financing mechanism, while already developed, have yet to be fully understood by DOH CHD staff and have yet to be uniformly applied across regions, with the exemption of ARMM where guidelines may have to be adjusted to respond to realities in the region.

PhilHealth provides a viable source for financing family planning and maternal and health services and products. The range of PhilHealth benefit packages include a maternity care package for normal deliveries that includes the first cycle of oral contraceptives, the first dose of injectable contraceptive postpartum, and the first dose of BCG for the infant. Philhealth also covers IUD insertion and voluntary sterilization. PhilHealth benefit packages also include a newborn care package that covers the cost of newborn screening. However, utilization of these benefit packages remains low. Furthermore, the issues on accreditation and reimbursement still need to be addressed.

At the local level, a number of LGUs have budgets for family planning and maternal and child health, including the procurement of contraceptives and essential maternal and child health drugs and supplies. This makes the LGU a significant market for private sector products. However, issues around procurement and willingness of suppliers to serve the LGU market still need to be addressed. Equally important is the availability of private sector providers in the community. While these are available, there is very little appreciation of the role of private sector in the delivery of basic public health services. Hence, the private sector is rarely tapped for family planning and maternal and child health services and local environments for private sector practice are not always favorable. Local policies for mobilizing the private sector in the delivery of public health still need to be developed and regulating systems are not strong.

Another challenge that the Project will be faced with is strengthening working relationships among national and local government agencies and institutions, such as DOH, DOLE, PHIC, and LGUs, to increase private sector engagement.

USAID has a wide experience in developing models for private sector service and product delivery which can be utilized to inform public policies and develop a sector-wide approach for FP and MCH provision.

However, scaling up of these initiatives to achieve critical mass is a major challenge. Likewise, transferring the capacity to provide technical assistance to the DOH, DOLE, LGUs and other national and local partners and obtaining commitment from these partners remains a challenge.

H. Problem Statement

While fertility rate may show a decline, the contraceptive prevalence rate has not changed significantly. The trend of contraceptive use in the country is summarized in Table 1 below. While not conclusive because of lack of accurate data, this implies that some pregnancies may have ended in abortions, spontaneous or induced. While year-to-year variations are not significant, modern methods show a decreasing trend while use of traditional methods is increasing. Almost half of the women surveyed in 2007 (as reported in the 2008 NDHS Preliminary Results) were not using any method, even as many of them have a desire to control the number and timing of their births. Fifty-four percent of women want no more children, while others stated that they would like to wait two or more years to have their next child.

Table 1. Percentage of currently married women aged 15 to 49 years using modern and traditional methods of, Philippines: 1968-2008

Survey	Total	Modern Method*	Traditional Method*
1968 National Demographic Survey*	15.4	2.9	12.5
1973 National Demographic Survey*	17.4	10.7	6.7
1978 Republic of the Philippines Fertility Survey*	38.5	17.2	21.3
1983 National Demographic Survey*	32.0	18.9	13.3
1988 National Demographic Survey*	36.1	21.6	14.5
1993 National Demographic Survey*	40.0	24.9	15.1
1995 Family Planning Survey	50.7	25.5	25.2
1996 Family Planning Survey	48.1	30.2	17.9
1997 Family Planning Survey	47.0	30.9	16.1
1998 National Demographic and Health Survey	46.5	28.2	18.3
1999 Family Planning Survey	49.3	32.4	16.9
2000 Family Planning Survey	47.0	32.3	14.7
2001 Family Planning Survey	49.5	33.1	16.4
2002 Family Planning Survey	48.8	35.1	13.8
2003 National Demographic and Health Survey	48.9	33.4	15.5
2004 Family Planning Survey	49.3	35.1	14.2
2005 Family Planning Survey	49.3	36.0	13.2
2006 Family Planning Survey	50.6	35.9	14.8
2008 National Demographic and Health Survey	50.7	34.0	16.7

Notes: *Based on currently married women aged 15 to 44 years
*Modern methods refers to pill, IUD, injection, diaphragm/foam/jelly/cream, male condom, ligation/female sterilization, vasectomy/male sterilization, mucus/billings/ovulation, basal body temperature, lactational amenorrhea method (LAM) and Standard Days Method (SDM)
*Traditional methods refers to calendar/rhythm/periodic abstinence and withdrawal

Source: National Statistics Office (NSO), 1996-1997, 1999-2002, 2004-2006 Family Planning Surveys; NSO and Macro International, 1993 NDS, Table 4.5; NSO, DOH and Macro International, 1998 NDHS, Table 4.5; NSO and Macro International, 2003 NDHS, Table 5.5; NSO, DOH and Macro International 2008 NDHS Preliminary Report, Table 5.

The maternal mortality ratio has not declined significantly. The Philippine Health Statistics 2003 reports the main causes of maternal mortality as: (1) other complications related to pregnancy occurring in the course of labor, delivery and puerperium; (2) hypertension complicating pregnancy, childbirth and puerperium; (3) postpartum hemorrhage; and (4) pregnancy with abortive outcome. While national statistics show a high percentage (91 percent reported in the 2008 NDHS) of mothers receiving antenatal care from health professionals, there are variations across regions. While infant mortality has decreased, neonatal tetanus continues to be a major cause of infant deaths. Seventy-five percent of mothers received tetanus toxoid (TT) injections during pregnancy. This implies that not all mothers who

received antenatal care were given TT injections. This is compounded by poor nutrition during pregnancy. In addition, only 62 percent of births are attended by health professionals and an even lesser 44 percent take place in a health facility. This represents very little improvement since 2003, when 60 percent of births were attended by health professionals and 38 percent took place in health facilities. These factors that are contributing to maternal and infant deaths could be averted or minimized if pregnancies are planned, there is access to trained providers and birthing facilities, and mothers are informed on proper maternal and neonatal care practices.

While immunization coverage for the first dose is high for each type of vaccine, it is not sustained with subsequent doses. The recommendation on immunization is for children to receive all the basic vaccines before the child reaches age one, which is not currently happening. Data from the 2008 NDHS show that only 70 percent of children have been fully immunized before reaching age one. Information on the benefits of immunization and compliance with health care standards could improve immunization coverage.

Malnutrition in the Philippines is most common in the first two years of life. During this stage of child growth and development, key child feeding practices are established, such as breastfeeding, followed by the introduction of safe and adequate complementary feeding. However, breastfeeding is not universal in the Philippines. The 2008 NDHS reports that only 34 percent of infants aged six months and below are exclusively breastfed. The coverage of Vitamin A supplementation, while it has showed an increase in 2006 (73.9 percent in 2005 and 78.4 percent in 2006) it is still low compared to previous years (87.6 percent in 2004). The consumption of foods with the Sangkap Pinoy Seal may be high, but most households don't know what the Sangkap Pinoy Seal is. Clearly there is a need to increase client and consumer knowledge on the importance of proper infant and child nutrition, especially on the benefits of breastfeeding and consuming fortified food.

Traditionally, health services are mainly provided through the public sector. The long-standing dominance of a public-sector-only model of service and product delivery has created market conditions that are unfavorable to a more vigorous commercial response among private providers capable of meeting the population's need for family planning and maternal and child health. Despite major efforts by the public sector in implementing family planning programs in the last forty years, only about half of the need for contraceptives has been met and only one-third of those using contraception are using modern methods. Until five years ago the private sector contribution was not even one-third of modern contraceptive use; and there is no systematic approach to recognize, much less encourage, private sector participation in maternal and child health service and product delivery.

USAID's support to increasing private sector participation has, in past years, generated positive results. Under the Well Family Midwife Clinic and PRISM projects, models and technical assistance packages have been developed to establish viable community private midwife clinics and birthing homes that offer quality and low-priced family planning and maternal and child health services. Under PRISM alone, around 200 midwife-owned birthing homes have been assisted in obtaining accreditation and improving their business. PRISM also developed various models of workplace health programs, including in ARMM, which can be used as vehicles for provision of FP and MCH services in the locality. Over 500 workplace-based family health programs were established reaching over 300,000 employees in the formal sector and large cooperatives. Through DKT and PRISM, 7 new oral and injectable contraceptives and 1 repriced oral contraceptive were introduced; affecting an increase in the total market for pills and injectables, with USAID supported products as market leaders. Finally, through PRISM, a new IUD brand and a new zinc tablet will soon be available in the Philippine market. The 2004, 2005 and 2006 Family Planning Survey results showed a significantly increasing trend of modern contraceptives obtained from private sector sources (32.8 percent, 35.6 percent and 40.7 percent in 2004, 2005 and 2006, respectively). While the increases are significant, they are not enough to affect the national figures for contraceptive use. There is a need for scaling up interventions developed and implemented with USAID support to significantly contribute to the achievement of national goals for family planning and maternal and child health as means to reducing maternal, infant and child mortality.

III. STATEMENT OF WORK

A. Project Objectives

The objectives of the "Private Sector Mobilization for Family Health" Project – Phase 2 (PRISM 2) are:

1. increase and sustain private sector provision of quality family planning and maternal and child health services and products;
2. increase utilization of quality family planning and maternal and child health services and products in and from the private sector; and
3. improve the policy environment for private sector provision of services and products.

While it is anticipated that PRISM 2 will impact on both public and private health sectors, the project will focus on results contributed by the private sector or those generated by utilizing private sector practices.

B. Expected Results and Indicators

PRISM 2 will be implemented within a period of five years, with nationwide coverage. The success of the project will be measured by a set of quantitative outcome, input and process indicators enumerated below.

B.1 Outcome Indicators

a. Increased CPR for modern methods obtained from private sector sources from a baseline of 34 percent in 2009* to 39 percent in 2014.
b. Increased share of deliveries attended by skilled birth attendants from a baseline of 62 percent in 2009* to 70 percent in 2014.
c. Increased contraceptive market for pills by 2 percent annually.
d. Increased contraceptive market for injectables by 6 percent annually.

* 2008 NDHS figure

B.2 Input indicators

<u>Family planning</u>

a. Number of people that have seen/heard family planning messages.
b. Number of people counseled.
c. Couple Years Protection
d. Funds leveraged for family planning/reproductive health

e. Number of people trained in family planning with USG funds.
f. Number of people trained in strategic information management with USG assistance.

<u>Maternal and child health</u>

a. Number of deliveries assisted by skilled birth attendants through USG-assisted programs.
b. No. of people trained in maternal/newborn health through USG-supported health programs.
c. Number of people trained in maternal/newborn health through USG-approved programs.
d. Number of cases of child diarrhea treated in USG-assisted programs.
e. Number of cases of child pneumonia treated with antibiotics by trained health workers in USG-assisted programs.
f. Number of children under 12 months old who received DPT3 from USG-assisted programs.
g. Number of people under 5 years of age who received Vitamin A from USG-supported programs.
h. Number of people trained in strategic information management with USG assistance.
i. Amount of Philhealth reimbursements under the Maternity Care Package for USG-assisted private providers/facilities.

Annual targets for the above input indicators will be jointly developed and agreed upon by USAID and the Contractor in the course of implementation.

B.3 Process Indicators

a. Increased number of workplace family planning and maternal and child health programs that include health information dissemination, counseling, service provision and referrals.
b. Increased proportion of employees/members in target companies/cooperatives reporting use of modern methods.
c. Increased proportion of pregnant women employees provided with ante-natal care services, information on nutritional needs of mother and child, breastfeeding and birth plan development.
d. Increased number of accredited or accreditable private practice midwives and other health professionals, as necessary, providing family planning and maternal and child health services. [Note: accreditable means those who have completed the requirements and submitted their applications to PhilHealth.]
e. Increased number of trained providers for permanent and long acting methods, such as BTL, vasectomy and IUD.
f. Increased sales of USG assisted contraceptives and selected MCH products.
g. Increased number of distribution outlets for USG assisted contraceptives and selected MCH products.
h. Increased claims for family planning products and services (such as IUD, BTL, and NSV) filed with Philhealth (the national health insurance system), private health insurance, or other third party financing sources.
i. Increased claims for PhilHealth maternity care package.
j. Developed and strengthened appropriate institutional linkages and partners that provide foundation for sustainability of program initiatives beyond project life.
k. Developed national and local policies supporting private sector provision of services and products.

Annual targets for the above process indicators will be jointly developed and agreed upon by USAID and the Contractor in the course of implementation.

IV. WORK REQUIREMENTS:

The Contractor shall, in accordance with the terms and conditions of this task order, furnish the personnel with the requisite ability and skills, facilities, equipment, materials and services (except as furnished by the USAID or GRP) and otherwise do all things necessary to perform in an efficient and effective manner to accomplish the below work requirements.

The Contractor shall implement a wide range of activities that shall: (a) harness private sector motivations and capabilities to increase the share of total need for maternal and child health services that is met by the private sector; and (b) reduce unmet need for family planning amongst women and men of reproductive age who have the capacity and resources to pay for these services. These activities shall build on partnerships with private and business sector organizations and shall work to expand affordable services and contraceptive supplies to local communities and low income individuals.

While the country's health goals are defined at the national level, the achievement of these health goals comes from local communities. For example, the contraceptive prevalence rate (CPR) goal is set at the national level, however, CPR measures whether people meet or fail to meet their needs for family planning. Furthermore, while national policies and structures provide a framework for health service provision, utilization by individuals of these services and the delivery of quality health services ultimately happen at the communities. For example, national policies encourage deliveries by skilled birth attendants, however, the decision to go to a midwife or traditional birth attendant are made by pregnant women or couples in the community. For the purpose of this SOLICITATION, these communities or localities are referred to as local markets.

The focus of this Project is to develop local markets for family planning and maternal and child health services and products. National level activities related to policy, systems and structural development that strengthen these local markets shall also be undertaken.

A local market is an interplay of suppliers (or providers) and consumers (or clients) of services and products and the regulatory environment where the local market operates. It encompasses both public and private providers for a fully-integrated approach to expanding and improving family planning and maternal health.

Even when the focus is on private services, there is still a need to engage the public sector since most enabling regulatory functions are the government's responsibility. If designed and implemented within the existing thrusts and priorities of government, private sector family planning and maternal and child health initiatives shall be better accepted, implemented and sustained. Furthermore, the public sector is also both a supplier and consumer of services and products in the local market. Hence, it is important to recognize the vital role of the public sector at the very onset of the project.

The Contractor shall further harness private sector participation and investments in health, at the local and national levels. This shall be done through training, technical assistance, advocacy, and Public-Private Partnerships or Global Development Alliances.

Family planning activities, including Public-Private Partnerships (PPAs) and Global Development Alliances (GDAs), shall be designed, developed and implemented in accordance with all applicable U.S. statutory and policy family planning and reproductive health requirements.

There are three **project components** that shall be addressed:

- ***Increasing and sustaining private sector provision of quality family planning and maternal and child health services and products***. This component addresses the issues of lack of private sector providers and limited coverage of the poorer segment of the population. This also addresses the issue of quality of care by private sector providers despite the weak regulatory system. A third issue that shall be addressed is the financing of private sector delivery of services and products.

- ***Increasing utilization of quality family planning and maternal and child health services and products in and from the private sector***. This component addresses the need for improving the marketing of family planning and maternal and child health services and products as a means to generate demand for family planning and maternal and child health services. This also addresses the need for improving private practice provider effectiveness in communicating to clients as well as encouraging clients to seek family planning and child health services from trained providers and deliver in birthing facilities, particularly private service providers and facilities for those who have the means to pay. This component also addresses the limited knowledge of clients on available sources of financing of family planning services and products, other than out of pocket spending, which is one of the major deterrents of utilization of these services and products.

- ***Improving the policy environment for private sector provision of family planning and maternal and child health services and products***. This component addresses the need for clear, specific and formal local and national government policies for mobilizing the private sector in the provision of family planning and maternal and child health services. This also addresses the need for streamlining policies governing private sector service providers and suppliers of essential family planning and maternal and child health products.

Crosscutting Concerns

The USAID Assistance Agreement with the GRP is underpinned on the following operating principles which are inter-related and complementary:

1. *Working through in-country expertise and resources.* Considerable expertise in health exist in-country and shall therefore be tapped into during project implementation. Foreign expertise may also be used to supplement local expertise. Likewise, financial resources are available in-country, from both public and private sectors that can be tapped in the provision of family planning and maternal and child health services and products.

2. *Strengthening capabilities and performance of in-country institutions.* USAID, through its implementing partners, work closely with in-country institutions, providing technical assistance that shall strengthen their capabilities in project management – from planning to implementation to monitoring. Such technical assistance is expected to also result in improved performance of these in-country institutions.

3. *Ensuring ownership and long-term sustainability of development efforts.* Improving the health situation of the country is ultimately the responsibility of the Filipino people. This entails a joint effort of both the public and private sectors. USAID therefore assists in: (a) mobilizing the private sector in the delivery of health services and products; (b) in developing the capacity of public sector institutions to engage the private sector in the provision of health services and products; and (c) building linkages and partnerships between and among these Filipino institutions to ensure ownership and long-term sustainability of development efforts in the health sector.

Hence, additional areas of activity shall be undertaken to achieve any of the three component activities under the scope of work. These are:

- ***Developing public-private partnerships or alliances and leveraging private sector investment.*** This crosscutting activity addresses the need to tap private sector expertise and financial resources for family planning and maternal and child health programs. Working through local partners has many advantages including low costs, local contacts and knowledge and a permanent platform for locally sustainable activities. An optimal approach would be public-private partnerships based on genuinely collegial relationships, cost sharing, and mutually beneficial results.

- ***Advocacy to private institutions to invest in family planning and maternal and child health.*** This crosscutting activity addresses the need to mobilize actions and commitments of private sector institutions to enter into public-private partnerships or investing in financial resources into those alliances whether motivated by profit or corporate social responsibility.

- ***Institutional capacity building and networking.*** This crosscutting activity addresses the need to strengthen capabilities of local institutions and establish linkages between and among these institutions to ensure ownership and sustainability beyond the life of the project.

These components and crosscutting activities are described in detail below.

Component 1: Increasing access to quality family planning and maternal and child health services and products

Task A. Workplace health (family planning and maternal and child health) programs for employees.

Under the current PRISM project, USAID supports companies and business associations in implementing family health programs for employees. PRISM provides clinical, management and counseling skills training for program managers, health/medical staff and peer educators among the employees. PRISM also built the capacity of around 30 private sector associations, nationwide, in the technology of establishing workplace health programs. The DOLE was trained to provide technical assistance to companies in establishing workplace health programs. Likewise the DOH was tapped to provide technical inputs (training and information) on the health aspect of the program.

Building on the DOLE, DOH and local private associations' expertise and commitment, USAID, through PRISM II, will continue to support workplace health initiatives focusing on interventions that directly contribute to delivery and utilization of services and products that are measured in terms of increasing contraceptive use by employees and increasing coverage of maternal and child health services in companies.

In the implementation of PRISM II, USAID expects the DOLE and these private associations to take on the responsibility of establishing workplace health programs in more companies and large cooperatives, as appropriate. USAID, PRISM II will provide technical assistance to the DOLE and private associations in terms of developing sustainability mechanisms for these institutions to continue assisting companies wanting to establish FP and MCH programs for their employees. This may include additional skills training; developing DOLE policies and guidelines that will be implemented uniformly across the regions; designing a monitoring system that builds upon existing systems of the institutions; and identifying financing mechanisms to support the institutions' continued assistance to companies. PRISM II shall provide technical support to the DOH in implementing quality standards of care at the workplace, including establishing a formal referral system and reporting system. This may include technical assistance to DOH on developing quality standards for company-based clinics and medical/clinical staff that shall be uniformly applied across regions; technical assistance to the DOH and/or LGUs on integrating workplace health service statistics into the public monitoring system.

In addition to investing in health services of their employees, some companies have corporate social responsibility programs that can be tapped for outreach programs that serve the poor in the communities where the companies are located. This is best done in coordination with the LGUs to complement and maximize public and private sector resources. The current PRISM Project has facilitated some of these arrangements that can be replicated. PRISM II shall assist LGUs to improve their capacity to tap into these corporate social responsibility programs to serve the health needs of their poor constituents.

Illustrative activities may include:

<u>Local Level</u>

- Assisting private associations, with capacity to provide technical assistance to companies, package, cost out, and develop strategies for marketing their services to companies in their locality. The package of technical assistance that these private associations shall provide to the companies shall include:
    - Installation of workplace FP and MCH programs.
    - Assisting companies develop employee health benefit package that include family planning and maternal and child health.
    - Assisting health management organizations and health insurance companies develop health packages for company employees that include family planning and maternal and child health services.
    - Assisting companies develop policies and identify financing sources for sustaining family health workplace programs.
- Assisting these private institutions improve their skills at leveraging company investments on employees' health, including refining tools for cost benefit analysis as advocacy for company management.
- Assisting LGUs develop a facility mapping tool that includes company-based clinics.
- Assisting the private associations and/or LGUs strengthen the links between and among the LGU, referral public and private providers, and companies in the delivery of family planning and maternal and child health services and products.
- Assisting LGUs develop a system for capturing health information and service statistics from workplaces programs.
- Assisting LGUs in developing options for company corporate social responsibility programs.

National and Regional Level

To be more efficient and increase the potential for wider application, certain activities need to be implemented at the national level and regional level. Activities may include:

- Assisting the DOLE perform research and assessment to improve design and implementation of company-based health programs.
- Assisting the DOLE refine its guidelines for implementing and monitoring compliance of Article 134 of the Labor Code (using the experience from the current PRISM Project in implementing workplace family health programs) and build the capacity of its regional offices to apply the guidelines in their respective jurisdictions.
- Assisting the DOH develop quality of care standards for company-based clinics and medical/clinical staff and develop DOH CHD skills to engage the DOLE in applying these standards.

Task B. Increasing the number of sustainable, accredited private health facilities/clinics providing quality family planning and maternal and child health services, including deliveries.

Private midwife clinics present a more acceptable transition from free services to fee for service for most women in the Philippines, especially in rural areas. The birthing home model has a number of features that make it well suited as an innovative private sector family planning and maternal and child health delivery system. For one thing, a high quality birthing home offers a facility-based alternative to home deliveries. The most accessible, economical, and comfortable birthing facility for many mothers in the community is a local birthing home staffed by a trained midwife.

Under the current PRISM Project, around 8 midwife associations and NGOs have obtained or improved their capacities for providing technical assistance to midwives in obtaining PhilHealth accreditation and improving their business. Around 200 birthing homes have been assisted in obtaining accreditation and improving their business. However, these 200 birthing homes are not equitably located such that not all communities in the project sites have access to these birthing homes. Building on the experience of the current PRISM Project and utilizing the expertise already developed, PRISM II shall provide support to increasing the number of sustainable accredited midwife clinics/birthing homes proving quality and affordable health services with wider population coverage.

This task addresses the issues of licensing, accreditation, financing, sustaining clinic operations, and ensuring quality of care. This also addresses the issues of affordability and accessibility to a larger population.

Illustrative activities may include:

Local Level

- Assisting midwife associations and NGOs, with capacity to provide technical assistance on obtaining PhilHealth accreditation and improving the midwife business, develop strategies for marketing their services to midwives or group practicing midwives in their locality who want to obtain PhilHealth accreditation and improve their business. The services which these technical assistance provider institutions provide directly or contract out may include:
    - Assisting midwives understand the requirements for accreditation.
    - Conducting clinical skills training required for accreditation.
    - Assisting midwives go through the application process.
    - Conducting business management training.
    - Assisting midwives develop marketing and promotional activities.
    - Assisting midwives develop business plans.
    - Assisting midwives develop service packages and pricing of services and products.
    - Assisting midwives go through the process of claiming for PhilHealth reimbursement.

    - Facilitating linkages to market opportunities, such as the workplace program, LGUs instituting client segmentation, and LGUs deciding to contract out the delivery of family planning and maternal and child health services.
    - Developing strong referral systems that include, as appropriate, private and public health providers and facilities in the locality.
    - Supporting mechanisms to ensure quality of services, such as clinical case conferences.
    - Assisting midwives attain BEMONC status, as necessary.
- Assisting LGUs develop a facility mapping tool that includes private midwife clinics/birthing homes in the locality.
- Assisting LGUs develop options for utilizing private midwife clinics/birthing homes in delivering services to their constituents, which may include a grant mechanism or contracting.
- Assisting LGUs modify their reporting system to include private midwife clinic/birthing home service statistics and contribution to improving health outcomes of the locality.

National and Regional Level

Because resolution of some issues around private midwife practice and birthing homes involve national and regional stakeholders, national and regional activities shall, likewise, be supported. Further, supporting national and regional activities shall work to widen the application and replication of midwife clinic/birthing home models developed under this scope of work. Activities may include:

- Conducting research relevant to birthing home models and qualitative studies of client satisfaction and different stakeholders' perceptions of birthing homes to guide strategic expansion.
- Refining training modules for midwives.
- Linking midwives to financing sources, such as PhilHealth reimbursement, revenue diversification and sponsorship (e.g. NGOs and companies with Corporate Social Responsibility Programs), revenue diversification, and loans from banks and microfinance institutions.

Task C. Building local capacity to provide long acting and permanent family planning methods.

Some modern family planning methods, like IUD insertion and voluntary surgical sterilization, are not available in midwife clinics. Not all midwives are trained in IUD insertion and midwives cannot perform vasectomy and bilateral tubal ligation, yet midwives provide information and counseling on all methods. Quality of care includes referring clients to other providers of services not available at the midwife clinic/birthing home. To strengthen the midwives' referral system and provide a wide range of methods, attention shall be given to developing more providers of these methods. Selection of providers to be trained shall be purposive, such that providers in localities where demand for such services is high shall be trained. The activities under this task can be done at the national, regional or local level, and may include:

- In collaboration with the DOH, develop high volume private and/or public providers of IUD and Voluntary Surgical Sterilization, through training and integrating them into the local referral network.
- Assisting providers of technical assistance to birthing homes and companies strengthen the referral system between and among the providers of long acting and permanent methods, the companies and the midwife clinics/birthing homes.

Component 2. *Increasing utilization of quality family planning and maternal child health services and products*

While Component 1 focuses on the supply side of the local market, Component 2 focuses on the demand side. Private sector providers and suppliers' survival is highly dependent on the demand for their services and products. Hence, private sector is mainly motivated by the buying (utilization) behavior of clients. As discussed earlier, there has not been any significant increase in contraceptive use in the country even as the private sector's contribution continues to grow. This implies that there has been little

to no new users of such services and products. It has also been observed that immunization and vitamin A supplementation coverage is higher when supported by strong promotional efforts. Likewise, breastfeeding and other appropriate maternal and child nutrition practices are more likely to occur when knowledge on these health issues is high. To increase utilization of private sector family planning and maternal and child health services, The Contractor shall implement a wide range of information, education and communication interventions directed at private providers and their clients.

Task A. Marketing and distribution of products as a means to generate demand for family planning and maternal and child health commodities.

Under this task, Contractor shall implement strategies and approaches of product marketing that shall contribute to an increased demand for family planning and maternal and child health services.

Local Level

Many marketing-related opportunities and obstacles are local in nature. Such problems maybe addressed by identifying local solutions, such as wider contraceptive and maternal and child health product reach through non-traditional outlets. Activities may include:

- Continuing support to the USAID Global Development Alliance with Alphamed and other local pharmaceutical companies with focus on increasing marketing efforts to LGUs and expanding distribution coverage at the localities.
- Linking Alphamed and other pharmaceutical industry partners that may be identified to LGUs with budgets for procurement of family planning and maternal and child health products and to companies and midwives.
- Through local institutions, support local marketing of family planning and selected maternal and child health products, such as iron supplements for pregnant women, vaccines for children under five, zinc, and fortified foods.
- Through midwife associations, PITC, Alphamed local distributors, and other partners, develop alternative distribution systems and distribution points, such as midwife clinics, Botika ng Bayan, Botika Express, company drugstores, and others.

National and Regional Level

- Assisting relevant government agencies to explore measures that promote low cost essential health commodities such as zinc, ORS, vaccines and contraceptives
- Developing and, on a limited scale, producing/printing of IEC materials.
- Assisting the DOH develop a strategy or strategies for growing the contraceptive market in the country that considers the presence of other donor support and subsidized social marketing initiatives.
- Assisting the DOH -
  - track the growth of the contraceptive market.
  - track the growth of the market for fortified foods, zinc, and other selected maternal and child products.
  - conduct pricing studies
- Developing recommendations for a multiple pricing and marketing model for contraceptives.

Task B. Marketing of private sector services

Marketing of private sector services are more effectively done at the local level. Activities may include:

Local Level

- With local partners, develop and distribute localized IEC materials promoting private midwife clinics or birthing homes. The assistance shall include tailoring the materials to the local culture and translating materials to local dialects.
- Limited printing and distribution support.

- Support local partners' innovative approaches for information dissemination, such as health fairs and campaigns.
- Assisting LGUs mobilize private sector for health information and education campaigns.

National and Regional Level

- Support national and regional initiatives to promote private sector services.
- Conduct of studies on the general effectiveness of marketing initiatives to guide strategy development and improvements.

Task C. Increasing private sector provider interpersonal communication and counseling skills.

One of the major influencers of client choices and health seeking behaviors are the service providers. The quality of service and good provider-client relationship are effective ways to promote services and products. A satisfied client would likely continue to come back and influence others to seek health services. Hence, it is important for a provider to have good interpersonal and counseling skills. Through technical assistance provider institutions, Contractor shall support various activities to improve provider knowledge and interpersonal communication and counseling skills.

Illustrative activities may include:

Local Level

- Training of company midwives, their back-up doctors and company health staff.
- Conducting client satisfaction surveys or exit interviews.
- Providing IEC materials and job aids.

National and Regional Level

- Support the development of national and regional approaches for reaching more providers, such as working through professional associations, midwife associations and educational and training institutions.

Task D. Increasing consumer or client information on family planning and maternal and child health issues.

This task addresses the need for more accurate and timely information to consumers or clients to guide them in making health decisions and the need for interventions to influence the health seeking behavior of private sector clients. Through the national and local partners developed under the current PRISM Project and the Health Promotions Project, PRISM II shall support a wide range of activities that will increase consumer knowledge and improve health seeking behavior.

Illustrative activities may include:

Local Level

- Supporting community-based information dissemination and educational activities, such as "buntis" parties (parties for pregnant women), mothers' class, health fairs, and other non-traditional ways of disseminating information.
- Supporting dissemination of information through local print and broadcast media.
- Developing and disseminating program, method and product specific IEC initiatives, such as those promoting breastfeeding, use of fortified foods, use of private sector facilities, facility-based deliveries, ante-natal care, new born screening, and method-specific family planning information materials.
- Disseminating information on the benefits of family planning and maternal and child health services.
- Disseminating information on PhilHealth benefits.

- Using existing structures and systems to disseminate information, such as through peer educators, internet, intra-net, company bulletins, establishing nutritional corners in canteens, and others.
- Supporting joint LGU and private sector IEC campaigns.

National and Regional Level

- Support national and regional IEC campaigns, as appropriate.

Component 3: *Improving the policy environment for private sector provision of family planning and maternal and child health services and products*

To address the need for clear and supportive policies and guidelines for private sector participation in the delivery of public health services, particularly family planning and maternal and child health, the Contractor shall implement varied activities related to the development and/or operationalization of policies for private sector mobilization. Focus areas for the policy work are those that are relevant to the family planning and maternal and health programs, including those affecting private providers and suppliers, such as licensing, accreditation, product registration, and regulation.

Task A. Assisting LGUs, DOH (national and ARMM DOH), DOLE, and other relevant agencies, develop and operationalize policies to mobilize private sector participation in the delivery of family planning and maternal and child health programs.

This task addresses the lack of clear and formal local and national policies on mobilizing private sector participation in the delivery of family planning and maternal and child health services. A favorable climate for private sector services requires polices that facilitate investments in private health services, licensing and accreditation, regulation, staffing, financial management, and other factors that relate to private sector.

Local Level

Because the focus of this Project is developing local markets, significant attention shall be given to developing policies at the local level that relate to private sector provision of family planning and maternal and child health services and products. Activities may include:

- Assisting LGU's develop and operationalize a private sector strategy.
- Assisting LGU's develop tools, mechanisms and systems for integrating private sector providers and/or utilizing private sector providers in the delivery of family planning and maternal health services and products in the locality. Examples of these are:
  - Providing inputs to the development of tools and systems for client segmentation where the LGU focuses its services to the poor and refers patients who can pay to private sector providers.
  - Developing mechanisms for LGUs to purchase private sector services for the poor and those in hard to reach areas.
  - Developing LGU financing schemes that can be made available to local non-profit organizations to assist in delivering health services and products.
  - Developing clear LGU policies on public midwives doing private practice.
  - Developing local public-private partnerships, such as using health facilities for private practice or tapping into corporate social responsibility program to serve the poor of the community.
  - Modifying LGU reporting system to include private sector data.

National and Regional Level

Since this Project does not cover all LGUs, it is important to have national policies for wider application. National policies, brought down to the LGUs through regional offices, shall be informed by experiences at the local level. Activities may include:

- Assisting the DOH develop and operationalize clear policies and a strategic approach to promote private sector contribution to improving family health.
- Assisting the DOH develop operating guidelines for policies that affect private sector provision of services and products.
- Assisting the DOH utilize project experiences in developing private sector strategies, policies, and financing guidelines. Examples of these are:
  - using performance-based grants to non-profit, non-government organizations to deliver public health services and products;
  - learning from accredited private midwife clinics/birthing homes in developing operational guidelines for implementing the DOH Maternal and Neonatal Care, Health and Nutrition administrative order; and
  - including private sector facilities in the DOH health facility mapping as the basis for the rationalization plan.
- Assisting the DOLE operationalize guidelines to implement Article 134 of the Labor Code.
- Assisting DOH and DOLE regional offices operationalize national strategies, policies and operational guidelines.

Task B. Streamlining DOH licensing requirements for private sector providers.

This task addresses the need for a clear DOH policy on licensing of private sector providers as a requirement for PhilHealth accreditation. Activities may include:

- Assisting DOH clarify its policy on licensing of private providers.
- Advocating for uniform implementation of the licensing policy across regions.
- Advocating for decentralizing licensing function to the CHDs.

Task C. Streamlining PhilHealth accreditation requirements and related PhilHealth procedures in the delivery of the maternity care and newborn screening benefits.

This task addresses the issues of non-uniform application of accreditation requirements and procedures and delayed reimbursements. Activities may include:

- Assisting DOH and PhilHealth streamline licensing and accreditation requirements.
- Assisting PhilHealth develop guidelines for uniform application across regions, such as those on competency-based training requirements.
- Assisting PhilHealth streamline its reimbursement procedures to reduce delay.
- Advocating for decentralizing accreditation function to the regional offices.
- Assessing the feasibility of third party accreditation on midwife clinics/birthing homes.

Task D. Streamlining product registration requirements and related regulations on product marketing and distribution.

This task addresses the issues of long and cumbersome procedures for product registration, and restrictive policies for marketing essential maternal and child health products, including family planning commodities. This task also addresses issues related to LGU procurement of family planning and maternal and child health products. Activities may include:

<u>Local Level</u>

- Assisting LGUs streamline the supplier accreditation process.

<u>National Level</u>

- Advocating for and working with Bureau of Food and Drug (BFAD) in developing streamlined registration procedures of family planning and maternal and child health products.

- Developing recommendations to the DOH and BFAD on re-classifying contraceptives as over-the-counter drugs.

Crosscutting Concerns

Some activities cut across all project components. These may have been already mentioned above but are discussed below for clarity.

Task A. Developing public-private partnerships or alliances and leveraging private sector investment

Developing public-private alliances can be done through the use of global development alliance approaches and through simple grants generated by issuing requests for applications. PRISM 1 experience shows that the global development approach yields more commitment and increases the potential for sustainability. The contractor shall allocate a portion of the total project budget to creating a grant mechanism for supporting public-private partnerships and alliances. Grants will be strategically used to leverage private sector resources. Activities may include:

- Developing global development alliances with commercial, for-profit organizations in increasing access to quality family planning and maternal and child health services and products and increasing utilization of quality family planning and maternal child health services and products. This entails:
    - coordinating family planning and maternal and child health program activities with the corporate sector rather than providing them with direct support;
    - identifying partner companies or for profit organizations during the design stage of the program, and looking for opportunities where USAID and the companies/organizations' activities can complement one another.

  For example, companies could focus on outreach, health education, and advocacy, while the contractor focuses on the improvement of their clinical and program management skills, the technical content of health education materials and activities, linkages to the public sector and other technical assistance as may be identified.

- Providing simple grants to non-profit, non-government organizations to increase access to and utilization of quality family planning and maternal and child health services and products. These grants, however, will not be used for funding the cost of clinic or health facility construction and renovation.

The Contractor shall develop and submit for USAID approval a "Grants Under Contract" manual defining the guidelines and details of the grant mechanism before awarding the first grant.

Task B. Advocating to private institutions to invest in family planning and maternal and child health.

Activities under this task may include:

- Supporting advocacy initiatives of local and national organizations, such as chambers of commerce, conglomerates and corporate foundations, to encourage their member companies to invest in family planning and maternal and child health programs. The support could include:
    - Pricing of project interventions.
    - Sharing the results of cost benefit analyses done under the project.
    - Disseminating successful models developed under the project.

Task C. Institutional capacity building and networking

To develop in-country capacity to sustain the interventions introduced by the project, the Contractor shall undertake activities that will build institutional capacities and linking these institutions to develop a network of service providers, suppliers, technical, training and financial and other resources for the delivery of family planning and maternal and child health services and products. Activities may include:

Local Level

- Providing training and mentoring to local partners to develop their capacities for providing technical assistance to companies, midwives and other providers as appropriate.
- Building the capacity of local training institutions to become training suppliers for companies, midwives, LGUs, and other local partners.
- Providing advisory support and mentoring to LGUs, including DOH ARMM, in mobilizing the private sector.
- Providing venues for exchanging successes and learning, such as local study tours or missions.

National and Regional Level

- Developing simple tools for project implementation, such as manuals for establishing workplace health programs, training modules, manual for conducting clinical case conferences, monitoring and evaluation tool, case studies of birthing home practice for use by DOH, DOLE, training institutions, banks and other financing institutions, midwife associations, grantees, and other local partners.
- Providing advisory support to the DOH, DOLE and PhilHealth in mobilizing the private sector.
- Training and mentoring of DOH, DOLE and PhilHealth regional offices.
- Organizing observation tours or missions for DOH, DOLE and PhilHealth staff to demonstrate project strategies and approaches.

Task D. Producing Project Documentation and Contributing to USG Development Outreach.

- In addition to the standard reporting requirements, the Contractor shall produce written materials to document and disseminate project successes and learning, such as technical notes and success stories.
- Contractor shall also organize or participate in VIP visits, contribute to the weekly reports to the Administrator (weekly reports on significant project events), and represent the USG in meetings or fora relevant to mobilizing the private sector for health.

Synergies and Coordination across Project Components

The contractor shall develop a geographic strategy in which project activities of the different components would be implemented together in implementation sites, where feasible, for maximum impact and sustainability. Based on PRISM I experience, in implementation areas where two or three of the project components happened to coincide, there were beneficial effects of the different components reinforcing each other. As much as practically all three components shall be implemented simultaneously in all the project sites. Private providers that will be assisted under the project will be linked to the workplaces and LGUs as part of the referral network or other arrangements for delivering services to employees. Likewise, pharmaceutical companies receiving assistance from the project will be linked to workplaces and private providers, and LGUs as potential market or distribution points for contraceptives and selected maternal and child health products.

Collaboration with Other SO3 Activities/Projects

USAID's assistance to health development, specifically SO 3, is expected to: (1) increase contraceptive prevalence rate of modern methods; (2) keep HIV seroprevalence rates among most at risk groups (MARGs) below 3 percent in all sentinel sites; and (3) increase the percentage of participating units achieving at least 85 percent treatment success rate for TB.

To achieve the objectives for health, the strategy focuses on the achievement of four intermediate results (IRs) in the context of province-wide health systems. These are:
IR 1 - LGU provision and management of health services strengthened,
IR 2 - Provision of quality services by private and commercial providers expanded,
IR 3 - Appropriate healthy behaviors and practices increased, and
IR 4 - Policy environment and financing for provision of services improved.

There are currently seven implementing mechanisms that jointly work to achieve the objectives and intermediate results for health. These are:

1. Strengthening Local Governance for Health (HealthGov), implemented by Research Triangle Institute (RTI) International. HealthGov aims to strengthen LGU commitment to health and their capacity to sustainably provide, finance, and manage quality health services, particularly family planning, maternal and child health, tuberculosis, HIV/AIDS, and other infectious diseases such as avian influenza and severe acute respiratory syndrome (SARS).
2. Sustainable Health Improvements through Empowerment and Local Development (SHIELD), implemented by Helen Keller International (HKI). SHIELD aims to achieve sustainable improvement of family health in communities in the Autonomous Region in Muslim Mindanao (ARMM).
3. Private Sector Mobilization Project (PRISM), implemented by Chemonics International. PRISM aims to catalyze the private sector as a vibrant and dynamic partner of the government in meeting the demand of Filipino families for family planning and maternal and child health products and services.
4. Micronutrient and Child Blindness Project (A2Z), implemented by the Academy for Educational Development. A2Z aims to increase the use of key micronutrient interventions to improve child and maternal health.
5. Linking Initiatives and Networking to Control Tuberculosis (TBLINC), implemented by the Philippine Business for Social Progress (PBSP). TBLINC aims to achieve at least 85 percent treatment success rate for TB in participating units through: 1) improving the policy, financing and regulatory environment for DOTS implementation, 2) improving systems capacity for quality DOTS implementation, and 3) improving utilization of DOTS facilities and services, and behavior and attitude for TB control and treatment.
6. Health Policy Development Project (HPDP), implemented by the UP School of Economics Foundation (UPECON). HPDP aims to establish a supportive policy and financing environment for priority health programs by encouraging policies and plans that increase and sustain access to quality health information, services and products.
7. Health Promotions Project (HealthPRO), implemented by the University Research Corporation (URC). HealthPRO aims to: 1) promote healthy behaviors and practices – especially in family planning, maternal and child health and nutrition, tuberculosis, HIV/AIDS and other infectious diseases like avian influenza, 2) mobilize and strengthen the capacity of appropriate national and local institutions, organizations and individuals to provide technical assistance to local health implementers in the design, implementation, monitoring and institutionalization of sustained and high quality health promotion and communication activities, and 3) promote high quality and effective health promotion and communication initiatives among USAID cooperating agencies by ensuring that health promotion and communication is part of the comprehensive technical assistance package made available to LGUs and other program partners.

PRISM II will be a major project under IR 2. Activities under this project will be coordinated with other health projects. Opportunities for collaboration include the following:

- Coordinating with SHIELD in building the capacity of DOH ARMM and the ARMM provinces in mobilizing the private sector.
- Coordinating with HealthGov in providing technical assistance to the CHDs, building the capacities of LGUs in mobilizing the private sector, and strengthening local health systems where private sector can participate, such as, client segmentation, referrals, training, and drug procurement.

- Coordinating with A2Z in marketing of zinc and other maternal and child health products.
- Coordinating with HPDP in developing the DOH private sector strategy and providing technical assistance to the DOH in developing policies and operational guidelines relevant to private sector.
- Coordinating with HealthPRO in developing communication strategies and IEC materials for private sector providers and clients.
- While PRISM II does not coincide with TBLINC's program element, PRISM II and TBLINC may be working with the same private sector partners, which presents an opportunity to collaborate.

Since all these projects are interdependent, close coordination will be necessary. The Contractor shall work closely with existing cooperating agencies and projects. Participation in already existing inter-CA technical working groups and regular meetings shall be important. To ensure synergy and integration among cooperating agencies, project activities shall be closely aligned with the provincial technical assistance plan that shall be jointly developed by USAID, cooperating agencies and the DOH.

Collaboration with Other Donors

USAID remains the largest supporter to the Philippine family planning and maternal and child health programs, with more than 40 years experience in the sector, including major programs on private sector provision of health services and products. While other donors are also providing assistance, the Philippines' PHN sector, USAID continues to be a leader in the sector.

The DOH undertook a donor mapping exercise to determine where and how all the donors are working in selected sectors. The programs of other donors, such as ADB, World Bank, JICA, WHO, AusAID, UNFPA, and EC, are generally more focused on addressing Maternal and Child Health, TB Control, and other infectious diseases. Most of these programs are concentrated in specific geographic regions of the country, which may or may not coincide with USG supported sites. The DOH is currently consulting with donors in developing the mechanism and guidelines for coordinating donor support. With USAID guidance, the Contractor shall actively participate in this process.

While USAID has phased-out its donated contraceptives to the Philippine family planning program, other donors, particularly UNFPA have increased their contraceptive donations, and KFW has supported the marketing of a socially marketing brand of contraceptives. With USAID guidance, the Contractor shall collaborate with these donors as the Philippine Government's Contraceptive Self-Reliance Initiative progresses.

Gender Considerations

Activities to be implemented under this project should strengthen both men and women's decisions making in determining the number and the spacing of children and in making decisions about their children's health. Efforts shall be made to consider gender sensitivities in delivering health services and products, such as training both male and female service providers, and ensuring health facilities receiving support from the project have the capacity to respond to special needs of men, women, boys and girls in providing FP and MCH services, products and information. The project monitoring and evaluation system will include gender specific data on issues in service, product and information delivery and how they are addressed; and project benefits to men, women, boys, and girls.

None of the proposed activities for the project inhibit the active participation of either men or women. Men and women are treated as equal partners in their roles as clients, as providers of services, and as potential implementers of USAID's technical assistance under this project.

The contractor shall develop a plan for addressing gender issues in implementing the project and documenting gender specific project benefits.

V. GEOGRAPHICAL COVERAGE

The project shall be implemented in all USG sites, as feasible. Currently, there are 28 USG sites, which are:

Luzon	Visayas	Mindanao Non-ARMM	ARMM
Pangasinan	Aklan	Zamboanga del Sur	Basilan
Cagayan	Capiz	Zamboanga Sibugay	Lanao del Sur
Isabela	Negros Occidental	Zamboanga del Norte	Maguindanao
Bulacan	Negros Oriental	Bukidnon	Sulu
Nueva Ecija	Bohol	Misamis Oriental	Tawi-Tawi
Tarlac		Misamis Occidental	
Albay		Davao del Sur	
		Compostela Valley	
		Sarangani	
		South Cotabato	
		Agusan del Norte	

Additional USG sites maybe identified during the course of project implementation. Other sites may be considered where private sector opportunities exist and the potential for greater impact and contribution to local and national health outcomes are high.

VI. IMPLEMENTATION ARRANGEMENT

The Chief of the Office of Health provides the overall direction of the health program, including the private sector activity. The Team Leader of the health private sector team shall manage the Project. S/he shall be responsible for the overall project direction, monitoring and coordination of projects under the IR and across IRs. USAID/Philippines will also be responsible for ensuring that monitoring, evaluation and audit requirements are complied with. In addition, Activity Managers from among the private sector team will be designated to assist in the day-to-day management of project components.

USAID management of the Project will emphasize collaboration and building synergy between this and other USAID projects in family planning and maternal and child health, and will also promote coordination with other health activities as may be programmatically or logistically appropriate.

VII. OTHER CROSS CUTTING RESPONSIBILITIES OF THE CONTRACTOR

The Contractor shall be responsible for the accomplishment of all work set forth in Section III, Statement of Work. Additionally, the Contractor shall assume primary responsibility for making programming and policy recommendations to assure the strengthened and expanded delivery of family planning and maternal and child health services and products in and/or by the private sector. The Contractor shall work and coordinate with business leaders, private companies and their associations, labor groups, private providers and their associations, NGOs, DOH, DOLE, other government agencies as appropriate, and LGUs. The Contractor shall ensure institutionalization and sustainability of activities throughout the course of project implementation. The Contractor shall continue to nurture the partnerships that have been established under PRISM I. (Refer to List of PRISM I Partners in Annex 4). Sustainability issues should be addressed in all components from day one of project implementation. The Contractor shall also collaborate with other USAID health projects and, as necessary, with other donors.

The Contractor shall be responsible for training, transferring project technologies to local partners, policy studies, operations research, advocacy and communications activities, provide grants, and other activities as needed, to achieve desired outputs and deliverables. The Contractor shall primarily utilize GDA processes in providing grants to leverage private sector investments for family planning and maternal and child health. The Contractor shall have the facility to support information sharing and USAID visits or observation trips that may arise in the course of project implementation.

VIII. TEAM COMPOSITION, RESPONSIBILITIES AND QUALIFICATIONS OF CORE POSITIONS

The contractor shall be responsible for providing long term advisors and short term consultants to accomplish the objectives of the Project. The following long-term staff positions are illustrative although offerors may propose other positions as they deem necessary.

1. **Chief of Party -** The Chief of Party (COP) shall supervise all activities under the contract and have overall responsibility for the successful performance of the technical assistance team. The COP shall provide strategic leadership and bear primary administrative responsibility on all administrative requirements of the contract ensuring that the performance objectives specified in this contract are met. The COP shall be the official representative of the contractor and shall maintain communication between all relevant parties including appropriate officials from DOH, other major national government agency and local government partners, the USAID Chief of the Office of Health, the Contracts Officer Technical Representative (COTR) assigned to this contractor and senior private sector leaders.

The COP responsibilities include the following:

1. Provide overall direction of all technical and administrative operations under the contract.
2. Provide leadership and support for technical issues in FP/MCH and integration and quality of services
3. Design management systems with standard operating procedures that can be used to implement all activities to be undertaken with funds provided in the contract.
4. Design and oversee an annual project cycle which formulates comprehensive annual contract work plans and budgets in accordance with the USAID annual planning cycle and assures timely disbursement of funds.
5. Direct and oversee planning and budgeting processes. Arrange for and oversee local financial staff that shall be responsible for disbursing all local costs under this project, monitoring and tracking expenditures, and preparing financial reports of project expenditures for submission to USAID.
6. Prepare quarterly and annual project activity reports as specified in the contract.
7. Monitor the progress and pace of project implementation.
8. Supervise all institutional subcontracts executed under the prime contract.
9. Supervise the work and assess the performance of all long term and short term advisors, consultants and staff.
10. Coordinate and identify with the Project Staff training needs and opportunities to support the project.
11. Together with project staff identify issues or challenges to effective implementation of workplan activities, and develop solutions or strategies to address the challenges.
12. Manage and supervise the Project Staff in the identification of all the project's technical assistance needs required to achieve the expected outputs of the contract, development of suitable scopes of work, recruitment of consultants, and execution of technical assistance contracts.
13. Develop strategies that would focus on improving the local provision and management of family planning and maternal and child health services.
14. Develop a strategy and directly oversee the implementation of institutional capacity building initiatives for national local public and private sector project partners
15. As the official representative of the contractor, ensure the success of and be liable for any failure, on behalf of the contractor.
16. Function as the primary liaison between the USAID, DOH, and other collaborating agencies on all pragmatic, administrative and financial matters related to the project.
17. Provide advisory support to national and local level implementing partners, including the DOH, DOLE, their regional offices, LGUs and key private sector partners.
18. Provide leadership in the management as well as in intellectual discussion within the project team and with USAID and partners. He/she shall prepare the work plan of the design team and make sure reports of team members are submitted on time.

Desired Qualifications for the COP:

1. At least masteral level education/training or its equivalent in Health Finance and/or Economics, Public Health, Business Administration, or a related field.
2. At least 10 years successful prior experience working with or in the private sector on the development and/or implementation of health programs preferably in the developing world.
3. At least five years prior experience of successfully managing health programs as a senior staff/officer in a government/public sector agency
4. Ability to identify creative and practical approaches to overcome challenges is highly valued
5. Extensive knowledge of USAID rules and regulations or similar donor rules and regulations
6. Successful prior experience in policy and advocacy projects in a developing country, preferably with experience working in the Philippines.
7. Prior experience in the management of professional and financial resources in a similar scale.
8. Significant previous experience in the implementation of family planning and maternal and child health (FP/MCH) programs in the field is an advantage.
9. Familiarity with private sector environment and procedures in the implementation of donor assisted projects.
10. Thoroughly conversant with health policy and financing issues relative to private sector health service delivery.
11. Expansive network of contacts who are key influencers in both the national and local government as well as in the private commercial and civil society sectors
12. Experience as international health consultant preferred
13. Must have at least 10 years experience in designing and evaluating Health Programs.
14. Must have demonstrated understanding of the challenges and opportunities in the health sector particularly population issues, family planning, maternal and child health. Knowledge of various program approaches in various countries as well as AID's Population and Health development framework is a requirement.
15. Proven experience working effectively with multiple stakeholders including government officials, LGU executives, business, and civil society
16. Must have excellent teamwork and teambuilding skills as well as excellent written and oral communication skills.
17. Proven track record of building and sustaining effective partnerships, advocating effectively and communicating to various constituencies is required.
18. Demonstrated experience managing donor-funded grants programs, Chief of Party experience on a USAID-funded program preferred

2. **Deputy Chief of Party / Project Technical Coordinator (D COP/PTC) -** The DCOP shall provide primary support to the functions of the COP in supervising the activities and services provided through this contract including managing all technical inputs required in achieving the outputs expected. Through the COP, the DCOP/TC shall receive technical guidance from the USAID COTR for the project.

   The DCOP shall be supervised by the COP and shall share the responsibility of day-to-day and long range activities of the contract. The DCOP shall assist the COP in tracking, coordinating and reporting information related to project activities conducted. S/he shall ensure the technical complementation and synergy of all project activities.

   The DCOP responsibilities include the following:

   1. Supervise the implementation of all project activities ensuring that performance schedules are observed and outputs are completed and delivered according to schedule.
   2. In coordination with the COP, provide principal technical oversight for all policy studies, diagnostic and/or operations research studies, demonstration projects, training and technical assistance needed to formulate recommendations for policy reform measures covered under the contract.
   3. Supervise the implementation of all project activities ensuring that performance schedules are observed and outputs are completed and delivered according to schedule.

4. With the COP, provide technical supervision and assign technical responsibilities as may be necessary to all-long term and short-term consultants working under the contract.
5. With the COP, identify solutions to operational issues and lead or delegate appropriate action to address these challenges.
6. Provide overall technical oversight for all work and activities necessary to achieve the objectives, outputs and deliverables expected under the contract.
7. Advocates and support policy development initiatives, seeking support from high level DOH and other GRP agencies and private sector entities for the technical areas covered under the contract. Ensure timely provision of feedback and guidance concerning the functioning and effectiveness of the various components of the contract.
8. Together with project staff identify issues or challenges to effective implementation of workplan activities, and develop solutions or strategies to address the challenges.
9. Liaise with the principal policy and decision makers within the DOH, and other government agencies, professional and trade associations, interest groups, and the community at large to assure that Project activities are relevant to the current policy issues and directives being debated in the health community at large.
10. Expansive network of contacts who are key influencers in both the national and local government as well as in the private commercial and civil society sectors
11. Represent the project in the country and be the liaison with project HQ; able to present the project's technical approach and accomplishments
12. Direct project management and coordination responsibility
13. As recognized expert in one or more of the project's key activities, s/he shall serve as technical advisor, perform essential analytical, evaluative and consultative work, develop and implement technical aspects of the project activities, provide technical assistance on a daily basis, and is a hands-on resource for ensuring activity implementation and building partners' institutional capacity
14. Coordinates all short term TA from the project: optimize scheduling of trips, help arrange meetings with counterparts and USAID, review trip reports and technical products, coordinates the project's quick response to new requests or changes in the ground
15. Communicates frequently with Project HQ and submits quarterly on progress and results and coordinates closely to track expenditures against budget

<u>Desired Qualifications for the DCOP</u>:

1. At least master's level education/training or its equivalent in health financing, marketing, economics, public health, health administration or related field.
2. At least 7 years successful previous experience working with national and local government on the development and/or implementation of health programs both at the national and local levels in the developing world.
3. Demonstrated understanding, thorough knowledge of and familiarity with health systems, health financing, marketing and health program policy issues confronting the Philippines.
4. As the technical coordinator of local level project implemention, the DCOP should have extensive knowledge and experience in all aspects of health systems delivery at the local level.
5. Familiar with principal individuals within the DOH, other government agencies, private/business sector, and the community at large who are responsible for health policy.
6. Proven experience managing all aspects of field operations for donor-funded preferably USAID-funded programs, including procurement, financial management, grants administration, human resources administration and activity design
7. Familiar with private sector health service provision.
8. Extensive work and prior experience in health policy offering private sector work in the Philippines.
9. Filipino citizen preferred but a U.S. citizen will be considered.

3. Other Key Personnel

3.1 Senior FP and MCH Service Delivery Advisor (SDA-FP/MCH) - The Senior FP and MCH Service Delivery Advisor (SDA-FP/MCH) shall direct and supervise the formulation and implementation of the strategy for engaging providers through this contract, including managing all technical inputs required in achieving the outputs expected. Through the COP and/or DCOP, the SDA-FP/MCH shall receive technical guidance from the USAID COTR for the project.

The SDA-FP/MCH shall focus on developing models, approaches and tools to identify and strengthen strategic service approaches to meet current demand and unmet needs while maintaining high quality FP/MCH services. S/he shall provide vision, leadership and state-of-the-art proven practices in the design, implementation, monitoring and evaluation of programs to expand FP/MCH services, by the private sector, in a variety of settings and circumstances (eg. hard to reach populations; youth; urban and rural poor; in the integration of services with other MCH services; and community linkages)

The SDA-FP/MCH shall work with the management and key personnel of the project to ensure that aspects related to other areas are integrated into the design of maternal health programs and projects.

The responsibilities of the Senior SDA-FP/MCH include the following:

1. Lead and provide technical direction in the development of the project's FP/MCH service delivery expansion strategy;
2. Lead and provide technical direction in the development and testing of models and use of state-of-the-art (SOTA) and locally appropriate technical approaches in service delivery expansion programming, including private provider associations and networks, FP integration with MNCHN services, FP/RH for young married couples, male FP/RH services, strengthened community-clinic linkages to improve access;
3. Guide, coordinate and collaborate with project staff and partners in the design, implementation, management, monitoring and evaluation of FP/MCH services expansion program approaches;
4. Ensure that all service expansion activities are linked to and benefit from demand and advocacy efforts to improve access to and utilization of FP/MCH services with significant involvement of the private sector;
5. Provide technical assistance to strengthen maternal, neonatal and child health program, LAM and postpartum contraceptives services, which includes advancement of service delivery guidelines, training curricula, behavior change interventions, commodity and logistics systems, and facility delivery provisions to ensure that content on LAM and postpartum contraception is appropriate
6. Lead and facilitate the development of training and performance improvement systems, strengthen FP in MNCH services, develop and standardize training curricula and service delivery guidelines, trainee performance
7. Lead and/or actively participate in the development and updating of standards, tools and approaches and support their integration and use in current and new maternal health programs and projects
8. Provide technical and programmatic support for studies designed to test, document and improve the understanding of the benefits of different service delivery approaches to increasing access to FP/MCH services, especially long-acting and permanent methods of contraception;
9. Synthesize data and write reports to disseminate lessons learned and best practices with PRISM experiences in creating access to FP/MCH services via multiple service expansion models;
10. Participate in the formulation of the project strategy for knowledge management in FP/MCH. Contribute to the discourse on increasing access to FP/MCH services and especially long-acting and permanent methods of contraception through technical papers and presentations, reports and publications to the professional community.
11. Stay abreast of ground-breaking evidence-based work in FP and MCH service delivery and support dissemination of new knowledge to project staff and partners and its incorporation into the project's programming

12. Coordinate with project staff and USAID to ensure the synergistic programming of the project's FP/MCH services delivery initiatives, and to ensure complementation with other project initiatives as well as with other USAID and partners' programs
13. Lead in the identification of policy issues that bear on FP and MCH and integrated FP/MCH service delivery involving the private sector, and work with the project's Policy Advisor and staff, USAID's policy project and other partners to address these;
14. Strengthen and expand options to strengthen the integrated delivery of FP/MCH services in relevant project areas and sites
15. Lead or participate in technical working groups, advisory groups and advocacy initiatives to advance FP in MCH programming at the national and local levels
16. Provide technical assistance to provincial project sites in the areas of maternal health and quality assurance

Desired Qualifications for the Senior SDA-FP/MCH:

- Demonstrated experience as strategic planner and programmer with strong technical knowledge about FP/RH and MCH and how services link to communities and special client groups in developing country settings. S/he shall have demonstrated success as a provider of technical assistance to staff and organizations from diverse backgrounds.
- S/He must have skills in dissemination of information and organizational learning so that all project teams, partner organizations and governmental systems can be kept up-to-date on the state of the art approaches and tools in service delivery
- Expertise and experience in family planning/reproductive health program design, management and assessment/evaluation. In-depth knowledge of a wide range of programmatic healthcare approaches, models and tools to improve the supply of FP/LAPMs and other RH services and MCH services and how supply links to demand and advocacy efforts
- Successful prior experience of managing a health program in family planning, contraceptive self reliance, maternal and child health programs, and other health areas.
- Demonstrated strong technical and programmatic knowledge and experience in the following areas: clinic-based FP services, MCH, client-provider interaction, training and quality improvement
- Advanced degree in Public Health, Medicine or a relevant discipline
- Proven track record of global and in-country experiences in service delivery for FP/MCH. An in-depth knowledge of and practicall skills in programming for a variety of service delivery expansion approaches, including PRISM's areas of interests – mobile services, private provider networks, FP integration with MCH/MNCHN, FP/MCH for young married couples, male FP/RH services, strengthened community linkages to improve access
- Experience in monitoring the quality of services in a variety of settings especially clinical service delivery, community-clinic linkages, private sector and/or NGO networks for FP/RH and MCH services
- Three to five (3-5) years international health experience, preferably in FP/MCH, either short-term or long-term, in a developing country
- Seven to 10 years of clinical experience including at least 5 years clinical training experience; Current and updated clinical skills in FP/MCH.
- At least 5 yrs experience working with maternal health programs in developing countries preferred.
- Demonstrated expertise in strategic program planning, implementation and TA provision.

3.2 Senior Social Marketing and Communications Advisor (SMCA) - The Senior Social Marketing and Communications Advisor (SMCA) shall lead the formulation of the project's strategies in social marketing strategy and behavior change communication. S/He shall work to integrate these two efforts for optimal contribution to project goals.

The Senior Social Marketing and Communications Advisor (SMCA) shall provide technical direction and oversight on the project's social marketing and behavior change communication activities. S/He shall

work with public sector partners and pharmaceutical companies and alternative distributors of FP/MCH products and services for the formulation of a marketing strategy that reaches the underserved and even the unserved populations. S/He shall provide technical support to project partners, coordinate communication activities to mobilize target client groups to improve access to FP and MCH services at the communities, in the workplace, and other project focus areas. S/He shall be responsible for providing assistance in the design and implementation of communication activities, as well as in monitoring the impact of these activities in terms of FP/MCH services delivery and utilization. S/He shall ensure that all projects' communication activities are evidence-based, results-oriented and gender-sensitive. S/He shall take on the development of a mass media communication strategy for the project and collaborate with the M&E officer in synthesizing, disseminating, and documenting project progress through technical reports, best/promising practices stories, others.

The responsibilities of the Senior SMCA include the following:

1. Responsible for the business management of one or more marketing functions including development of marketing strategies, product and volume forecasts and ROI, product pricing and programs, financial modeling, customer communications, communication with and training of sales teams and/or management of business activities.
2. This position shall work with the service delivery advisor, the communications specialist, and the policy advisor and other partners to ensure achievement of business goals. Uses excellent interpersonal skills to engage with complex array of customers to achieve business objectives while maintaining customer integrity
3. Lead the development of the project's social marketing strategy and oversee its implementation
4. Initiate efforts to develop a market segmentation mechanism that can be functional for both the public and private sectors
5. With the Alliance/Partnership Development Advisor, coordinate with multisectoral stakeholders for the formulation of a Total Market Approach in FP/MCH goods and services
6. Provide technical assistance to partners on strategically pricing FP/MCH products and services and on the development of their business plans
7. Develop a monitoring and evaluation mechanism for tracking progress of social marketing efforts that are linked to communication for behavior change
8. In close coordination with the project's Communications Specialist and project partners, the SMCA shall lead the development and implementation of a communications for behavior change (BCC) strategy for the project, including mass media messages, and community mobilization
9. Take the lead in the formulation of the project social marketing strategy for increasing utilization of FP/MCH services with private sector involvement
10. Build capacity of implementing partners to implement communication activities in the BCC strategy to improve the target audiences' access to FP/MCH services
11. Coordinate development/adaptation and dissemination of existing BCC materials and messages outlines in BCC strategy
12. Work with public and private providers, public and private health financing sources, pharmaceutical companies and alternative institutional distributors of FP/MCH products and services towards increasing FP/MCH services delivery and utilization
13. Build and develop relationships with the Service Delivery and Communications Unit of the DOH towards achievement of project goals, in the medium-term, and towards strengthening the DOH's institutional capacity for social marketing and behavior change communication.

    Desired Qualifications:

    - At least master's level education/training or its equivalent in health financing, marketing, business, economics, health administration or related field.
    - Experience as a sales/marketing director, and strong business acumen in areas of business process and analysis would be highly valued and considered
    - Demonstrated experience in developing and implementing BCC approaches to address FP and MCH requirements
    - Experience working with local and international NGOs and donors preferred

- Successful prior experience in social marketing and behavior change communication
- Experience in the management of P&L, development of pricing strategies that allow for regional differentials, development of strategy for all marketing channels, generation of marketing plans, implementation of customer roadmap
- Familiarity with principal individuals within the DOH, other government agencies, private/business sector, and the community at large who are responsible for health policy.
- Familiarity with private sector health service provision.
- Filipino citizen preferred but a U.S. citizen will be considered.

3.3 Senior Health Policy and Financing Advisor (SPFA) - The Senior Health Policy and Financing Advisor (HPFA), in consultation with the project officers and partners, shall be responsible for leading efforts to strengthen national and local level policies that impact on FP/MCH services delivery and utilization, following through with the pertinent policy-making institutions, and ensuring readiness for take-up or operationalization.

The HPFA shall take the lead in initiatives to improve the effectiveness, efficiency and equity of health financing mechanisms, involving both public and private sources, towards expanding delivery of FP/MCH services.

S/he shall be responsible for overseeing the project's health policy and health finance portfolio.
S/he shall represent the project in health financing and policy activities on the ground and is responsible for ensuring their successful implementation.

The responsibilities of the Senior HPFA include:

1. Lead, facilitate and/or coordinate the formulation of policy advocacy strategy and the health financing strategy towards improving delivery of FP/MCH services, with particular attention to how current and proposed policies can be operationalized
2. In coordination with the COP, provide principal technical oversight for all policy studies, diagnostic and/or operations research studies, demonstration projects, training and technical assistance
3. Develop monitoring and evaluation systems for policy and financing work that shall allow measurement of short-term gains or shortfalls, consistent the project goals and initiatives
4. Serve as technical advisor, perform essential analytical, evaluative and consultative work, develop and implement technical aspects of the project's health financing and health policy activities, provide technical assistance on a daily basis, and is a hands-on resource for ensuring activity implementation and building partners' institutional capacity
5. Provide the necessary expertise in determining viable options to improve financing of health services both at the national and local levels. Recommend viable ways of operationalizing health investment planning and budgeting at the local level.
6. Actively participate in the USAID Policy technical working group, and other policy venues, with the conscious agenda that reflect private sector concerns and interests;
7. Strengthen or lead the formation, if non-existent, of a health policy discussion group that involves public and private sector partners;
8. Work closely with the Department of Health's Policy Unit, as well as with attached agencies such as PhilHealth and the Bureau of Food and Drugs for policies, regulations and processes that bear on the delivery and utilization of FP/MCH services
9. In coordination with project staff, actively contribute to the design of health financing models and approaches for FP/MCH services delivery in various settings or involving different provider and client groups; Also be involved in the monitoring, evaluation, documentation and lesson-taking from project field experiments/experiences
10. Provide the project staff and USAID regular updates on the progress of the project's as well as partners' policy and financing initiatives
11. Build and sustain an effective partnership with the DOH Policy Unit in support of project FP/MCH service delivery goals and towards strengthening the capacity of DOH in policy and financing

Desired Qualifications for the Senior HPFA:

- Master's level education/ training or equivalent experience in finance, health economics, or related field. Familiarity and understanding of local government financial systems, development of systems for resource mobilization for family planning and other health programs.
- Contacts with key officers of the DOH, PhilHealth and BFAD
- Familiarity with FP and MCH issues and other health areas that are related to FP/MCH

3.4 **Alliance Public/Private Partnership Development Advisor (APDA) -** The Alliance/Public-Private Partnerships Development Advisor (APDA) shall work to maximize the engagement of civil society organizations in all aspects of the project. This shall include developing and implementing strategies to encourage greater private sector participation in FP and MCH services delivery.

The APDA shall facilitate institutional capacity development, problem solving, demand creation, and information flows between private and public organizations. Under the overall guidance of the USAID COTR through the COP, and in coordination with project partners, the APDA shall develop new and strengthen partnerships with and among the public and private organizations in support of project goals and towards partner institutions' capacity development

The responsibilities of the APDA include the following:

1. Lead the development and implementation of the project's partnership strategies, policies and approaches taking into account the special requirements of various partnership/alliance target groups
   - Coordinate with relevant project staff so that progress in technical working groups that the project participates in are all factored in into the project's alliance/partnerships building initiatives
   - Work with relevant teams – government, USAID, other USAID projects, the private business and civil society sectors, and LGUs on FP/MCH issues, events and activities
2. Leverage resources, skills, knowledge and experience of partner organizations at the national and local levels, in the public and private sectors, in support of the implementation of project goals and activities
3. Forge and strengthen meaningful private sector engagement with the public sector, with particular consideration for the USAID Global Development Alliance principles and guidelines
4. Lead the development and implementation of the strategy for grants management, in synergy with the project's alliance and partnership building strategy and in support of project goals
5. Actively participate in the selection of grant partners, and in monitoring and evaluation for continuing grant project improvement
6. Participate in the development and implementation of project strategies and policies
7. Provide the external partners' perspective in the development of project organizational policy and strategies
8. Ensure regular and timely communication of key messages and project-related updates with partners, networks and technical assistance partners
9. Ensure understanding and communication among partners regarding project requirements and responsibilities in other project-related processes
10. Develop strong and effective working relationships with public and private partner organizations and networks at the national and local levels, particularly those from priority populations and priority sites
11. Leverage skills, knowledge and experience of partner private and public organizations to support implementation of project activities and project grants while ensuring capacity development and institutional buy-in of such partners
12. Provide recommendations to strengthen private involvement in both project and project grant activities
13. Facilitate and identify technical support needs for project partners with an emphasis on sourcing internal resources and in-country support providers

14. Ensure, facilitate and support the visibility of partners as key participants in project activities
15. Ensures communication exchanges and coordinates with project staff and USAID on the progress and issues in alliance and partnership building to ensure synergy with project efforts, with overall USAID health efforts, and those of partners.

Desired Qualifications for the APDA:

- Proven track record of building and sustaining effective partnerships, advocating effectively and communicating to various constituencies
- Demonstrable effective prior experience in grants management
- Successful prior experience as technical facilitator or coordinator of multisectoral organizations or formations involving both the public and private sectors
- Advanced university degree in public health, development studies, social work and community development, public relations or other relevant area or equivalent professional training or self-study/work experience
- A wide network of contacts who are key influencers in both government, LGUs, civil society and the business sector at the national and local levels
- Has at least 5 years experience working in government and in the private sector
- 7-19 years experience working in projects or initiatives involving multiple stakeholder groups, including NGOs
- Experience working in developing country contexts
- Innovative thinker and solution-oriented; ability to develop practical and realistic solutions to identified issues; Self-starter; able to work under pressure, tight deadlines and delivery timely and high quality work
- Focused on results and pragmatic outcomes
- Ability to coordinate across various projects and teams in a dynamic environment
- Strong project management skills

Key Qualifications:

All the foregoing core project positions shall require the following qualifications:

- Exceptional interpersonal and relationship-building competencies coupled with strong written and verbal communication skills
- Demonstrable experience or knowledge of monitoring and evaluation mechanisms that contribute to health project strategy improvements
- Experience in identifying and presenting findings, results and lessons learned to international audiences
- Significant long- and/or short-term experience in providing field-based technical assistance in the area of expertise in at least two developing countries
- Experience with USAID projects
- At least master's level education
- Fluency in English at the S5/R5 level required
- Demonstrated understanding and knowledge of and familiarity with health systems, health financing, and health program policy issues in the Philippines and/or other developing countries.
- At least 10 years experience in designing, managing, or assessing and evaluating health programs in a developing country setting, preferably in the Philippines or in Asia
- Skills in writing, analysis and preparation of evaluation reports highly desirable.
- Demonstrated understanding and knowledge of and familiarity with health systems and public health program management in the Philippines.
- LGU experience. Work experience in the field of governance, including health governance.
- A thorough understanding of the Local Government Code of the Philippines, the complexity, dynamics and nuances of local government administration, and the regulatory and current issues of LGUs in the Philippines.
- Familiarity and experience working with or on:
    - The DOH health sector reform agenda and strategy

- Roles and functions and issues of DOH, Bureau of Food and Drugs (BFAD) and PhilHealth, DOLE,
- The Philippine's contraceptive self-reliance (CSR) strategy
- Developmental perspective/poverty reduction approaches via health initiatives
- Multisectoral coordination skills
- A network of contacts in government, LGUs, business and civil society

- Proven successful prior experience in building and maintain relationships with partners, USAID, DOH, LGUs, and pertinent other government agencies and instrumentalities at the national and local levels
- Conceptual and analytical ability, good judgment, and adaptive, flexible capacity

IX. BACKGROUND READING

The following documents can be downloaded from the USAID/Philippines website using this link: http://philippines.usaid.gov/ophn.php

1. PRISM End-of-Project Evaluation, March 2009
2. PRISM Mid-Term Evaluation, March 2008
3. PRISM Strategy Assessment, December 2006
4. Contraceptive Social Marketing: Performance and Prospects, June 2005

For an overview of all the US legislative and policy requirements for family planning programs visit the USAID external website at this link: http://www.usaid.gov/our_work/global _health/family planning.

Other PRISM reports and documents are found in this link: http://dec.usaid.gov/.

X. EVALUATION CRITERIA

The Technical Proposal will be evaluated and point scored by a Technical Evaluation Committee, comprised of panel members from USAID and the Host Government, utilizing the criteria set forth below.

The Technical Proposal in response to this solicitation should address how the offeror intends to carry out the Statement of Work described in this solicitation. It should also demonstrate a clear understanding of the work to be undertaken and the responsibilities of all parties involved. The technical proposal should be organized in accordance with the technical evaluation criteria listed herein.

1.0 Proposed Approach 32 points

1.1. Offerors must describe their understanding of the implementation challenges beyond restating the information in the RFP. As elaborated in the proposed work plan, the project approach shall be evaluated based on the likelihood of achieving the expected results within the proposed timeframe and budget and the appropriateness of the activities with respect to achieving the Mission's objective for family planning and health. Lastly, building on past and present experience, Offerors must describe clearly the new techniques and approaches to ensure that key implementation results shall be sustained following completion of the Project. (**10 points)**

1.2. Descriptions must demonstrate a clear understanding of the cultural, social and institutional norms in the country, consider lessons learned from past related activities as well as an understanding of local capacities and demonstrated inclusion of the affected populations in program planning and implementation. The Offeror must demonstrate a clear understanding of how the private health, health financing and business sectors operate in the Philippines and how experiences in other countries shall be brought to bear on the Philippines. They must also demonstrate an understanding of the roles and approaches the public sector must play in facilitating an active private sector in family

planning and suggest approaches to ensuring that necessary public sector approaches take place. **(10 points)**

1.3 To the extent possible, performance indicators and performance standards by which USAID will monitor the contractor's achievement of results, including how data will be collected, must be clearly identified in a draft Performance Monitoring Plan. A customer service plan for ensuring customer satisfaction must also be adequately described. **(6 points)**

1.4 Technical proposals should be as concise and to the point as possible. The technical proposal should state clearly its understanding of the requirements in the Statement of Work, its proposed approach to accomplish the contract objectives and achieve the expected results, as well as its personnel and organizational credentials to carry out the activity. Clarity, completeness, and directness are imperative. **(6 points)**

2.0 Proposed Personnel 25 Points

Proposed personnel (both key personnel and other project staff) must demonstrate relevant expertise and experience in managing and implementing similar projects. Project personnel must demonstrate sector specific experience/capability in the proposed activities and appropriate knowledge of the targeted areas and stakeholders. Curricula Vitae, no more than three (3) pages long, should be included for each key project personnel proposed. The Offeror's shall be scored based on the following sub criteria:

1) the demonstrated quality of proposed Chief of Party (**10 points**)
2) the demonstrated quality of other proposed personnel (**10 points**)
3) the demonstrated understanding of the Statement of Work (SOW) as evidenced by over-all staffing plan (**5 points**).

3.0 Management Plan 15 points

Offerors are required to submit a Management Plan which discusses the overall management approach toward planning and implementation. The Management Plan shall:

- Provide the organizational structure for managing the project;
- Provide brief position descriptions for core team members;
- Discuss the role and responsibilities of the Chief of Party (COP), Deputy COP, and other personnel not identified in the RFTOP;
- Discuss the field core staff role, composition, and organization;
- Discuss the support capabilities of home office;
- State the target date for having the team in the Philippines;
- Explain the offeror's ability to find qualified consultants; and outline how the offeror shall access consultants that might be required for specialty areas such as, public sector contracting of private sector services, franchising models for midwives, business development, concept marketing (e.g. FP/MCH, facility-based deliveries), micro-financing, and US statutory and policy family planning requirements compliance.

4.0 Past Performance Using Small Business Concerns 3 Points

As part of the evaluation of past performance, USAID will evaluate the extent the offeror used and promoted the use of small business concerns under current and past 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 the offeror's small business subcontracting plan and other similar small business incentive programs set out in the offeror's contracts.

5.0 Gender Concerns **5 points**

Demonstrated understanding of the role of both men and women in making decisions in determining the number and the spacing of children and in making decisions about their children's health and how it proposes to address these roles in the course of project implementation. The evaluation will also assess the extent of the offeror's knowledge of gender sensitivities in delivering health services and products and how it proposes to ensure health facilities receiving support from the project have the capacity to respond to special needs of men, women, boys and girls in providing FP and MCH services, products and information.

6.0 Cost Proposal **20 points**

The review of the cost proposal shall include primarily cost realism, allowability, completeness and reasonableness analyses. This will consist of a review of the cost portion of an Offeror's proposal to determine if the overall costs proposed are realistic for the work to be performed, if the costs reflect the Offeror's understanding of the requirements, and if the costs are consistent with the technical proposal. As a result of the cost realism analysis, the Government may adjust the Offeror's proposed costs to reflect any additions and reductions in cost elements of realistic levels.

The cost evaluation will use several bases of comparison including established rates in the Offeror's IQC, independent government estimate, comparison with other Offerors' proposals, market and recent prices for same or similar services, and supporting data included in the proposal will be consider but not be limited to the following:

- Cost realism, reasonableness and completeness of cost proposal and supporting documentation.
- Overall cost control evidenced by proposal (such as avoidance of excessive salaries, excessive home office staff visits, and other costs in excess of reasonable requirements).
- Amount of proposed fee

TOTAL **100 points**

Determination of the competitive range and contract award:

(i) The Government intends to evaluate proposals and may award a contract without discussions. However, the Government reserves the right to conduct discussions if determined by the Contracting Officer to be necessary. Therefore, each initial offer should contain the Offeror's best proposal from both a cost and a technical standpoint.

(ii) Award: In accordance with FAR 52.215-1(f) and in connection with the subject IQC, the Government intends to award a task order resulting from this solicitation to the responsible Offeror whose proposal represents the best value after evaluation in accordance with the factors and sub-factors as set forth in this solicitation.

XI. REPORTS AND DELIVERABLES OR OUTPUTS

All reports shall be in the English language. The Contractor shall promptly notify the COTR of any problems, delays or adverse conditions which materially impair the contractor's ability to meet the requirements of the contract.

All project outputs and deliverables will be submitted to the COTR in both hard copy and electronic (pdf or editable) format. Hard copies will be printed/copied double sided.

(a) Monthly Reports: The Contractor shall provide to the COTR, within 5 days after the end of each month, a report on the activities undertaken during the month. The monthly report should seek to be a

brief yet precise, description of the activities, with emphasis on issues that have arisen, impacts made, constraints encountered, and suggestions for additional actions that might be taken. The monthly report should also include the Contractor's accrued monthly expenditures. The COTR is responsible for transmitting this information to the USAID financial management office responsible for the contract.

(b) Quarterly Reports: Quarterly Reports shall be submitted within seven calendar days before the start of the new quarter. The scope and format of the quarterly reports will be determined in consultation with the COTR.

(c) Annual Workplans: Annual Workplans shall be required of the Contractor that will detail the work to be accomplished during the upcoming year. The scope and format of the Annual Workplan will be agreed to between the Contractor and the COTR during the first thirty days after the award of the contract. These Annual Workplans may be revised on an occasional basis, as needed, to reflect changes on the ground and with the concurrence of the COTR.

The first Annual Workplan shall be submitted within one month of award of the contract and subsequent annual workplans shall be submitted to the COTR no later than November 15th of each year for the next planning year. The workplan should include the estimated monthly funding requirements during the upcoming year of program implementation, necessary to meet all program objectives within the contract. USAID will respond to the workplan within five calendar days.

(d) Final Report: The Contractor shall prepare a final report that matches accomplishments to the specific paragraphs of the Scope of Work. The final report will be drafted to allow for incremental improvements in the process, both generally within USAID and specifically with respect to this contract.

(e) Short-Term Consultants Reports: Upon completion of the services of all short-term consultants, the Contractor shall submit a report to the COTR summarizing the activities, contributions, and recommendations of the consultant.

(f) Special Reports: In addition to the reports specified herein, the Contractor, at USAID's request shall provide USAID with reports on specific aspects of contract implementation. For example, it is assumed that informal, frequent, and detailed progress reporting will be provided to USAID in a manner agreed upon between the Contractor and the COTR. Other examples of special reports are success stories and technical notes.

(g) Branding Strategy and Marking Plan: The Contractor shall submit a Branding Strategy and Marking Plan to the COTR and the Contracting Officer no later than 90 days after contract award.

XII. USE OF GOVERNMENT FACILITIES OR PERSONNEL

The Contractor and any employee or consultant of the Contractor is prohibited from using U.S. Government facilities (such as office space or equipment) or U.S. Government clerical and technical personnel in the performance of the services specified in the Task Order unless the use of Government facilities or personnel is authorized in advance, in writing, by the Contracting Officer.

XIII. LOCATION OF WORK

The Duty Post for this task order is Manila and other appropriate locations in the Philippines.

XIV. PERIOD OF PERFORMANCE

A. Performance shall be from the date of the signing of the Task Order through September 30, 2014.

B. Subject to the ceiling price of this Task Order, The Contractor's performance and the prior written approval of the COTR, the Contractor may be authorized to extend the estimated completion date set forth herein, provided that the extension does not cause the elapsed time for completion of the work, including the furnishing of all deliverables, to extend beyond 60 calendar days from the original completion date. The Contractor shall provide a copy of the COTR's approval to the final voucher submitted for payment. In no event shall the expiration date of this Task Order, with any authorized extension, exceed the expiration date of the basic IQC contract with any currently approved Task Order performance extension period, unless an extension to the base contract or further Task Order performance period extension is affected by the USAID/W Contracting Officer.

C. It is the Offeror's responsibility to ensure that the COTR's approved adjustment to the original completion date does not result in costs incurred that exceed the ceiling price for this Task Order. Under no circumstances shall each adjustment authorize the contract to be paid any sum in excess of the task order.

XV. PERFORMANCE STANDARDS

Evaluation of the Contractor's overall performance will be conducted jointly by the COTR and the Task Order Contracting Officer, and will form the basis of the Contractor's permanent performance record with regards to this task order. USAID will evaluate contractors performance at least annually and upon task order completion in accordance with AAPD 06-05 Evaluation and Use of Contractor Performance Information. USAID will utilize the National Institutes of Health (NIH) Internet based Contractor Performance System to perform these evaluations.

XVI. MONITORING, EVALUATION, AND AUDIT

In close coordination with implementing partners, the principal technical assistance contractor for this phase of the PRISM Project will develop a performance monitoring plan. This plan will identify expected results, performance indicators, baseline and annual targets, data sources, collection frequency, and collection responsibility. Based on annual work plans, the contractor will prepare quarterly progress reports, identify implementation challenges and recommendations to facilitate and improve performance. USAID/Philippines and other implementing partners will monitor progress on a regular basis.

An evaluation of the PRISM Project will be conducted during year 3 of the implementation of the Program to assess contractor performance, determine impact, measure accomplishments, and validate program design. This will provide the basis for modifying plans for the final years of program implementation, and determining future directions.

USAID will also arrange for external audits when deemed necessary, and to comply with any USAID audit requirements.

XV. LOGISTIC SUPPORT

The Contractor shall be responsible for providing or arranging for all logistic support needed to successfully complete the Task Order.

XVI. ACCESS TO CLASSIFIED INFORMATION

The Contractor shall <u>not</u> have access to classified information.

XVII. LANGUAGE REQUIREMENT

Proficiency in English language is required to accomplish the requirements of this Task Order.

XVIII. AUTHORIZED GEOGRAPHIC CODE

The authorized geographic code for procurement of goods and services under this award is 000. In addition, the Cooperating Country is an authorized source for local procurement in accordance with 22 CFR 228.40 and in accordance with paragraph (b) (1) of the Standard Provision Entitled "USAID Eligibility Rules for Goods and Services."

XIX. TITLE TO AND CARE OF PROPERTY

Title to all property acquired and financed hereunder shall vest in the U.S. Government, subject to the requirements of AIDAR 752.245-71 regarding use, accountability, and disposition of such property.

XX. HOST COUNTRY TAXES

Under the bilateral agreement between USAID/Philippines and the Government of the Philippines development assistance programmatic funds are exempt from taxes to the GRP. As such USAID does not finance any identifiable host country taxes. The Contractor is responsible for asserting and obtaining the necessary tax exemptions. On request USAID/Philippines will provide available documentation to support allowable exemption from host-country taxes.

The GRP has a Value Added Tax (VAT) of 12% that it levies on all commercial transactions. The VAT is not an allowable cost under this contract. Before incurring this tax, the Contractor shall contact the COTR about an exemption certificate from VAT.

XXI. SECURITY

The Contractor must be aware of security conditions in the Philippines and, by entering into the contract, assumes full responsibility for the safety of its employees. Prior to commencing work in the Philippines, the contractor shall consult with USAID on procedures to be put in place which will keep the contractor adequately informed of the security situation and will enable it to locate and rapidly contact its employees working in the Philippines in order to advise them of situations or changed conditions which could adversely affect their security. Contractors and their dependents are required to follow all Security Advisories, Pyramid Alerts and Warden Notices that are issued at post.

In keeping abreast of security conditions in the Philippines, the contractor shall seek information from the U.S. Embassy Regional Security Office (RSO) and USAID for all areas where its employees work or travel.

The Contractor shall designate an employee, and an alternate, who will be responsible for contacting employees in the event that USAID requests the Contractor to do so. The Contractor shall provide USAID with the name, address, home telephone number and mobile phone number of the designated employee. The Contractor shall ensure that USAID has available at all times a telephone number in country where either the designated individual or an alternate has the means to rapidly contact all other affected employees.

XX. PHILIPPINE VISAS FOR CONTRACTOR STAFF AND DEPENDENTS

The Contractor shall be responsible for securing the appropriate visas for its long-term/short-term staff, including accompanying dependents. The Contractor is advised that special, non –immigrant, multiple entry visas under Section 47(a)(2) of the Philippine Immigration Act of 1940 are needed for its employees and their dependents. Fifty-nine day visas need to be obtained before coming to post. USAID may provide the Contractor's in-country staff with a certification regarding their employment under this contract.

XXI. USE OF PROJECT VEHICLES

It is USAID policy that the Contractor shall use project vehicles only for official transportation. Personal use of project vehicles (whether purchased or rented) is not authorized. Prohibited uses of USAID-financed vehicles include recreation or commuting (unless commuting use is approved by the Contracting Officer and a free-for-use system is established). The USAID Contracting Officer must approve any exception to this policy.

XXII. AIRFARE TRAVEL RESTRICTION

Costs for airfare in excess of the lowest customary economy coach or equivalent airfare are unallowable except when such travel accommodations require circuitous routing, excessively prolong travel, result in increased cost that would offset transport savings, are not reasonably adequate for the physical or medical needs of the traveler as determined by a practicing medical doctor. However, in order for airfare costs in excess of such economy coach airfare to be allowable, the applicable condition(s) set forth above must be documented, justified and specifically approved by the Contracting Officer.

XXIII. FOREIGN GOVERNMENT DELEGATIONS TO INTERNATIONAL CONFERENCES

Funds in this award may not be used to finance travel, per diem, hotel expenses, meals, conference fees pr other conference costs for any member of a foreign government's delegation to an international conference sponsored by a public international organization, except as provided in Ads Mandatory Reference :Guidance on Funding Foreign Government Delegations to International Conferences (http://www.info.usaid.gov/pubs/ads/300 refindx3.htm) or as approved by the Contracting Officer.

XXIV. SALARY SUPPLEMENTATION

No payment shall be made to any employee of any government without the advance written approval of the Contracting Officer.

XXV. EXECUTIVE ORDER ON TERRORISM FINANCING

The Contractor/Recipient is reminded that U.S. Executive Orders and U.S. law prohibits transactions with, and the provision of resources and support to, individuals and organizations associated with terrorism. It is the legal responsibility of the contractor/recipient to ensure compliance with these Executive Orders and laws. This provision must be included in all subcontracts/subawards issued under this contract/agreement. Refer to http://treasury.gov/ofac for which lists entities or individuals as terrorists or entities or individuals that pose a significant risk of terrorist acts.

Pursuant to the requirements of USAID Acquisition & Assistance Policy Directive (AAPD) 04-07, dated March 24, 2004, the Recipient has signed and dated the Revised Certification Regarding Terrorist Financing Implementing Executive.

XXVI. PROHIBITION ON THE USE OF FEDERAL FUNDS TO PROMOTE, SUPPORT, OR ADVOCATE THE LEGALIZATION OR PRACTICE OF PROSTITUTION – TIP ACQUISITION (MAY 2007)

(a) The U.S. Government is opposed to prostitution and related activities, which are inherently harmful and dehumanizing, and contribute to the phenomenon of trafficking in persons. None of the funds made available under this contract may be used to promote, support, or advocate the legalization or practice of prostitution. Nothing in the immediately preceding sentence shall be construed to preclude assistance designed to ameliorate the suffering of, or health risks to, victims while they are being trafficked or after they are out of the situation that resulted from such victims being trafficked.
(b) The contractor shall insert this clause, in its entirety, in all sub-awards under this award.

(c) This provision includes express terms and conditions of the contract and any violation of it shall be grounds for unilateral termination of the contract, in whole or in part, by USAID prior to the end of the term.

XXVII. 752.7101 VOLUNTARY POPULATION PLANNING ACTIVITIES (JUNE 2008)

(a) *Requirements for Voluntary Sterilization Program.* None of the funds made available under this contract shall be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any individual to practice sterilization.

(b) *Prohibition on Abortion-Related Activities.*

(1) No funds made available under this contract will be used to finance, support, or be attributed to the following activities: (i) procurement or distribution of equipment intended to be used for the purpose of inducing abortions as a method of family planning; (ii) special fees or incentives to any person to coerce or motivate them to have abortions; (iii) payments to persons to perform abortions or to solicit persons to undergo abortions; (iv) information, education, training, or communication programs that seek to promote abortion as a method of family planning; and (v) lobbying for or against abortion. The term “motivate”, as it relates to family planning assistance, shall not be construed to prohibit the provision, consistent with local law, of information or counseling about all pregnancy options.

(2) No funds made available under this contract will be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilizations as a means of family planning. Epidemiologic or descriptive research to assess the incidence, extent or consequences of abortions is not precluded.

(c) The contractor shall insert this provision in all subcontracts.

(End of clause)

Alternate I (JUNE 2008). If a contract with family planning activities is contemplated, add the following paragraphs (d-g) to the basic clause:

(d) *Voluntary Participation and Family Planning Methods.*

(1) The contractor agrees to take any steps necessary to ensure that funds made available under this contract will not be used to coerce any individual to practice methods of family planning inconsistent with such individual's moral, philosophical, or religious beliefs. Further, the contractor agrees to conduct its activities in a manner which safeguards the rights, health and welfare of all individuals who take part in the program.

(2) Activities which provide family planning services or information to individuals, financed in whole or in part under this contract, shall provide a broad range of family planning methods and services available in the country in which the activity is conducted or shall provide information to such individuals regarding where such methods and services may be obtained.

(e) *Requirements for Voluntary Family Planning Projects.*

(1) A family planning project must comply with the requirements of this paragraph.

(2) A project is a discrete activity through which a governmental or nongovernmental organization or public international organization provides family planning services to people and for which funds obligated under this contract, or goods or services financed with such funds, are provided under this contract, AAPD 08-01 Voluntary Population Planning Activities – Updated Requirements and Clause except funds solely for the participation of personnel in short-term, widely attended training conferences or programs.

(3) Service providers and referral agents in the project shall not implement or be subject to quotas or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning. Quantitative estimates or indicators of the number of births, acceptors, and acceptors of a particular method that are used for the purpose of budgeting, planning, or reporting with respect to the project are not quotas or targets under this paragraph, unless service providers or referral agents in the project are required to achieve the estimates or indicators.

(4) The project shall not include the payment of incentives, bribes, gratuities or financial rewards to (i) any individual in exchange for becoming a family planning acceptor or (ii) any personnel performing functions under the project for achieving a numerical quota or target of total number of births, number

of family planning acceptors, or acceptors of a particular method of contraception. This restriction applies to salaries or payments paid or made to personnel performing functions under the project if the amount of the salary or payment increases or decreases based on a predetermined number of births, number of family planning acceptors, or number of acceptors of a particular method of contraception that the personnel affect or achieve.

(5) No person shall be denied any right or benefit, including the right of access to participate in any program of general welfare or health care, based on the person's decision not to accept family planning services offered by the project.

(6) The project shall provide family planning acceptors comprehensible information about the health benefits and risks of the method chosen, including those conditions that might render the use of the method inadvisable and those adverse side effects known to be consequent to the use of the method. This requirement may be satisfied by providing information in accordance with the medical practices and standards and health conditions in the country where the project is conducted through counseling, brochures, posters, or package inserts.

(7) The project shall ensure that experimental contraceptive drugs and devices and medical procedures are provided only in the context of a scientific study in which participants are advised of potential risks and benefits.

(8) With respect to projects for which USAID provides, or finances the contribution of, contraceptive commodities or technical services and for which there is no sub-contract or grant under this contract, the organization implementing a project for which such assistance is provided shall agree that the project will comply with the requirements of this paragraph while using such commodities or receiving such services.

(9) (i) The contractor shall notify USAID when it learns about an alleged violation in a project of the requirements of subparagraphs (3), (4), (5) or (7) of this paragraph; and (ii) the contractor shall investigate and take appropriate corrective action, if necessary, when it learns about an alleged violation in a project of subparagraph (6) of this paragraph and shall notify USAID about violations in a project affecting a number of people over a period of time that indicate there is a systemic problem in the project.

(iii)The contractor shall provide USAID such additional information about violations as USAID may request.

(f) *Additional Requirements for Voluntary Sterilization Programs.*

(1) The contractor shall ensure that any surgical sterilization procedures supported in whole or in part by funds from this contract are performed only after the individual has voluntarily appeared at the treatment facility and has given informed consent to the sterilization procedure. Informed consent means the voluntary, knowing assent from the individual after being advised of the surgical procedures to be AAPD 08-01 Voluntary Population Planning Activities – Updated Requirements and Clause followed, the attendant discomforts and risks, the benefits to be expected, the availability of alternative methods of family planning, the purpose of the operation and its irreversibility, and the option to withdraw consent anytime prior to the operation. An individual's consent is considered voluntary if it is based upon the exercise of free choice and is not obtained by any special inducement or any element of force, fraud, deceit, duress, or other forms of coercion or misrepresentation.

(2) Further, the contractor shall document the patient's informed consent by (i) a written consent document in a language the patient understands and speaks, which explains the basic elements of informed consent, as set out above, and which is signed by the individual and by the attending physician or by the authorized assistant of the attending physician; or (ii) when a patient is unable to read adequately a written certification by the attending physician or by the authorized assistant of the attending physician that the basic elements of informed consent above were orally presented to the patient, and that the patient thereafter consented to the performance of the operation. The receipt of this oral explanation shall be acknowledged by the patient's mark on the certification and by the signature or mark of a witness who shall speak the same language as the patient.

(3) The contractor must retain copies of informed consent forms and certification documents for each voluntary sterilization procedure for a period of three years after performance of the sterilization procedure.

(g) The contractor shall insert this Alternate I in all subcontracts involving family planning activities.

XXVIII. USAID DISABILITY POLICY – ACQUISITION (DECEMBER 2004)

(a) The objectives of the USAID Disability Policy are (1) to enhance the attainment of United States foreign assistance program goals by promoting the participation and equalization of opportunities of individuals with disabilities in USAID policy, country and sector strategies, activity designs and implementation; (2) to increase awareness of issues of people with disabilities both within USAID programs and in host countries; (3) to engage other U.S. government agencies, host country counterparts, governments, implementing organizations and other donors in fostering a climate of nondiscrimination against people with disabilities; and (4) to support international advocacy for people with disabilities. The full text of the policy paper can be found at the following website: http://www.usaid.gov/about/disability/DISABPOL.FIN.html.

(b) USAID therefore 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."

Attachment 2

ORGANIZATIONAL CONFLICTS OF INTEREST REPRESENTATION

1. (a) The contractor represents, to the best of its knowledge and belief, that the award to it of a delivery order or the modification of an existing delivery orders does [ ] or does not [ ] involve an organizational conflict of interest.

   (b) The term "organizational conflict of interest" means that a relationships exists whereby an offeror or a contractor (including its chief executives, directors, proposed consultants or subcontractors) has interest which (i) may diminish its capacity to give impartial, technically sound, objective assistance and advice or may otherwise result in a biased work product, or (ii) may result in an unfair competitive advantage. It does not include the normal flow of benefits from the performance of a contract.

   (c) The term "Contractor" means any person, firm, unincorporated association, joint venture, partnership, corporation or affiliate thereof, which is a party to a contract with the United States of America. As used in this definition, the term "affiliate" has the same meaning as provided in FAR 19.101.

2. If the contractor indicates that there are organizational conflicts of interest in the "Organizational Conflicts of Interest Representation", the contractor shall provide a statement which describes in a concise manner all relevant facts concerning any present or current planned interest (financial, contractual, organizational, or otherwise) relating to the work to be performed in the proposed delivery order and bearing on whether the contractor has a possible organizational conflict of interest with respect to being able to render impartial, technically sound, and objective assistance or advice, or being given an unfair competitive advantage. The contractor may also provide relevant facts that show how its organizational structure and/or management systems limit its knowledge of possible organizational conflicts of the organization and how that structure or system would eliminate or neutralize such organizational conflict.

_____
Name of Contractor

By : _____
Signature

Name : _____
Type or printed name of authorized official

Date : _____