Request for Proposals

Service Providers for 23 lots to Provide Health Services in South Sudan

June 2016

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List of Abbreviations

BEmONC	Basic Emergency Obstetric and Neonatal Care
BHI	Boma Health Initiative
BPHNS	Basic Package of Health and Nutrition Services
BSF	Basic Services Fund
CBHMIS	Community based health management information system
CBO	Community Based Organisation
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHD	County Health Department
CMAM	Community Based Management of Acute Malnutrition Model
CMW	Community Midwife
CP	County Partners
CV	Curriculum Vitae
DDQ	Due Diligence Questionnaire
DFID	Department for International Development
DHIS	District Health Information System
DPs	Development Partners
ECHO	European Community Humanitarian Office
EmONC	Emergency Obstetric and Neonatal Care
EPI	Expanded Programme for Immunisation
EU	European Union
FBO	Faith Based Organisation
FMA	Financial Management Assessment
FMS	Finance Management System
GESS	Girls' Education South Sudan
GRSS	Government of the Republic of South Sudan
GSI	Gender and Social Inclusion
HHP	Home Health Promoter
HIS	Health Information System
HMIS	Health Management Information Systems
HPF	Health Pooled Fund
HPF2	Health Pooled Fund Phase 2
HRH	Human Resources for Health
HRIS	Human Resource Information Systems
HSDP	Health Sector Development Plan
ICCM	Integrated Community Case Management
IDSR	Integrated Disease Surveillance and Response
INGO	International Non-Governmental Organisation
IMR	Infant Mortality Rate
IP	Implementing Partner
LLITN	Long-Lasting Insecticide-Treated Net
M&E	Monitoring and Evaluation
MAM	Moderate Acute Malnutrition

MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOU	Memorandum of Understanding
NIDs	National Immunisation Days
NNGO	National Non-Governmental Organisation
NTDs	Neglected Tropical Diseases
OFDA	Office of U.S. Foreign Disaster Assistance
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PPH	Post-partum Haemorrhage
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit
PMIS	Pharmaceutical Management Information System
QSC	Quantified Supervisory Checklist
SAM	Severe Acute Malnutrition
SIDA	Swedish International Development and Cooperation Agency
SMOH	State Ministry of Health
SP	Service Provider
SSDP	South Sudan Development Plan
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAWG	Violence against Women and Girls
VFM	Value for Money
WASH	Water Sanitation and Hygiene
WFP	World Food Programme

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1. Section A: Introduction

1. The Ministry of Health (MOH), Government of the Republic of South Sudan (GRSS) and the Health Pooled Fund (HPF) are pleased to announce this Request for Proposals (RFP) for Service Providers (SPs) to work with GRSS in the following eight (former) states: Central Equatoria, Western Equatoria, Eastern Equatoria, Lakes, Warrap, Unity, Northern Bahr el Ghazal, Western Bahr el Ghazal.

   Under the HPF Phase II (HPF2), Service Providers are sought to support the Government of the Republic of South Sudan:

   - To increase access, use and quality of health services across all levels, particularly for women, children and vulnerable groups.
   - To strengthen the health system under the stewardship of the County Health Departments (CHDs).
   - To increase access to nutrition services particularly for pregnant women and young children

   Further information on the activities under this RFP can be found at Section F: Terms of Reference, of this document.

2. This is a full and open competition under which any type of organisation, large or small, commercial (for profit) firms, faith-based, and non-profit organisations, either independently, or in partnership or consortia, are eligible to compete.

3. The HPF encourages partnership with local, non-governmental organisations (NGOs), faith-based organisations (FBOs) and community based organisations (CBOs) in order to build local capacity and ensure long term sustainability.

4. Only one contract will be awarded per lot. Whilst the contract may be awarded to a consortia of organisations, there must be one designated lead agency accountable to the MOH and the HPF.

5. Bidders selected as the preferred provider of the services specified in the Terms of Reference ("the Services"), in any of the 23 lots covered by the RFP, will be expected to sign a contract which will, amongst other things:
   1. be governed by and construed in accordance with English law
   2. be written in the English language
   3. state the period during which the services are to be performed, with key milestones
   4. specify key personnel, fee rates and other chargeable costs fixed for the duration of the contract
   5. include the original Terms of Reference, modified to incorporate any agreed revisions
   6. detail reporting requirements

6. The complete RFP document is composed of:
   1. Section A: Introduction (this section)
   2. Section B: General Conditions
   3. Section C: Proposal Preparation and Instructions

4. Section D: Bid Evaluation Process and Criteria
5. Section E: Negotiation and Contract Award
6. Section F: Terms of Reference
7. Terms of Reference Annexes
8. Appendix A: Documents for submission
9. Appendix B: Standard form of contract for Service Providers

2. Section B: General Conditions

2.1 Definitions

- "Bidder": an organisation submitting a bid in response to this RFP
- "Client": refers to Crown Agents Limited
- "Consortium": the grouping of organisations (i.e. the main bidder and its partners for the purpose of implementing the proposed action)
- "Service Provider": an organisation appointed to provide the services required under this RFP

2.2 Conflict of Interest

1. The selected Service Providers are required to be professional, objective, and impartial, at all times holding the client's interests paramount, strictly avoiding conflicts with other assignments or its own interests, and acting without any consideration for future work.
2. Every Service Provider has an obligation to disclose to the client any situation of actual or potential conflict that impacts its capacity to serve the best interest of the client. Failure to disclose such situations may lead to the disqualification of the Service Provider or the termination of its contract and/or further sanctions.
3. Without limitation on the generality of the foregoing, and unless stated otherwise a Service Provider shall not be hired under the circumstances set forth below:

   Relationship with the HPF's staff: a Bidder (including its Experts and Consortium Partners) that has a close business or family relationship with a professional staff member of the HPF, who is directly or indirectly involved in any part of (i) the preparation of the Terms of Reference for the assignment, (ii) the selection process for the Contract, or (iii) the supervision of the Contract, may not be awarded a Contract, unless the conflict stemming from this relationship has been declared and resolved in a manner acceptable to the Client throughout the selection process and the execution of the Contract.

2.3 Consortium

The Service Provider may bid as a consortium of organisations in order to provide the services but must declare, at bidding stage, the following information:

- Name of each organisation in the consortium
- Roles and responsibilities of each organisation in the consortium
- The relevant experience of each organisation in the consortium

Bids that are submitted by a consortium of organisations, must clearly state the lead agency in the consortium. The memorandum of understanding between the consortium members must be included as an annex to the technical proposal.

2.4 Substitution of key personnel

1. If, during bid evaluation, any of the Key Personnel (three field-based staff) become unavailable, the Bidder shall provide a written adequate justification and evidence satisfactory to the Client together with the substitution request.
2. If the justification and evidence for substitution is not satisfactory to the Client, then the bid will not be evaluated further.
3. In the event that the Client accepts such justification, the Bidder shall provide a replacement *curriculum vitae* (CV) which will be evaluated in line with the stated evaluation criteria to determine its suitability. Under no circumstances will any technical score that the Bidder has achieved in evaluation be increased as a result of substitution, however in the event that the replacement CV is not considered equal to the original CV submitted with the bid, then the evaluation panel may reduce any technical score already assigned to that bid.

2.5 Anti-bribery and Corruption

All Service Providers are expected to operate with the highest integrity and conduct. Any Service Provider under the HPF that pays, solicits, receives, authorises, colludes in, or condones, the payment, solicitation, or receipt of a bribe will be liable to summary termination of their, or its, contract for cause, without prejudice to any other claim or remedy to which the client may be entitled under the contract or the law.

2.6 Eligibility

1. This tender is open to organisations from any country and there is no limitation or preference given on the basis of nationality.
2. Bidders can be national or international non-government organisations (NGOs), not-for-profit organisations, faith based organisations (FBOs), community based organisations (CBOs) or commercial organisations.
3. Bidders can be consortia of organisations, but a consortium must have a designated lead organisation that will be held responsible for the consortium's delivery. The HPF encourages international organisations to partner with national NGOs, FBOs and CBOs where this will increase sustainability and make delivery cost effective.

2.7 Sanctions and Prohibitions

Any organisation or individual sanctioned:

1. by any of the funding partners of the Health Pooled Fund
2. by any of the International Financing Institutions (i.e. World Bank, African Development Bank etc.)
3. by the Government of the Republic of South Sudan

shall be ineligible to be awarded a contract funded by the HPF, or to benefit from an HPF-financed contract, financially or otherwise, during such period of time as the fund shall determine. Furthermore, it is the Bidder's responsibility to ensure that its key staff, consortium partners and employees are not ineligible.

3. Section C: Proposal Preparation and Instructions

3.1 Composition of the bidding documents

1. This RFP is divided into 23 lots. There is no restriction on the number of lots for which bidders can bid.
2. The Terms of Reference at Section F detail the activities and objectives required from the Service Provider for each lot.
3. Appendix A provides the templates which bidders must return with their bids, consisting of:
   - A1: Technical bid submission letter (required for each lot)
   - A2: Technical proposal template (required for each lot)
   - A3: Technical proposal work plan, target table and health facilities template (required for each lot)
   - A4: List of Consortium Partners (required for each lot where applicable)
   - A5: Financial bid submission letter (required for each lot)
   - A6: Budget template and justification (required for each lot)
   - A7: Business Partner Questionnaire (BPQ) (required for each lot)
   - CVs of proposed field-based Key Experts (required for each lot)
4. Appendix B provides the Standard Contract into which the successful bidder will be expected to enter.

3.2 Tender Lots

The lots for the tender are listed in the table below:

Table 1: Lots being tendered

Lot number	Geographical area
1	• Torit County • Magwi County • Nimule Hospital (focus on CEmONC[1]) • Torit State Hospital (focus on CEmONC)
2	• Lopa-Lafon County • Ikotos County • Isohe Mission Hospital (St Teresa) (focus on CEmONC)
3	• Budi County • Kapoeta South County • Kapoeta Mission Hospital (focus on referral system) • Kapoeta Civil Hospital (focus on CEmONC) • Chukudum Hospital (focus on CEmONC)
4	• Kapoeta North County • Kapoeta East County
5	• Jur River County • Wau County • Wau Comboni Hospital (focus on referral system) • Wau Teaching Hospital (focus on CEmONC)
6	• Raja County • Aweil North County • Aweil West County • Raja Hospital (focus on CEmONC)
7	• Rumbek North County • Rumbek Centre County • Rumbek East County • Cueibet County • Wulu County • Cuibet Hospital (focus on CEmONC) • Rumbek State Hospital (focus on CEmONC)
8	• Yirol West County • Yirol East County

[1] Comprehensive Emergency Obstetric and Neonatal Care

	• Awerial County • Mapuordit Mission Hospital (focus on CEmONC) • Yirol Hospital (focus on CEmONC)
9	• Twic County • Gogrial East County • Gogrial West County • Turalei Mother Teresa Hospital (focus on CEmONC) • Kwajok Hospital (focus on CEmONC)
10	• Tonj North County • Tonj East County • Tonj South County • Marial Lou Hospital (focus on CEmONC) • Tonj Hospital (focus on CEmONC)
11	• Aweil East County • Aweil South County • Aweil Centre County • Aweil State Hospital (focus on CEmONC)
12	• Mayom County • Abiemnom County
13	• Pariang County
14	• Bentiu State Hospital (focus on CEmONC) • Rubkona County • Guit County
15	• Leer County • Mayendit County
16	• Koch County
17	• Payinjiar County
18	• Terekeka County
19	• **Juba County** • El-Sabah Children Hospital (focus on referral system) • Juba Teaching Hospital (focus on referral system)
20	• Lainya County • Lainya County Hospital (focus on CEmONC or referral system) • Yei County • Yei Hospital (focus on CEmONC or referral system) • Morobo County • Morobo County Hospital (focus on CEmONC or referral system) • Kajo Keji County • Kajo Keji Civil Hospital (focus on CEmONC or referral system)
21	• Mvolo County

	• Maridi County • Maridi Hospital (focus on CEmONC or referral system) • Mundri West County • Mundri East County • Lui Hospital (focus on CEmONC or referral system)
22	• Tambura County • Tambura Hospital (focus on CEmONC or referral system) • Nagero County
23	• Nzara County • Nzara Hospital (focus on CEmONC or referral system) • Ezo County • Ezo County Hospital (focus on CEmONC or referral system) • Yambio County • Yambio State Hospital (focus on CEmONC or referral system) • Ibba County

3.3 Bid Submission

1. Bidders are required to submit a **separate technical and financial submission for each lot**.
2. The documents **required** for submission are shown in the table below:

Table 2: Mandatory documents to be supplied with bids

Documents required *A1–A7 are available to download from the HPF website www.hpfsouthsudan.org*	**With Technical bid**	**With Financial Bid**
A1: Technical Bid submission letter	✓	
A2: Technical Proposal template (required for each lot)	✓	
A3: Technical Proposal work plan, target table, and health facilities template*	✓	
A4: List of Consortium Partners (where applicable)	✓	
A5: Financial Bid submission letter		✓
A6: Budget Template and justification**		✓
A7: Business Partner Questionnaire (BPQ)	✓	
CVs of proposed field-based Key Experts	✓	

** A3 must be adapted to the situation in the geographical area. Sample activities are included in the work plan template; additional activities can be added and activities changed to fit the situation in the counties and reflect the strategic objectives of HPF. Please ensure all three worksheets are completed.*

*** A6 must be completed in British Pounds Sterling detailing the total price for delivery of the services. The contract will be awarded on the basis of monthly reimbursable expenditure. However, for evaluation purposes, bidders are required to provide details of the proposed staff inputs, timings, rates and expenses for the delivery of the services.*

3. The deadline for submission of proposals is **16:00 hours** South Sudan time on **Wednesday, 27 July 2016.**

4. **Submission must be made in hardcopy, one original plus 3 copies, prior to the deadline, to the following address:**

   HPF South Sudan
   Crown Agents-Health Pooled Fund Office is opposite European Union Office
   Kololo Road-Tonpeny
   First Class Residential Area Plot No 54,
   Juba
   South Sudan

5. Your outer envelope must be marked: **"HPF South Sudan: Lots 1-23 bid submission. Lot number [enter the lot number you are bidding for]. Do not open until bid closing date"**

6. ***** If you are bidding for multiple lots please ensure that each lot is submitted in a separate package *****

7. **Please note that the evaluation panel will not open any Financial Proposals until the technical evaluation phase is complete.**

8. **It is the responsibility of the bidder to ensure that correct reference and closing date are included on the envelope.**

When preparing proposals to undertake this assignment, Bidders should take note of the Evaluation Criteria set out in Section D of this RFP.

3.4 Bidding Language

All proposals should be submitted in English.

3.5 Cost of bidding

The Bidder shall bear all costs associated with the preparation and submission of its proposal, including site visits. The Client shall not be responsible or liable for any costs regardless of the conduct, or outcome, of the selection process.

3.6 Bid Clarifications

1. Any requests for clarification from bidders should be submitted in writing, in English, to the following address: **Clarifications@hpfsouthsudan.org**
2. The final deadline for clarifications is **29 June 2016**

3. Bidders should not approach any other parties (including DFID or the South Sudan Ministry of Health) for information during the tender period. Only requests for clarification submitted in writing to HPF will be responded to.
4. Clarifications will then be sent promptly to all confirmed bidders, revealing both the question and the response but not the name of the bidder sending the request for clarification.

3.7 Proposal validity

All proposals submitted must be valid for acceptance until **noon (South Sudan time) on 30 October 2016**.

3.8 Cancellation of Tender

The Client is not bound to accept any proposal and reserves the right to annul the tender procedure and not to proceed with the appointment of a Service Provider for any lot at any time prior to contract award without thereby incurring any liability.

4. Section D: Bid Evaluation Process and Criteria

4.1 Bid Stages

The bid evaluation process will consist of four (4) stages as follows:

1. Bid Receipt
2. Bid Opening and Initial Assessment
3. Technical Evaluation
4. Financial Evaluation

Each stage will result in a specific communication being given to bidders as discussed in further detail below.
The technical proposal and financial proposal will be independently evaluated to determine that the bid complies with the Terms of Reference, and the organisation's capacity to deliver the objectives effectively. A combination of the total technical score and the total financial score will be used to determine the successful bidder.

4.2 Bid Receipt

Upon receipt of a bid submission by the Client, bidders will receive a stamped acknowledgement confirming the time and date of the receipt of their bid **(*Communication No. 1*)**,

This acknowledgement is confirmation of receipt only. It does not infer or imply any other information and should not be interpreted to be any confirmation that the bid in question has passed any part of the evaluation process.

4.3 Bid Opening and Initial Assessment

1. Immediately after the bid closing time the HPF Contracts Team will undertake the following activities for all bids received:
    a) Check that the bid was submitted before the deadline. If the deadline was not met the bid will automatically be rejected;
    b) Confirm that all mandatory documents for technical and financial proposals, as stated in Table 2 of this RFP, have been submitted;

2. Following this initial assessment, bidders will receive a further communication **(*Communication No. 2*)** to confirm either:
    a) That their proposal has passed the initial assessment and **WILL** proceed to the next stage of evaluation (i.e. technical evaluation); or
    b) That their proposal has failed the initial assessment and **WILL NOT** be considered further.

4.4 Technical Proposal Evaluation

1. The Technical Evaluation will be scored by a Technical Evaluation Committee consisting of MOH and HPF staff.
2. Proposals will be evaluated in accordance with the technical evaluation criteria set forth below. A total of 100 points are available. The relative importance of each criterion is indicated by the number of points it is assigned. Bidders should note that these criteria: (1) serve as the standard against which all proposals will be evaluated, and (2) serve to identify the relative weight of each section of the RFP to be addressed by Service Providers in their proposals.
3. The information and/or questions outlined under each bulleted scoring criterion below are intended to inform the scoring process broadly; each will not be individually scored or equally weighted. An award will be made to the Bidder whose proposal offers the most effective technical approach, the greatest likelihood of success and the highest value for money as per the guidelines outlined below.

Technical Approach **50 points**

This section provides a clear description of the overall strategies and details of the proposed technical interventions and activities to achieve the programme objectives. The proposal reflects excellent understanding of the overall terms of reference, scope of work and its objectives, and the ability to synthesise and apply lessons learned. The technical approach will be evaluated on its potential for achieving intermediate results, especially for building sustainable South Sudanese capacity in health delivery. It is important to clearly define linkages with other programs in the geographical area covered and describe how synergy between programmes will be developed. Reviewers will evaluate the overall quality and feasibility of the technical approach design. A strong technical design will:

Technical Approach Sub Criteria
• Reflect a sound understanding of the health situation in South Sudan, the response of the MOH, SMOH, CHDs, civil society, and development partners, the South Sudanese health system and the policies, strategies and plans as listed under Section 6.1 (Terms of Reference). • Reflect a deep understanding of the geographic location context including a nuanced understanding of the CHD and its operations, disease dynamics, weather patterns, unique issues in the community, and an understanding of specific gender and conflict issues. • Provide an overview of the Service Provider's strategy and describe how the proposed approaches are sufficient to effectively achieve the objectives described in the RFP. • Describe the Service Provider's approach to increasing access and utilisation of quality health services that are particularly responsive to the needs of women, children and vulnerable groups, with

consideration of the pertinent areas of the BPHNS, strengthening CEmONC in selected hospitals (including the faith based), and the referral system from community level to primary health care (PHC) facilities and hospitals.

- Service Providers should explicitly explain the approach to improving quality of services across all levels of the health system, indicating specific priorities for PHCUs, PHCCs and hospitals in the geographical area.
- Describe how the Service Provider will increase community participation, utilisation and demand for health services, with strong focus on increasing community governance and strengthening the linkages and synergies between other community programmes, health facilities, and the CHD.
- Describe how the Service Provider will strengthen the health system under the stewardship of the CHDs. This should show ways in which the Service Provider will continue to build on the local capacity and ensure skills transfer. Health systems areas should include: Human Resources for Health, Health Management Information System, Medical Products, Supplies and Technologies; Health Financing and Governance and Leadership.
- Describe how the Service Provider will increase access to information, preventive and curative nutrition services particularly for pregnant women, young children and other specific vulnerable groups. The nutrition service approach should be based on needs and describe how the programme will link with the formal health care system and with other nutrition activities.
- Explain how gender equity and social inclusion (GESI), and mitigating violence against women and girls (VAWG), will be given stronger emphasis than the previous programmes. This should show the approach to, access to services for marginalised groups, involvement of women and marginalised groups in decision making, developing plans responsive to GESI barriers and working with key stakeholders in the geographic area.
- Describe the programme's approach to resilience planning for the changing context and contingency plans for risks faced in the geographic area.
- Explain how a conflict sensitive approach will be adopted in programme, including showing the contextual understanding, operational resilience and responsiveness.
- Describe how the Service Provider's technical approach will complement and coordinate with the activities of other donor programmes and NGO activities to maximise the impact and avoid duplication, (including the humanitarian actors). This should demonstrate coordination with stakeholders in non-health sectors such as Education, Gender, WASH, ICCM, Nutrition, Advocacy Programmes, Protection, etc.
- Specify how the Service Provider will monitor, evaluate and report progress, which includes collecting and sharing evidence on lessons learned and value for money

Management Plan **30 points**

This section provides an overview of the Service Provider's proposed management of the project, including personnel and a work plan of activities (see Appendix A3).

Management Plan Sub Criteria
• Demonstrate that the Service Provider has a complement of proposed key and required personnel, with respective skills and expertise, responsive to the leadership and management requirements of the project. Three field-based staff should be included as key personnel. One staff must be presented as the Programme Manager, and two others should be one of the following focal persons at the field-level: maternal/child health, health systems strengthening, community, or nutrition. • Demonstrate capacity to develop an effective system for supporting the CHDs (including co-location) and engaging other organisations and projects to implement the HPF2. • Explain proposed partnerships to work with or build capacity of local NGOs, FBOs, or CBOs. Otherwise this section should include an explanation for not engaging such organisations. • Explain the proposed plan for supporting hospital management specific to the lot requirements. • Demonstrate strong organisational, human resources, financial, and information management structures and mechanisms, with clear roles and responsibilities of key staff that will liaise with HPF including M&E, finance and contracts. Explain plans for dealing with staff changes. • Explain that the Service Provider is able to manage support to delivery of health services even in times of emergencies, while at all times maintaining a responsible duty of care towards their staff. • Contain a realistic work plan for rapid start-up of the project and timeline consistent with targets. • Describe clearly, if there is a consortium, the roles of each consortium member and the agreement already in place between the organisations. • Show that the bidder is maximising use of local skills and expertise in implementing the programme.

Past Performance **20 points**

This section demonstrates the Service Provider's track record of providing high quality services, cost control, timeliness of performance, effective management practices, and evidence of customer satisfaction.

Past Performance Sub Criteria
The Service Provider should show: • Examples of experience in implementing similar, complex projects in fragile and post-conflict situations. • Examples of experience in implementing similar scopes of work including primary and secondary health care, health systems, community and nutrition interventions as well as linkages across the health system. • Successful management of project funding of amounts similar to the ones requested, showing strong evidence of value for money. • If working in consortium, a description and evidence of experience of working with other consortium

members as well as rationale for the consortium in this project.

- Evidence of working with government at all levels (national, state, county) and with communities, of resolving emerging project implementation issues.

HPF will also assess the previous reporting performance of the Service Provider, in terms of compliance and quality of submissions. This includes the submission of work plans, programmatic reports and financial reports. If the bidder is new to HPF, provide evidence of other major funding reporting performance (e.g. reference or grant closure certificate)

Any bid in which the Technical Proposal contained therein fails to score the minimum threshold requirement of fifty (50) out of one hundred (100) points will **NOT** proceed to Financial Proposal evaluation.

4.5 Bid Clarifications

To assist in the examination, evaluation and comparison of Proposals, the Client may at its discretion, ask the Bidder for clarification of any part of its Technical Proposal. The request for clarification and the response shall be in writing and no change in price or substance of the proposal shall be sought, offered, or permitted as part of a clarification.

4.5.1 Communication Three (3)

1. Following the technical evaluation phase all bidders that had their technical proposals evaluated will receive a communication **(*Communication No. 3*)** confirming one of the following:

    a) That their technical submission has met the minimum technical threshold and their bid **WILL** proceed to financial evaluation; OR
    b) That their proposal has failed to meet the minimum technical threshold and **WILL NOT** proceed to the financial evaluation stage.

4.6 Financial Proposal Evaluation

Only those bidders whose technical and financial submission passed the initial assessment and whose technical submission meets the technical threshold will have their financial bids evaluated.

4.6.1 Financial Evaluation by Evaluation Committee

The Financial evaluation will be scored by a separate evaluation committee from the technical proposals. Financial Proposals will be assessed as follows:

Table 3: Financial Technical Evaluation Scoring

Financial Evaluation Sub criteria	Maximum Score
Whether the financial proposal is realistic and consistent with the technical proposal: are the interventions budgeted corresponding with the most essential gaps identified for instance in terms of staffing and equipment.	4
Whether the financial proposal has a realistic, consistent, and costed work plan meeting the set targets of the technical section.	4

Justify a balanced allocation of resources among the key components of the project (e.g. primary, secondary, health systems, community and nutrition) to maximise health services in the geographic area.	4
Overall cost control: This will include comparison between direct and indirect costs (e.g. excessive salaries, per diems and realistic levels of effort, correct exchange rate)	8

4.6.2 Bid Clarifications

To assist in the examination, evaluation and comparison of Proposals, the Client may at its discretion, ask the Bidder for clarification of any part of its Financial Proposal. The request for clarification and the response shall be in writing and no change in price or substance of the proposal shall be sought, offered, or permitted as part of a clarification.

4.7 Weighting and Final Combined Evaluation Score

The weights given to the technical and financial proposal are:

Technical = 80

Financial = 20

Total Proposal Score = **Technical score** + **Financial score**

5. Section E: Negotiation and Contract Award

5.1 Negotiation

1. The Bidder ranked first after the evaluation process will be invited by email for negotiations with the Client.

2. Negotiations will be conducted in person in Juba, South Sudan.

3. Negotiations will include a discussion of the Technical Proposal, the proposed methodology (including a work plan, target table and health facilities baseline data), staffing, and any suggestions made by the Bidder to improve the Terms of Reference. The Client and Bidder will then agree final Terms of Reference, staffing, the work plan, and reporting. The agreed work plan and final Terms of Reference will then form part of the contract.

4. Financial negotiations will reflect agreed technical modifications in the cost of the services, and will include a clarification of the Bidders' tax liability (if any) in South Sudan and the manner in which it will be reflected in the contract.

5. Notwithstanding the contents of Clause 2.4 above, having selected the preferred Bidder in part based on an evaluation of proposed key experts, the Client expects to negotiate a contract on the basis of the experts named in the proposal. Before contract negotiations, the Client will require written assurances that the experts will be available. If this is not the case and if it is established that key staff were offered in the proposal without confirming their availability, the firm may be disqualified.

6. Any Bidder called to negotiation will be required to provide their procurement policy(ies), CVs of staff they propose to undertake any procurement activities and a procurement plan covering the period from contract start-up until the end of February 2018.

7. The negotiations will conclude with a review of the form of the contract. On completion of negotiations, the Client and the preferred Service Provider will initial the agreed contract. If negotiations fail, the Client will invite the organisation whose proposal received the second highest score to negotiate a Contract.

5.2 Award of contracts

1. Prior either to the award of the contract, or first fund disbursements, successful Service Providers may undergo an onsite Financial Management Assessment (FMA) to identify the particular fiduciary risks associated with the financial arrangements and the corresponding mitigating controls which should be put in place to manage the risks identified. This will typically include an on-site review of the proposed financial management processes proposed by the applicant. The FMA is only undertaken on organisations selected as Service Providers and as a result, the purpose of this assessment is to identify and manage risks rather than exclude organisations because they may be higher risk.

2. Contracts will be awarded following negotiations. After negotiations are completed and contract awards are approved by the Steering Committee, bidders will receive a final communication **(*Communication No. 4*)** to advise either:

    a) that they have been awarded a Contract and which Lot that contract is for; OR
    b) that they were unsuccessful in being awarded any Contracts.

    Bidders may be provided with feedback on their bid irrespective of whether they were successful or not. Bidders can request more detailed feedback from the client. If a bidder requests a debriefing meeting in Juba, South Sudan; the bidder shall bear all their costs of attending such a debriefing meeting.

6. Section F: Terms of Reference

When the Republic of South Sudan came into existence on 09 July 2011 it immediately became one of the poorest countries in the world. Years of conflict had prevented the establishment of physical and social infrastructure, eroded what infrastructure existed, caused the death and displacement of millions of people, and made South Sudan one of the most underdeveloped regions of the world. Poverty remains widespread and just over half (51%) of the population lives below the national consumption poverty line,[2] and predominantly in rural areas (81.2%).[3] The conflict beginning December 2013 further devastated the lives of millions of South Sudanese. It displaced an estimated 2.3 million people - approximately 1.7 million were displaced internally and 648,000

[2] World Bank Database, South Sudan http://data.worldbank.org/country/south-sudan, accessed 06 March 2016.
[3] UN DESA (2014), World Urbanization Prospects.

becoming refugees in neighbouring countries.[4] This is in addition to a variety of conflicts in the country, including a rise in localised conflicts over land and cattle, which contribute to an overall volatile context which will affect programme implementation. A peace deal, signed in August 2015, has signalled an end to the violence and movement towards a stable government. The return of Riek Machar (Vice-President) and formation of the Transitional National Government of Unity,[5] is helping the peace process move forward.

The health needs of the people of South Sudan are immense and are a direct result of pervasive poverty and a long history of conflict. South Sudan has a very basic health care system which was weakened by each successive conflict, a severe shortage of health workers, and lack of access to health facilities. South Sudanese returning from Sudan since independence have increased the burden on these health facilities, particularly in border counties.[6]

The GRSS Health Sector Development Plan 2012–16 (HSDP) states three main objectives: 1) to increase use and quality of health services; 2) to empower communities to take charge of their health; and 3) to improve the efficiency, effectiveness and equity of the health system.

The cornerstone of the HSDP is the Basic Package of Health and Nutrition Services (BPHNS), which contains a set of high impact interventions aimed at reducing the leading causes of morbidity and mortality. The HSDP emphasises the importance of adequate human resources for health, improved accessibility of the health service by the population, and community empowerment through health education.

The HPF launched in October 2012, following the principles of aid effectiveness and public health approaches to support the MOH deliver health services; while increasing ownership, capacity, and accountability of the MOH at all levels. It started with a period of bridging contracts to transition health services from previous funding mechanisms. After the bridging period, long term contracts were issued based on the County Model, covering health service delivery, health systems strengthening and strengthening community ownership. The HPF has supported county hospitals, faith based hospitals, State hospitals, and family planning services in six states.

In April 2016, HPF2 expanded its geographic coverage to eight of the ten former states, funded by the British Government's Department for International Development (DFID), the Government of Canada, the European Union, the Swedish International Development and Cooperation Agency (SIDA), and the United States Agency for International Development (USAID).

6.1 Scope of Work

To support the goal of the GRSS to reduce maternal and infant mortality, ensure universal coverage, and improve the overall health status as well as the quality of life of the South Sudanese population, actions should be designed in accordance with:

[4] UN Office for the Coordination of Humanitarian Affairs (OCHA) South Sudan, www.unocha.org/south-sudan, accessed 03 March 2016.
[5] *Sudan Tribune*, www.sudantribune.com/spip.php?article58800, accessed 29 April.
[6] Twelve counties along the border, according to the 2014 10-state model for South Sudan

1. The National Health Policy, 2015-2025
2. The National Health Sector Strategic Plan, 2015-2019
3. The Health Sector Development Plan (HSDP) 2012 – 2016
4. The Basic Package for Health and Nutrition Services in Primary Health Care, 2011,
5. The Basic Package for Health and Nutrition Services in Secondary and Tertiary Health Care, 2011
6. Reproductive Health Policy and Strategic Plan
7. MOH CMAM guidelines and nutrition related policies and strategies
8. Other recent and relevant strategic documents in the health sector in South Sudan.

The actions will support and build the capacity of the CHD to deliver quality health services that are accessible by the population. Service Providers should consult with the relevant CHDs and MOH to develop programmes that align with the priorities, timings and requirements of the CHDs' plan. Gaps and challenges should be identified, and clear solutions to these should be demonstrated. Service providers are responsible for supporting communities, PHCUs, PHCCs and the relevant hospitals. Support to faith based hospitals focuses on discreet and specific activities, listed in Annex 4; it is not HPF's intention to manage the entire hospital. Service providers need to remain flexible to South Sudan's overall context and adapt if the situation changes, especially if the context deteriorates.

Service Provider activities under the HPF2 will have the following objectives:

- Objective 1: To increase access, use and quality of health services across all levels, particularly for women, children and vulnerable groups.
- Objective 2: To strengthen the health system under the stewardship of the County Health Departments (CHDs).
- Objective 3: To increase access to nutrition services particularly for pregnant women and young children

6.2 Objective 1: To increase access, use and quality of health services across all levels, particularly for women, children and vulnerable groups

Service Providers will be expected to support the County Health Department to provide services that align with the Basic Package for Health and Nutrition Services in Primary, Secondary and Tertiary Health Care. The focus of the service delivery component of HPF2 is on PHC service delivery for women and children with an additional focus on comprehensive emergency obstetric and neonatal care (CEmONC), and the referral system. The services should also align with the County Health Plans. The key services under the BPHNS are included in Annex 1, which shows the activities that should be carried out at PHCU and PHCC levels. Lot specific health data is provided in Annex 2. Guidance on hospital support is provided in Annex 3 and Annex 4.

Service Providers should demonstrate how they will further expand the health service coverage and improve the quality of services provided in the different health facilities. Service Providers should explicitly explain how the quality of services will be improved.

One of the greatest challenges to improving quality is to increase the number of skilled and motivated health staff in the health facilities. Service Providers should, in conjunction with the CHD:

- Recruit and retain qualified health staff needed for service delivery
- Ensure that all relevant MOH treatment guidelines are followed by the health staff
- Train and implement quality standards, with particular focus on infection prevention and control (IPC) and BEmONCS
- Provide supportive supervision, including on the job training and mentorship improve the quality of care
- Train facility staff in different technical areas including maternal health, child health, communicable diseases, non-communicable diseases, family planning, and quality of care
- Strengthen communities' preparedness to refer patients to the appropriate health facilities and establish a functioning referral system from community level up.

Priority services that should be delivered are listed in the sections below.

6.2.1 Safe motherhood and reproductive health

Essentials of Primary Health Care Services and activities
Focused antenatal care
Care of uncomplicated delivery
Emergency Obstetric and Neonatal Care
Focused postnatal care
(Adolescent) Sexual and Reproductive Health and Family Planning / Birth Spacing

Activities that focus on safe motherhood and reproductive health are the mainstay to achieving these targets. Service Providers supporting the CHDs should propose a comprehensive approach to implement maternal health, family planning, adolescent reproductive health, HIV/AIDS and prevention of gender based violence. The approach needs to be responsive to gender and social exclusion barriers that may inhibit the uptake of key reproductive health services.

Service Providers need to demonstrate how they:

- Work with male and female community members to increase awareness about the benefits of antenatal care; when a pregnant woman should start antenatal care services; nutrition during pregnancy; location of services; treatment of malaria in pregnancy; danger signs that should prompt a pregnant woman to go to a health facility immediately; birth preparedness and complication readiness. The antenatal care visits should be linked to safe delivery and the survival of both the mother and the infant, as well as the avoidance of obstetric emergencies.
- Work with the CHDs to increase the access (Mon-Fri), quality of antenatal care services and the utilisation of the fourth antenatal care visit. During antenatal visits, the clients should be given the full package of services according to the MOH protocols, including a long-lasting insecticide treated mosquito net, intermittent preventive treatment for malaria (two doses), iron/folate supplements, tetanus toxoid injection (two doses), de-worming medication, and HIV and syphilis tests.

- Support the increased availability (24/7) and acceptance of delivery services in PHCUs, PHCCs and hospitals in the catchment area.
- Strengthen the referral system from the community to the primary health care and secondary/tertiary health care facilities for women in childbirth.
- Increase access to, and utilisation of, postnatal care visits. This includes increasing community awareness about care of the newborn and the mother, integrating focussed postnatal care within the EPI and family planning services, offering the postnatal services in all functioning health facilities in the catchment area and through home visits by home health promoters (HHPs).
- Strengthen family planning activities, awareness and other high impact interventions (such as use of chlorhexidine) across all levels of the health system. Advocate for the use of family planning across the county using existing structures (e.g. radio talk shows, church groups, dramas, etc.)
    - Ensure all facilities have the contraceptives in stock in line with the MOH guidelines for supplies, including oral, injectable, condoms and permanent methods.
    - Ensure that health workers are sufficiently trained and knowledgeable in family planning, using MOH standardised materials where available. Special family planning/birth spacing clinics or youth friendly services might be offered in the relevant health facilities.
    - Service Providers will need to demonstrate how the community, HHPs, health staff and managers will be involved to raise awareness and increase acceptance of family planning/birth spacing.

Service Providers will need to demonstrate how an efficient and effective allocation of resources for emergency obstetric and neonatal care (EmONC) at PHCCs and secondary/tertiary health care facilities will be achieved. This should include identification of facilities that will provide basic BEmONC and CEmONC, and the minimum services that will be available at facilities in the county. Service Providers should demonstrate how they will support the CHDs to increase referral linkages to the next level of care. The identified BEmONC and CEmONC centres are expected to offer all seven BEmONC or nine CEmONC signal functions:

1. I.V antibiotics administered
2. I.V. oxytoxics administered
3. I.V anti-convulsants administered
4. Manual removal of the placenta
5. Assisted delivery by vacuum extraction
6. Manual vacuum aspiration of retained products of conception
7. Neonatal resuscitation
8. Caesarean sections (CEmONC only)
9. Blood transfusions (CEmONC only)

Violence against women and Girls (VAWG) represents a major challenge in South Sudan. Service Providers should make available emergency contraceptives, post exposure prophylaxis and counselling as a standard service in all geographic areas. Service Providers will be responsible for monitoring and reporting incidents.

6.2.2 Child health

Essentials of Primary Health care services and activities
Immunisation/EPI services

Integrated Management of New-born and Childhood Illness
School Health

Service Providers will need to show how they will support the CHDs to increase the quality and availability of child health services and to attain geographic specific targets in Appendix A3.[7]

Immunisation coverage across the county will be improved through routine EPI in all health facilities, outreach and community interventions as well as tracing and referring of defaulters for completion of the vaccination schedule.

Activities should show how routine immunisation services will be expanded in the geographic area and practical aspects of immunisation campaigns that are linked to UNICEF/ WHO programmes including community mobilisation, catch-up child immunisation days in areas of displacement or maintenance of the cold chain. Cold chain equipment and supplies can be procured as long as they are in line with the Performance Quality and Safety devices catalogue for pre-qualified equipment for EPI.

The MOH is in the process of finalising the revised Integrated Management of Newborn and Childhood Illness (IMNCI) guidelines. Service Providers need to demonstrate how support is provided to MOH to train the health workers in the PHCCs and hospitals to adhere to the new guidelines so as to improve quality of care, while demonstrating a clear link with the community based health interventions (such as ICCM).

School health activities are a relatively new component. Service Providers are expected to demonstrate how the County Education Department and CHD will jointly integrate health activities into schools. Service Providers should also collaborate with Girls' Education South Sudan (GESS) partners. This could include planning activities involving school teachers and school children's parents or caregivers. Activities could include (but are not limited to) the establishment of school health clubs, de-worming of children through schools, sessions at schools about health related topics (including sexual education), provision of youth friendly services at schools, or the distribution of re-usable sanitary pads to girls in schools. Context-appropriate messages on sexual education or sexual and gender based violence should also be communicated.

6.2.3 Most common diseases and public health risks

Essentials of Primary Health care services and activities
Malaria
Diarrheal, Enteric Infections and Infestations
Acute Respiratory Infection
Tuberculosis
STI, HIV/AIDS
Neglected and Tropical Diseases

[7] Each county will also have county plans developed annually.

Common, endemic, communicable diseases in South Sudan exert a significant toll on the population. These common diseases contribute to a high disease burden and are a public health threat in the country. Interventions for the communicable diseases must include both curative and preventative actions. Service Providers must show how they will work with the CHDs to standardise and follow national treatment guidelines, as well as expand case detection and diagnostic modalities of the diseases. Service Providers must show how they will increase community awareness and knowledge of these common diseases, increase treatment seeking, and ultimately reduce transmission of these endemic diseases.

Strategies should show how community awareness about the danger signs of malaria, pneumonia and diarrhoea will increase, as well as the importance of early health care seeking, preventive measures that can be taken and the increased availability of community based management of these three diseases. Service Providers need to demonstrate a clear link with other community based initiatives such as the ICCM programme and support to HHPs.

Service Providers should show how they will support existing HIV programmes, including treatment and counselling and testing programmes. Strategies should show how to expand prevention of mother to child transmission (PMTCT) and how to link to other programmes particularly those funded by the Global Fund and PEPFAR.

Strategies have to outline how coordination with other donor funded programmes including Global Fund, Rollback Malaria, South Sudan's NTD programmes and others will be made possible, with emphasis on a synergistic modes of operation.

6.2.4 Non communicable, high priority diseases and conditions

Essentials of Primary Health care services and activities
Diabetes and Hypertension
Primary Eye Care
Other conditions (mental health, road traffic accidents, violence related trauma, substance abuse, and cancers)

The Government recognises that the emphasis will remain on the prevention and the treatment of communicable diseases and maternal and child health in the short and possibly medium term, however hypertension and diabetes have to be recognised and responded to as the most common chronic non-communicable diseases. Service Providers should support the CHDs to improve case detection and quantification of diabetes and hypertension. While focusing on diabetes and hypertension is not a high priority at this moment, Service Providers should start supporting CHDs to be aware and cognisant of non-communicable diseases, particularly for medium and long term planning.

The Government is committed to preventing avoidable causes of blindness which contribute to nearly 75% of blindness. These include cataract, corneal scarring diseases including trachoma and vitamin A deficiency, onchocerciasis, refractive errors, low vision and childhood blindness. Interventions in primary health care should focus on increasing awareness and knowledge in the community, community based treatment campaigns and

ensuring simple eye diseases can be treated at the lowest level of primary health centre. Interventions should include prevention of eye infections through regular face washing, management of uncomplicated cases through antibiotic ointments, and support to mass treatment campaigns.

Strategies to address other non-communicable conditions such as mental health, road traffic accidents, violence related trauma, substance abuse, and cancers can be included as well, based on needs.

6.2.5 Community participation, utilisation and demand for health services

The MOH places a high emphasis on increasing community participation and a key outcome is community empowerment through health education and awareness. This should enable communities to take charge of improving their health and integrate effective health interventions into existing community structures. Empowered communities which demand health services will result in more sustainable health outcomes, while increasing the transparency and accountability of development partners in the health system. Increasing utilisation of health services requires not only accessibility and quality, but also user knowledge of, and demand for, health services. Thus, involving the local population in planning and increasing their participation can increase the community's commitment to the programme as well as helping to develop appropriate skills and knowledge to identify and solve local problems with local solutions. Involving the community also helps to increase the resources available for the programme, promotes self-help and self-reliance, and improves trust and partnership between the community and health workers.

Service Providers should support the implementation of the Boma Health Initiative (BHI) in a phased approach, complementing existing health facility services and other community based initiatives, particularly the ICCM programme. The BHI package is based on the BPHNS, and Service Providers will demonstrate how they will work with CHDs to ensure critical elements of this basic package will delivered at the community level, using existing community based workers, or training a select number for the BHI. Critical elements should be based on needs and service Providers should demonstrate linkages with other community based programmes.

The Service Provider shall identify opportunities and propose an approach and specific management and technical support activities to increase the participation of the community to a level that can be sustained by the CHDs. These activities should complement other activities outlined in this section and should be carried out in conjunction with the CHD. They should include, but are not limited to:

- Scale-up the post-partum haemorrhage (PPH) prevention activities by advance distribution of misoprostol at the community level including training, supervision of HHPs, and reporting usage.
- Advocate for the use of family planning among community leaders (e.g. paramount chiefs, payam administrators, chiefs and other community leaders)
- Organise integrated outreach services on a regular basis in coordination with the nearest health facilities
- Create awareness of the effects and dangers of Violence against Women and Girls (VAWG)
- Support the implementation of the BHI in an integrated and focused approach, coordinating with other partners
- Work with community members to increase awareness of key safe motherhood messages, child health and nutrition

- Increase access to services using HHPs and other community based health workers (e.g. PPH, ICCM, surveillance, WASH activities and promotion of safe drinking water)
- Utilise existing community based structures to promote health awareness messages
- Increase awareness of the danger signs of the most common diseases and health risks (malaria, pneumonia and diarrhoea)
- Support community based treatment campaigns.

6.3 Objective 2: To strengthen the health system under the stewardship of the County Health Departments

The CHDs guarantee the implementation of the health policy, coordinate with other authorities and actors and oversee health activities by all agencies or stakeholders working in the county. The CHDs coordinate other actors and supervise activities including: strategic planning, monitoring and evaluation, referral systems, and human resources planning and management. CHDs should also take the lead in development of comprehensive sector wide County Health Plans. The CHDs are the critical link between the MOH, NGO/FBO service delivery partners, facilities, vertical programs, and the community. It is recognised that human resource implications might have constrained some CHDs from fully performing many of these functions in the past.

It is imperative for Service Providers to explicitly state how they will support existing CHDs and assist in the establishment of CHDs where they do not exist. They will be encouraged to consider co-location of support staff with the CHD to build partnership and strengthen CHD capacity. Service Providers should show how they will be adequately supporting the CHD in all aspects of the health systems strengthening objective. Innovative approaches are welcomed to ensure sufficient capacity to support all geographic locations in the lot. To strengthen the health system, the following areas must be considered.

6.3.1 Human resources for health

Service Providers must show how they will support the CHDs to adequately plan and implement the Human Resource (HR) needs of the county at both facility and CHD level. The goal is to efficiently staff and effectively manage facilities with the right cadre of qualified workers according to BPHNS in order to provide services that are fully responsive to the needs of the county. This will entail building the capacity of existing workers, but also support for the cost of training a limited number of new health workers in MOH training institutes or in a regional health training institutions. This will be done so they obtain the required skillsets and existing health workers are retained at the county level where HR for health is most needed. It would also support qualified health workers to return to government posts while at the same time striving to fill existing gaps through staff recruitment.

Service Providers need to demonstrate how they will support the CHDs to rationalise their staffing needs in facilities both in accordance with BPHNS, but also as dictated by population or disease dynamics. This might include redeployment of health workers to reach a more equitable distribution of the right skills required to deliver services effectively in the county. This would require coordination with the State MOH for re-assignment and secondment of health workers to achieve county requirements. Standard procedures are available in the Local Government Human Resources Manual.

The Service Provider should work with the CHD, in the long term, to transition health workers from the NGO to the Government payroll. Following government guidelines, this will include assisting the CHD to assume preparing, maintaining and processing payroll responsibilities and provide logistical support to ensure payment is executed and recorded properly. Service Providers will also support the accurate reporting of key data points in the Human Resource Information System (HRIS), South Sudan Electronic Payroll System (SSEPS), and attendance monitoring of health workers. The data should be captured for government and NGO staff.

Service Providers should support the CHDs to ensure:

- Support to the implementation of the task shifting policy[8] so that more skilled staff members will be available for EmONC services
- Staffing plans for the health facilities are kept current, including strategies of rationalising the distribution of health workers
- Financial support to the recruitment of critical additional staff for the PHCC/PHCUs and hospitals continues based on the harmonized salary policies of the MoH
- Job descriptions for all the health workers are updated and made available, in line with government standards
- Job aids are made available at all health facilities
- Training and mentoring to support the consistent use of the Human Resources Information System (HRIS) to assist in HR planning
- Continue to support the payroll management and use of the SSEPS, coordinating with the county administration
- Development and implementation of staff attendance monitoring processes
- Receipt of health worker salaries at facility level are recorded
- Training needs of staff are identified and in-service training and other capacity development activities provided, in accordance with MOH Guidelines
- Review the barriers to increasing the number of births attended by skilled birth attendants and develop plans for improving the situation
- Establish and update personnel records of each health worker based on training and capacity development activities (paper records and through the HRIS)
- Continuous staff appraisals are conducted and other nonfinancial motivation schemes for staff retention are established

6.3.2 Health management information systems

The Health Management Information System (HMIS) is a key tool in monitoring the performance of the health sector, and provides pertinent information for making decisions and planning in the county. Service Providers should support the CHDs in strengthening the functioning of the HMIS in the county, as well as its utilisation in the county plans. IPs and CHDs should ensure that critical data from the community and facilities is collected and

[8] 2014 MOH Task-Shifting Policy For Basic Package Of Health And Nutrition Services In South Sudan

verified by the CHD, validated at county and state level and thereafter fed into the national HMIS. Plans are being formulated by the M&E Technical Working Group, led by the MOH, for the implementation of DHIS 2.

Service Providers will support the CHDs to continue institutionalising the use of the HMIS at facility (PHCUs, PHCCs and hospitals) and expand to the community level, following standard MOH guidelines. Activities should ensure that data is regularly and consistently recorded on MOH approved registers and reported through the national system. Additional efforts should be made to improve data quality, rollout hospital-based HMIS and link with available community based HMIS (CBHMIS) such as HHP reporting

Service Providers should assist the CHDs to ensure:

- The CHD are able to analyse and use the HMIS data for decision making and as a basis for planning
- Health workers, at facility and community level, are adequately trained to capture, report, and use HMIS data, using the DHIS
- Quality assurance measures are instituted at the facility level to enhance the reliability of the HMIS data specifically
- A feedback system exists on the HMIS data between the health facilities and the CHD
- There is timely use of the IDSR data to monitor potential disease outbreaks, in coordination with other partners
- All relevant tools (e.g. registers) are available in facilities
- Rollout of inpatient tools in the hospitals and CEmONC sites
- Relevant plans are made for the roll out of the DHIS 2 to include training, equipment and supervision
- Community-based information is captured alongside the current HMIS reporting lines
- Maternal death surveillance and response activities are initiated

6.3.3 Medical products, supplies and technologies

The HPF2 will procure essential medicines as part of a separate output to this RFP. Service Providers are expected to support the CHDs in strengthening the supply chain management and utilisation of quality pharmaceuticals and medical products in the county. Presently, most of the pharmaceuticals are delivered in a “push” system in the form of pre-packed kits, but Service Providers should support the CHDs to develop activities that will move this to a “pull” system according to the needs of the facilities, while still aligning to the MOH Essential Drugs list. This will require coherent strategies that will oversee quantification, procuring, financing, storage and distribution of drugs and supplies. This will mean using standard requisition and reporting forms, stock cards and monitoring the utilisation of drugs at facilities.

Service Providers should demonstrate how they will support the CHDs to improve the county supply chain through improvements in quantification, requisitioning, reporting, storage and distribution of drugs and supplies, especially through supportive supervision activities. Service Providers should work with the CHDs to ensure there is a continuous and consistent supply of essential medicines. This could include training of the CHD on basic supply chain management, ensuring the consistent use of stock cards at facilities and warehouses, providing support to the county warehousing, and storage options.

Health services use several supply chains to provide the necessary commodities. Supply chain efficiencies should be sought between the national system and other relevant supplies such as nutrition commodities, vaccines and the ICCM programme.

At the facility level, Service Providers should describe how they will encourage and promote health workers to rationally use drugs and use best practice in drug prescription. Service Providers should also describe how they will work with the CHDs to improve drug usage among the community.

The Service Provider should, in collaboration with the CHD:

- Support essential medicines transport from CHD store to the health facilities based on needs
- Ensure availability and usage Pharmaceutical Management Information System (PMIS) tools at the CHD and facilities
- Implement supportive supervision and continuous capacity building activities to, for example, improve the supply chain and rational usage of drugs and tools
- Renovate the drugs store where necessary
- Improve warehouse management systems through regular dejunking, inventory checks and oversight
- Ensure monthly reporting of drug consumption to HPF team and MOH Logistical Management Unit
- Explore surveillance of health facility drugs using mobile health solutions
- Seek supply chain efficiencies with the nutrition commodity and the ICCM programme
- Strengthen cold chain management ensuring that it is functional throughout the county. Provide essential equipment for health service delivery based on needs in PHCCs, PHCUs and CEmONC sites.

6.3.4 Health financing

Service Providers will have to demonstrate how they will transition responsibility to CHDs in planning for and overseeing the health budgets and financial plans in their county. This should include supporting the CHD to prepare the budget according to the needs and priorities of the county, provide technical assistance in budget execution, monitoring, accounting and timely reporting. Service Providers should also facilitate an integrated or "one budget" principle by supporting CHDs to consider all sources of funding available in the county, including other development partners. Service Providers will support the CHD to prepare budgets for health in mandated templates and within the timelines set by budget call circulars. This should also include showing evidence of cost efficiency and cost effectiveness in the delivery of health services. The budgeting should be linked to the MOH planning and budgeting cycle. The Service Providers will support the CHD to conform their local finance process to the processes and forms set out in the Local Government Manual.

Service Providers will work with the CHDs to improve the accountability and transparency of financial resources in the county. Service Providers will have to show commitment to minimising the risk of corruption, and support the CHDs to implement measures which could include diligent reporting to the SMOH and through the various community health committees.

The MOH is providing transfers to different health units including the CHDs, hospitals, PHCCs and PHCUs. Service Providers are expected to support each recipient to apply and qualify for these grants, and complete the

necessary reports according to the relevant guidelines (e.g. Local Government Planning, Budgeting and Reporting Guidelines and the PHCC Grant Manual).

Service Providers will assist the CHD to:

- Prepare the county health budgets using the government planning and budgeting cycle
- Produce one budget for the county including other development partners
- Train hospitals, facilities and health committees in the Local Government Planning, Budgeting and Reporting Guidelines.
- Utilise government approved financial forms and processes for the CHD, hospitals and PHCCs, as set out in the Local Government Manual
- Support the CHDs to use the government approved templates for reporting
- Provide continuous support to strengthen the capacity of all health units (CHDs, hospitals, PHCCs and PHCUs), to properly access, account for, and manage, the government transfers.

6.3.5 Governance and Leadership (County Level)

Good governance and leadership of the health services is the essential factor in ensuring that health service delivery is well implemented. The MOH is committed to institutional development to provide leadership, ensure good governance and have effective management at all levels. The CHDs are the essential link between non-governmental organisations, vertical programmes, SMOH and MOH. Building the capacity of the CHDs to oversee this vital stewardship function is critical to health service delivery in the county.

The Service Providers will demonstrate how they will strengthen the capacity of the CHD to function with the overall leadership and stewardship of health in the county. This will include ensuring the development of key skills and knowledge needed for planning, supervising, and evaluating health system performance. CHDs should be supported in developing comprehensive, costed, annual joint work plans that consider the priorities of the county across all development partners at the county-level (including vertical programme, humanitarian actors and other line ministries). Particular attention should be paid to improving linkages to the DFID-supported ICCM and GESS programmes. Mechanisms of monitoring and evaluating the plan, as well as indicators of success must be explicitly stated. Strategic plans should also consider how to engage the communities and increase the involvement of communities in the health system.

The Service Provider will assist the CHD in resilience planning. The Service Provider will assist with developing local plans to deal with potential changes in context and contingency plans for specific risks (e.g. stock outs of essential supplies during the rainy season or other shortages, humanitarian emergencies, disease outbreaks). The Service Provider should outline clear strategies on how they will work with the CHDs to ensure services continue during periods of inclement weather, including buffer stocks of drugs, relevant forms for record keeping and communication channels. The resilience planning should also include local conflict analysis (see Section 6.7 on conflict sensitivity).

Service Providers and the CHD should work together to ensure that feedback mechanisms and communication channels between the community, facilities and the CHDs are functional and in use. These should include, but are

not limited to, feedback on the quality of services and drug availability, feedback on health facility staffing attendance, articulating the urgent health priorities of the community and reporting stock outs.

The Service Provider will support the CHDs to enhance its leadership role, covering activities at the county, facility and community levels. These include, but are not limited to:

- Ensuring cohesive teams are built at the county level to enhance and encourage strong local leadership
- Resilience planning (emergency preparedness and response): planning for seasonal weather changes, floods, disease outbreaks, other humanitarian emergencies and ways to mitigate against these risks – plans should include health committees
- Provide training and support for continuous quality assurance of health services at all levels
- Joint planning, using the HMIS and HRIS data, and in coordination development partners (to share resources) – planning should be responsive to gender and social exclusion barriers[9]
- Development of an effective referral system linking the different levels of service delivery (community, health facilities and hospital)
- Joint supportive supervision of health facilities, while building the capacity of the relevant CHD staff to effectively use the quantified supervisory checklist (QSC) tool to report quarterly through DHIS
- Strengthen stakeholder coordination forums for all vertical programmes and other funding streams in order to harmonise activities to optimise use of resources
- Establish linkages with other programmes locally to enhance the HPF2 implementation and create synergies
- Organise quarterly review of progress with other development partners, help the CHDs re-prioritise activities and support weekly CHD management meetings
- Strengthen medical waste management in facilities.

6.3.6 Governance and Leadership (Community Level)

The community also has a critical role in local governance. Strengthening the community, in particular the health committee, to participate and oversee health services is a vital stewardship function that Service Providers are expected to support.

In accordance with MOH guidelines available, Service Providers should work with the CHDs to continue to strengthen the leadership of health committees that will serve as interface between the CHD, Service Provider, health facility and the community. Service Providers should encourage a gender balance in the health committees and encourage women to take leadership roles. Service providers should prioritise health facilities where there is no health committee and facilitate the establishment of one. These committees should meet regularly, with minutes and action points recorded and sent to the CHD. Activities could include the following:

- Establish and strengthen the leadership of health committees and their involvement in oversight of health facilities

[9] See Section 1: 6.6 Gender and Social Inclusion description

- Support health committees to hold regular meetings with the Service Provider, CHD and health facility, to improve community governance of health services
- Support and promote health committees to develop local partnerships to address underlying health determinants
- Utilise the health committees to communicate the goals and objectives of the HPF2 to the community
- Support health committees to promote messages the Right to Health[10]
- Provide mechanisms for communities to obtain feedback including whistleblowing on fraud, corruption or malpractice.
- Collaborate with health committees for health facility renovations and infrastructure improvements, including water and sanitation facilities

6.4 Objective 3: To increase access to nutrition services particularly for pregnant women and young children

Global Acute Malnutrition is common in South Sudan and Essential Nutrition Action is an integrated part of health care. Greater attention will be given to nutrition given the high rates of malnutrition and resultant impact on broader public health, especially amongst women and children and the availability of proven, highly effective interventions to address the problem.

Service Providers should show how integrated approaches to nutrition counselling, growth monitoring, treatment, and referral will be done in the geographic location. Activities under the HPF2 are not expected to include procuring nutritional supplements and commodities since they can be provided as gift-in-kind.

Service Providers will prioritise strengthening core nutrition services for women of reproductive age and infants and young children. These services are already included in the Basic Package of Health and Nutrition Services and these should be integrated into county health plans.

After strengthening core nutrition functions, Service Providers should support the Infant and Young Child Feeding (IYCF) programme including rollout of UNICEF's training programme, delivery through mother-care groups and establishing support through community nutrition volunteers. Linkages to the BHI programme, the current ICCM programme, the Nutrition Cluster, and other development partners must be taken into account.

The following core nutrition services for women of reproductive age and infants and young children are expected to be included:

- Adolescents, women of reproductive age and during pregnancy; reducing pre-conception anaemia, delaying first pregnancy; dietary advice, nutrition supplements for maternal undernutrition
- Exclusive breastfeeding for the new-born
- Vitamin A supplementation, micronutrient powders and de-worming for children

[10] World Health Organisation: Right to Health. http://www.who.int/mediacentre/factsheets/fs323/en/. Accessed 14 June 2016.

- Community-based growth monitoring and counselling, and counselling about IYCF practices
- Community-based promotion of proper nutrition practices using locally available food, identification and referral of suspected cases of acute malnutrition
- Community based treatment of uncomplicated SAM and MAM in critical locations, with appropriate referral of complicated cases
- Nutrition supplements for children 6-59 months with severe, or moderate, acute malnutrition
- A coordinated approach with other development partners

Above the core activities, Service Providers should plan for:

- Implement the IYCF training programme
- Establish, train and utilise mother-care groups and community health volunteers
- Collaborate with ongoing nutrition programmes at the local level
- Document lessons learned of nutrition programmes across all implementing partners in the geographic area
- Research potential locations where the use of micronutrients is feasible

6.5 Ineligible activities

While the HPF2 aims to strengthen the delivery of health services and health system strengthening, there are some activities that will not be funded under this RFP. The HPF2 will not provide funding for:

- **Procurement of nutritional and feeding supplements**. The funding should not be used to procure nutritional supplements. The HPF will support nutrition activities including growth monitoring, promotion and effective referral systems, but will not support the procurement of nutritional supplements as they are provided by other partners.
- **Surveys.** The funding will not fund small scale surveys unless in exceptional circumstances and prior approval from the HPF management team. Monitoring will be standard across all Service Providers.
- **Construction or major rehabilitation of health facilities**. Construction of new facilities will generally not be supported. The HPF2 will support minor rehabilitation and preventative maintenance of health facilities. New structures will only be constructed, following thorough consultation with the CHD and SMOH, and as a process of rationalising the locations of health facilities, a compelling justification for constructing a new facility is brought forward. The HPF2 will however support the construction/rehabilitation of critical drug stores or other structures that are needed to strengthen the health system; the provision of water points and sanitation at facilities where these have not been developed, and specific needs identified for CEmONC functionality can also be considered. These will include boreholes, rain water harvesting and storage systems.
- **Procurement of anti-TB therapy, HIV drugs or other drugs and supplies that are procured through existing international or nationally supported vertical programmes.** The funding may support procurement of a 'buffer stock' of these supplies as appropriate. The HPF2 will support the limited procurement of top up drugs on the very essential list of drugs. There will be a separate mechanism managing the national procurement of essential medicines. Therefore, large procurements of anti TB,

HIV, and the MOH essential medicines will not be supported. Drugs and supplies that are already being procured through other vertical programmes will also not be eligible.

6.6 Gender and Social Inclusion

HPF2 requires that gender equality and social inclusion (GESI) is mainstreamed throughout the project. GESI mainstreaming is an approach which addresses unequal power relations between women and men and between different social groups. It focuses on the need for action to rebalance these power relations and to work towards achieving equal rights, opportunities and respect for all individuals regardless of their gender and/or social identity. GESI acknowledges the diversity among women and other excluded/marginalised groups. It recognises that specific focus and intervention is necessary to target their interests and needs. Embracing a GESI approach entails the need for analysis as part of training and post-training action planning as to the root causes of unequal gender relations, discrimination, local power structures among and between different ethnic groups, and decision making at the household and community level.

When there is a clear understanding of the reasons for social inequity and the barriers that restrict women's, and many marginalised people's, access to services, resources or benefits Service Providers can then work towards becoming more responsive to ensuring equal access to health services. GESI mainstreaming within HPF2 must include men and boys as equal partners.

A strategy should also include risks and mitigating activities towards violence against women and girls (VAWG). Because HPF2 will seek to continue service delivery in conflict affected areas, work plans will need to include ongoing attention to the health requirements of different groups of displaced people.

VAWG represents a major challenge to the delivery of health services in conflict-affected parts of South Sudan. Levels of VAWG are high throughout South Sudan even in more peaceful times and settings. There is a real need for a common agenda to address VAWG among all health partners. Service Providers are expected to work with state and county structures as well as communities to consider mechanisms and dedicated funds to prevent and mitigate VAWG.

Mainstreaming a gender and social inclusion perspective into the project could include:

- A gender equality and social inclusion mainstreaming training for relevant stakeholders
- Ensuring the county plan is adequately responsive to gender and social exclusion barriers that may inhibit uptake of key reproductive health services
- Ensuring training courses are gender appropriate and all strategic behaviour change communication addresses family planning and birth spacing gender issues
- Work with state and county structures as well as community on mechanisms to prevent and mitigate VAWG
- Ensure a gender balance in the relevant health committees, encourage women to take leadership roles and track women's participation on meetings/design making processes.

- Work plans to include attention to the health requirements of different groups of displaced people: not solely women, but also adolescents, the elderly, members of minority ethnic groups/vulnerable groups.
- Support the roll out of the comprehensive gender responsive supportive supervision to county level and from there to PHCC and PHCU
- Identify needs and plan targeted interventions for socially excluded groups in the geographic area

6.7 Conflict sensitivity, emergency preparedness and response

Considering the context in which HPF2 operates, an appreciation of conflict sensitivity[11] on the part of the Service Providers will be crucial. Violent conflict is not new in South Sudan, and, since the early 1980s, South Sudanese have lived through large-scale wars. The outbreak of widespread violence in South Sudan in December 2013 sharpened a resolve that all development programmes should not only be conflict sensitive but should aspire to reduce conflict. Conflict has been experienced differently in each state of South Sudan. While violence was most sustained and intense in the states of Greater Upper Nile, Juba and a number of other areas also experienced violence between armed groups and government forces, often along tribal/ethnic lines. Most recently, conflict dynamics evolved into repeated bouts of violence in parts of the Equatorias and Greater Bahr el Ghazal. In affected states and regions, the conflict significantly interrupted and in places suspended, health service delivery. Localised conflicts also continued as people seek revenge for grievances, or for opportunities to further their own interests. Conflicts also exist related to historic grievances, ethnic polarisation, neo-patrimonial systems of governance, and new supplies of arms. In contrast, some regions of South Sudan have seen relative stability. Here, narratives of conflict can potentially themselves fuel conflict by justifying a centralisation of power and security, which in turn, tends to fuel local grievances. In addition, rising criminality has disrupted delivery of humanitarian supplies and goods via road, as well as beneficiaries' ability to access services. In 2015, even the states of South Sudan assumed to be the most peaceful, flared into conflict highlighting the fragile nature of peace across all regions of South Sudan.

Therefore, Service Providers must recognise the local divergence in conflict experience and have the flexibility in their conflict sensitivity plan and implementation plans to respond to evolving local dynamics. Successful applicants will be expected to include analysis of local social dynamics as part of their launch and ongoing operations, in order to adjust and adapt programs during implementation. Service Providers need to remain flexible to South Sudan's overall context and adapt if the situation changes, especially if the context deteriorates.

[11] HPF2's definition of conflict sensitivity refers to the discipline and capacity of an organization to: 1) Understand the conflict context in which programs are being implemented; 2) Understand how the context might affect programs and how programs might affect the context; 3) Act on this understanding to minimize risk of negative impacts on programs (i.e., staff, beneficiaries, communities, results) and the conflict dynamics; and 4) Identify options for positively impacting the conflict context.

6.7.1 Contextual Understanding

The foundation of the Service Provider's conflict sensitive approach will be an understanding of the local context. This will be achieved by undertaking a conflict context analysis in collaboration with CHDs. Service Providers are expected to have a demonstrated ability to translate contextual understanding into more effective interventions. While the challenges to conflict sensitivity risks and opportunities will differ from one county to another as a result of these varying local contexts, examples of situations to be avoided include: exacerbating divisions between conflicting groups in the service area through perceived unequal distribution of health provision; inadvertent marginalisation of minority groups in conflict contexts; and staffing , operational, and procurement procedures which are insensitive to the local context or do not acknowledge and plan for conflict-related risks that may affect the program's implementation, staff, or beneficiary safety. An enhanced understanding of the local context will allow Service Providers to avoid aggravating local conflict dynamics, while planning more effectively for conflict-related risks that could adversely impact program implementation, staff, or beneficiary safety.

Service Providers should demonstrate an understanding of the need to show the Government's increasing responsiveness and relevance to local populations; thereby increasing its legitimacy – a vital state building commodity. Service providers will be expected to develop regular context analyses and adjust their programme and work plan, if the context changes.

6.8 Operational Resilience

Service Providers should demonstrate their ability to operate in conflict affected counties. Operational resilience will be essential to ensure that Service Providers are able to cope with a fluctuating security situation. Where relevant, Service Providers should demonstrate, for purposes of evaluation, a proven ability to manage support to delivery of health services even at times of increased conflict and fragility, while at all times maintaining a responsible duty of care towards their staff.

6.8.1 Responsiveness

Service Providers should demonstrate their responsiveness to changing local contexts through an ability to work at different points on the development-humanitarian spectrum. Service providers should have emergency preparedness and response plans, and ensure they are able to respond to a sudden emergency on a small scale, prior to other funding being made available and other partners being mobilised. Such plans should include: the ability to fund a small amount of activities needed in the first few days of an emergency, ability to provide initial investigative sample collection and activities to follow-up on outbreak rumours in the community. Plans should also include seasonal preparedness such as prepositioning supplies in strategic locations, and in areas where higher levels of health risks are anticipated (e.g. displacement or natural disasters) to support health service continuity throughout the year.

6.9 Appropriate technology and innovative programming

The use of appropriate technology and innovative ways of delivering programming is encouraged under HPF2. It is important to note that innovation is not limited to new technologies, such as mobile telephones or use of the internet; it is more likely to involve approaches applied in other parts of the country, region and world. The key to innovation is therefore to adapt existing, or new, approaches to South Sudan's diverse context. These would include strategies for increasing uptake of key services (such as use of HHPs to deliver insecticide treated nets,

condoms and other family planning supplies). It could also include the use of mobile telephones to improve the reliability and accuracy of monitoring, evaluation, and reporting in remote areas.

HPF2 seeks to foster innovative approaches that utilise high quality data and evidence to inform decision-making at all levels of health care service delivery in South Sudan. In practice, this means better leveraging the existing evidence-base knowledge from South Sudan, neighbouring countries and globally in all aspects of health care service delivery in HPF states. While it is unlikely that the evidence base will precisely fit South Sudan's needs, the HPF envisages Service Providers will develop innovative ways to adapt, and perhaps even trial, approaches from the existing evidence base. Applicants are therefore strongly encouraged to clearly articulate how their proposed programming utilises evidence based programming and fits within a broader theory of change.

Service Providers should support the CHDs in any suggested innovative programming, and clearly articulate how a particular innovation would fit into the South Sudan context, providing operational effectiveness over more traditional ways of programming as well as considering its sustainability.

6.10 Lesson learning and information dissemination

The HPF seeks to continually improve its programming and is committed to sharing best practice among all the major stakeholders in South Sudan including the MOH, donors, fund managers, NGOs and the community. The sharing of knowledge and best practice among Service Providers that are funded by the HPF, will ultimately improve the delivery of health services not only in the regions that the HPF supports, but throughout the entire country. As such, Service Providers will be expected to regularly submit success stories, case studies, and best practice through various fora.

Success stories are an important part of HPF's lesson learning culture. Submission of success stories is required as part of Service Providers' quarterly reporting. Success stories must include all the mandatory elements listed in the guidelines such as direct quotes from beneficiaries, supporting data and quality photographs. They should focus on demonstrating real world impact and value for money achieved through HPF support. Ultimately, success stories should tell a human interest story to personalise the positive results of HPF programming.

Lesson learning and information dissemination also requires active participation at the relevant technical working groups, presentations at County Coordination Meetings and sharing experiences at an annual HPF conference. Service Providers are expected to support the CHDs to establish and maintain a lesson learning culture, and assist in the dissemination of information to the communities. Lesson learning should be embedded throughout the project lifecycle. Best practice should also be modelled on experiences from neighbouring, and other, countries further strengthening the delivery of health services in South Sudan.

6.11 Branding and visibility

Branding enhances the visibility and value of HPF support while transparently informing beneficiaries of the source of that aid. Proper HPF branding, as described in the HPF branding policy document, is a mandatory contractual requirement for Service Providers. The HPF logo, and those of its donors, must be visible in all the health facilities supported. The MOH logo must also be appropriately visible to reflect the ownership of the South Sudanese government.

Marking HPF program sites and vehicles and other valuable assets is a large part of HPF's branding efforts. It is critical that the people who visit HPF supported clinics know that those facilities are provided, or are upgraded, with the support of HPF, its donors and the MOH. All sites and valuable assets financed by HPF must prominently display the HPF logo. Temporary signs must be erected early in the construction or implementation phase. When construction or implementation is complete, the Service Provider must install a permanent, durable and visible sign, plaque, or other marking.

Facilities supported by the HPF, including health facilities, CHD offices, other project sites must be branded with standard signposts, which reflect the ownership of the MOH. In the case where local partners, such as Faith-Based Organisations, have an ownership and/or stewardship role, that must also be recognised.

The minimum requirements for the branding of health facilities and valuable assets are set out in the HPF Branding Policy.[12]

6.12 Monitoring, evaluation and reporting

Results monitoring is a key element of the HPF programme. The MOH at all levels, donors, and the HPF require data and information to improve performance, effectiveness, efficiency, sustainability and relevance of the program to the health sector. This data will generate evidence that continually improves the HPF program, supports the national M&E system, and informs planning and management decisions. The end goal is to achieve demonstrable programme impact.

The Service Provider shall monitor local progress in achieving the following indicators and targets indicative of the work plan; the purpose of this monitoring is to enable the Service Provider and the HPF to monitor and assess the HPF contributions towards country goals and to align and adjust project implementation accordingly. HPF reporting will feed into the MOH HMIS system where HPF indicators correspond to the MOH HMIS indicators. The relevant impact level indicators include:

- Under 5 mortality rate (per 1000 live births)
- Maternal mortality ratio (per 100,000 live births)

While the county project will contribute to the HPF indicators noted above, the majority of these indicators are only measured through national prevalence surveys, such as the South Sudan Household Survey or Demographic Health Surveys, and clearly cannot be measured and reported by this project.

Therefore, the Service Provider will also be required to report on the set of indicators outlined in Appendix A3, which are subject to change by HPF. The Service Provider will be expected to submit a brief plan based on the attached template (Appendix A3), and propose specific targets. Targets should be set in consideration of the geographic context, in consultation with the CHDs, and take into account the programme management cycle.

[12] Currently being updated

Service Providers will be expected to develop M&E plan for their geographic area, and update it annually in accordance to CHD operational plans. Ideally, it should demonstrate coordinated governance arrangements, data flow, data sharing and harmonised supervision. Service Providers should ensure data is collected for all three objectives. In cases where the Service Provider proposes not to use the MOH indicators, the indicators selected should have widely shared definitions and allow aggregation of results across the geographic area, and disaggregation by age and gender, for a selection of indicators. In addition, the M&E plan should describe the following details:

- Analysis of Service Provider's M&E system (including an analysis of M&E capacity at community, sub-national and national levels)
- A brief description of M&E strengths and strategies to address weaknesses, if any, in the M&E system (including through capacity building)
- M&E roles and responsibilities at various levels or offices of the Service Provider (national, sub-national and community levels)
- Plans for collaborating in strengthening the HMIS, and mainstreaming gender into the Service Provider's M&E system
- A brief description of the Service Provider's existing indicators system, aligned with the HPF 2 Tools and Indicator Definitions
- Routine and non-routine data collection and reporting arrangements, including qualitative data collection and feedback mechanisms involving the community
- Regular conflict analysis monitoring across the geographic area
- Reporting on VFM indicators and qualitative VFM case studies
- Standard M&E functions such as: data analysis, verification, validation, management, quality assurance, and supportive supervision arrangements
- Information dissemination, use and a brief statement on the equipment, tools, and software currently at the disposal of the Service Provider in support of M&E activities
- Detailed budget and work plan for M&E, which is aligned with the HPF2 M&E work plan and the service providers' technical proposal.

6.13 Management Reviews and Evaluations

The work plan, target table and health facilities data (Appendix A3) submitted by the Service Provider shall be subject to approval of the HPF and will form the basis of Quarterly Performance Reports. It will also form the basis for an annual joint management review by the HPF, Service Provider and the CHDs to monitor achievements, management and implementation issues, and make recommendations for any changes as appropriate.

At any time during program implementation, the HPF may conduct one or more evaluations to review overall progress, assess the continuing appropriateness of the project design, and identify any factors impeding effective implementation. The HPF will utilise the results of the evaluations to recommend any required mid-course changes in strategy and to help determine appropriate future directions. Site visits and third party verification may occur at any time.

6.13.1 Reporting

The Service Provider shall submit reports to the HPF as described below. The exact format for preparation of and timing for submission of all reports will be determined in collaboration with the HPF.

1. **Work plan**
   The Service Provider will prepare a joint work plan for the award on a schedule and format agreed upon by the HPF and the MOH. These joint work plans will be submitted to the HPF with mutual approval from the CHDs.
2. **Quarterly programmatic and narrative reports**
   The Service Provider shall submit electronic copies of the narrative report to the HPF. The template for the quarterly reports will be shared with Service Providers. The narrative reports are required to be submitted quarterly and shall include, but are not limited to, the following information on activities: 1) explanation of quantifiable output of the programs or projects; 2) reasons for variance in established goals (why they were not met), if appropriate; and 3) analysis and explanation of cost overruns, underspends or high unit costs. Further, notification must be given in the case of problems, delays or adverse conditions which materially impaired the ability to meet the objectives of the programme. These notifications must include a statement of the action taken or contemplated and any assistance needed to resolve the situation.
3. **Financial reports**
   The Service Provider shall submit to the HPF:
   - **Monthly invoices:** The Service Provider shall submit monthly invoices to the HPF with statements verifying and certifying the accuracy of the invoiced costs, both electronic and hard copies by the 15th of every month.
   - **Monthly expenditure forecasts**: The Service Provider will submit a monthly expenditure forecast containing a summary page which shows spending by program component, cumulative spending to date, available funding for the remainder of the activity and any variances from planned expenditures. The Service Provider will also submit a quarterly asset register which has been verified.
     If there are significant accrued expenditures for the quarter being reported upon which for some reason have not yet been billed to the contract, the Service Provider will include a brief note to that effect, with the specific amount involved, thus enabling the HPF to accurately track the project's expenditure rate.
   - **Independent audit report:** Independent audits will be required from all Service Providers within 30 days after the end-date of the contract. The HPF will send guidelines on audit requirements and for the selection of independent auditors to all Service Providers.
4. **Final report**
   The Service Provider shall submit an electronic copy of the final narrative report no later than 30 days after the end-date of the contract. The final report shall include an executive summary of the Service Provider's accomplishments in achieving results and conclusions about areas in need of future assistance; an overall description of the Service Provider's activities and attainment of results of the geographic area during the life of the Contract; an assessment of the progress towards achieving the objective and expected results; significance of these activities; important research findings, comments and recommendations; and a fiscal report that describes how the Service Provider's funds were used.

5. **Other reports**
   - With support from the Service Providers, CHD will provide HMIS and QSC data through the DHIS, by the 15th day of every month
   - The Service Provider will submit a copy of the DHIS Export File to HPF
   - Report IDSR Weekly information to MOH as per the guidelines
   - Provide drug consumption reports when required, based on standard procedures of MOH
   - Any other endorsed reporting by the MOH

6.14 Contracting period

The contracting period for the services will be from 01 October 2016 to 28 February 2018.[13] A formal performance appraisal will be conducted during the contract period, to draw up detailed work plans or remedial actions. At the end of this period, the Service Provider's work will be formally evaluated by the Government and HPF.

6.15 Financial allocations

The indicative total contract award value for the different lots are[14]:

Lot number	Geographical area	Contract award ceiling (GBP)
1	• Torit County • Magwi County • Nimule Hospital (focus on CEmONC) • Torit State Hospital (focus on CEmONC)	**4,581,000**
2	• Lopa-Lafon County • Ikotos County • Isohe Mission Hospital (St Teresa) (focus on CEmONC)	**1,944,000**
3	• Budi County • Kapoeta South County • Kapoeta Mission Hospital (focus on referral system) • Kapoeta Civil Hospital (focus on CEmONC) • Chukudum Hospital (focus on CEmONC)	**1,669,000**
4	• Kapoeta North County • Kapoeta East County	**1,496,000**
5	• Jur River County • Wau County • Wau Comboni Hospital (focus on referral system) • EmONCWau Teaching Hospital (focus on CEmONC)	**4,174,000**
6	• Raja County	**3,288,000**

[13] Subject to change by the client

[14] Subject to change by client or Steering Committee

	• Aweil North County • Aweil West County • Raja Hospital (focus on CEmONC)	
7	• Rumbek North County • Rumbek Centre County • Rumbek East County • Cueibet County • Wulu County • Cuibet Hospital (focus on CEmONC) • Rumbek State Hospital (focus on CEmONC)	**3,726,000**
8	• Yirol West County • Yirol East County • Awerial County • Mapuordit Mission Hospital (focus on CEmONC) • Yirol Hospital (focus on CEmONC)	**2,484,000**
9	• Twic County • Gogrial East County • Gogrial West County • Turalei Mother Teresa Hospital (focus on CEmONC) • Kwajok Hospital (focus on CEmONC)	**3,858,000**
10	• Tonj North County • Tonj East County • Tonj South County • Marial Lou Hospital (focus on CEmONC) • Tonj Hospital (focus on CEmONC)	**2,667,000**
11	• Aweil East County • Aweil South County • Aweil Centre County • Aweil State Hospital (focus on CEmONC)	**3,482,000**
12	• Mayom County • Abiemnom County	**926,000**
13	• Pariang County	**469,000**
14	• Bentiu State Hospital (focus on CEmONC) • Rubkona County • Guit County	**1,690,000**
15	• Leer County • Mayendit County	**1,069,000**
16	• Koch County	**743,000**
17	• Payinjiar County	**702,000**
18	• Terekeka County	**1,500,000**

19	• Juba County • El-Sabah Children Hospital (focus on referral system) • Juba Teaching Hospital (focus on referral system)	**2,430,000**
20	• Lainya County • Lainya County Hospital (focus on CEmONC or referral system) • Yei County • Yei Hospital (focus on CEmONC or referral system) • Morobo County • Morobo County Hospital (focus on CEmONC) • Kajo Keji County • Kajo Keji Civil Hospital (focus on CEmONC)	**4,958,000**
21	• Mvolo County • Maridi County • Maridi Hospital (focus on CEmONC or referral system) • Mundri West County • Mundri East County • Lui Hospital (focus on CEmONC or referral system)	**3,258,000**
22	• Tambura County • Tambura Hospital (focus on CEmONC or referral system) • Nagero County	**1,741,000**
23	• Nzara County • Nzara Hospital (focus on CEmONC or referral system) • Ezo County • Ezo County Hospital (focus on CEmONC or referral system) • Yambio County • Yambio State Hospital (focus on CEmONC) • Ibba County	**3,645,000**

7. Terms of Reference Annexes

7.1 Annex 1: Essentials of the PHC – BPHNS Services and Activities

While the Basic Package of Health Services defines an already streamlined and focused package of health services, it is acknowledged that even this package might not be realistic in the present situation and given resource limitations in South Sudan. While not the sole cause, this is particularly related to the availability of human resources which could require several years to build up sufficient quantity and quality. Therefore, the following table presents the very essential services to be provided.

These activities have to be carried out as an absolute minimum. In locations where circumstances are less constrained, the BPHS can and shall be provided comprehensively.

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
SAFE MOTHERHOOD AND REPRODUCTIVE HEALTH				
Focused Antenatal Care				
IEC	✓	✓	✓	✓
Identification of pregnant mothers and counselling for early initiation and compliance with ANC	✓	✓	✓	✓
Referral for ANC, PMTCT, STI prevention and treatment	✓	✓	✓	✓
Monthly ANC mobile clinic services. – identification of high risk cases and referral to CH or SRH		✓	✓	
Nutrition counselling; Micronutrient supplementation; iron, folic acid, Vit A	✓	✓	✓	✓
Malaria prevention, LLINs and IPT	✓	✓	✓	✓
Preparation and timely travel for BEmONC or CEmONC (according to risk status), arrangements for waiting homes	✓			
Management of normal deliveries		✓	✓	
Management of moderate complications and risks: infection, post partum haemorrhage: volume replacement – ORS – Infection: cotrimoxazole – Pallor: iron, folate and multivitamins, HBP, refer to PHCC/CH			✓	✓
Management of high risk cases or complications to CH or SRH (EmNOC centre) incl. i.v., antibiotics, MVA, PAC, caesarean section – CPD, fluid retention, previous C/section, multiple pregnancy and grand multiparity, antepartum haemorrhage, severe oedema, severe antepartum fits				✓
All signal functions of Comprehensive EmONC (at antenatal preparation)				✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
Care of uncomplicated delivery				
Referral of all mothers in labour to PHCU for clean hygienic assistance of uncomplicated delivery	✓	✓		
Clean hygienic assistance of delivery for precipitous labour, while transferring to PHCU/PHCC	✓			
Provision of clean hygienic assistance of uncomplicated delivery for abrupt labour, oral misoprostol (or cytotec)		✓		
Clean hygienic assistance of uncomplicated delivery: gloves, cotton wool, clean blade, soap, oral misprostone-cytotec			✓	
Refer obstructed labour and haemorrhage: to CH or SRH	✓	✓	✓	
Comprehensive non surgical and surgical obstetric care (24hrs)				✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓
Emergency Obstetric and Neonatal care				
Awareness raising on, identification of high risk labour and refer to CH: CPD and other obstructed labour, haemorrhages, fever, convulsions	✓			
Identification of haemorrhage and stabilise with ORS for volume replacement for transfer to CH		✓	✓	
Transfer cases of obstructed labour, eclampsia, high fever, sick neonates tp CH		✓	✓	
The signal functions of Basic EmONC: − I.V antibiotics administered − I.V. oxytoxics administered − I.V anti-convulsants − Manual removal of the placenta − Assisted delivery by vacuum extraction − Manual vacuum aspiration of retained products of conception − Neonatal resuscitation			✓	✓
The signal functions of Comprehensive EmONC, in addition to basic EmONC: − Surgical obstetrics: caesarean section and emergency hysterectomy				✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓
Focused Postnatal Care				
Maternal and IECHC counselling	✓	✓		
Referral for PNC and Child Health Clinic	✓	✓		

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
Identification, treatment and immediate referral: – To CH or SRH: postpartum haemorrhage; inevitable or incomplete abortion volume replacement with ORS, MVA and misoprostol – To PHCC: infection: cotrimoxazole; pallor: iron, foliate, multivitamins; convulsion: clear airway, oral sedative	✓	✓	✓	
Counselling Referral for PNC and Child Health Clinics			✓	✓
Immediate treatment for puerperal complications: – (i) Postpartum haemorrhage/inevitable or incomplete abortion: volume replacement with IV fluids, MVA/PAC and parenteral oxytocics or oral misoprostol – (ii) Infection: parenteral antibiotics – (iii) Anaemia:: iron, folate and/or referral – (iv) Convulsion: clear airway, iv anticonvulsants			✓	✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓
(Adolescence) Sexual and Reproductive Health and Family Planning				
Awareness creation/demand generation for ARH and counselling of women and their sexual partners to accept FP/RH services.	✓	✓	✓	
Youth focused services: CT, SMSTI and counselling on sexuality and ABC	✓	✓	✓	
Promotion of VCT and SMSTI.	✓	✓	✓	
CBD of oral FP methods	✓	✓	✓	✓
Condom promotion and supply	✓	✓	✓	
(in next phase include: BP check, SMSTI, VCT Pap Smear, LT contraceptives-IUD and Sc implants; palpation for breast masses by quarterly appointments)		✓	✓	
Surgical male and female contraception				✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓
Men's RH				
Advocacy for gender equitable sexual roles.	✓	✓		
Counselling for gender equitable sexual roles, referral for VCT and SMSTI	✓	✓	✓	
Social marketing of condoms	✓	✓	✓	
Awareness creation on male reproductive organ disorders, urethral stricture, prostate hypertrophy and cancer and testicular cancer	✓	✓	✓	
Identification and referral for male reproductive organ disorders		✓	✓	

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
Case identification and referral			✓	
Limited care on male reproductive organ disorders, urethral stricture,			✓	✓
(in next phase include outreach surgery and referral of prostatic hypertrophy and all prostatic and testicular cancer)				✓+ refer
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓

Child Health

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
CHILD HEALTH				
Immunisation/EPI services				
Promotion of EPI among parents	✓			
Defaulter tracing of < 5 immunisation, counsel and refer	✓	✓	✓	
Mobilisation of communities to attend mass outreach/mobile immunisation or during NIDs.	✓	✓	✓	
Surveillance and reporting of cases of vaccine preventable diseases	✓	✓	✓	
Monthly routine outreach/mobile immunisation and static centres		✓	✓	✓
Daily routine immunisation, five days a week			✓	✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓
Essential Nutrition Action				
Counselling: prevention of pre-lacteal feeding, exclusive breast feeding for first six months, timely weaning and continued feeding for 24 months	✓	✓	✓	
Community based growth monitoring and counselling and training/demonstrations in diet rich in protein and calories by selection and enrichment of local weaning diet.	✓	✓	✓	
Screening and supplementary feeding for moderate malnutrition and for children in families of at risk child.	✓	✓	✓	
Mass de-worming and micronutrient supplementation on NIDs	✓	✓	✓	
Growth monitoring (detect malnutrition, esp. in families of at risk child)		✓	✓	✓
Nutrition rehabilitation for the mild to moderately malnourished children			✓	
Referral of severe malnutrition to therapeutic feeding	✓	✓	✓	
Treatment of severe malnutrition at designated TFCs				✓

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓
Integrated Management of Childhood Illness				
Creation of awareness and promotion of ITNs on NIDS and mass distribution days	✓			
CHWs to use simple algorithms of assessing, classifying and assigning treatment or refer cases of fever (treatment of uncomplicated fever with ACT)		✓	✓	
Refer children with danger sings to CH (severely cold or hot body, inability or refusal to feed, fast breathing, skin pinch returns very slowly)		✓	✓	
Creation of awareness on recognition of diarrhoea, promote and train parents on use of ORS, zinc supplement and encouragement of increased frequency of feeding during and post diarrhoea	✓	✓	✓	
Creation of awareness on recognition of pneumonia (counting number of breaths/ minute and in chest in-drawing and encouragement of increased frequent feeding during and post ARI	✓	✓	✓	
Early treatment and referral with cotrimoxazole for cases of cough, rapid breathing in drawing of chest and nasal flaring		✓	✓	
Sedation for cases of convulsion and referral for first time convulsion		✓	✓	
Encouragement of isolation of sick children and quarantine for children during epidemic outbreaks of cholera and meningitis	✓	✓	✓	
Algorithm guided treatment of malaria with ACT or second line treatment		✓	✓	✓
Algorithm guided treatment of moderate dehydration from diarrhoea (ORS) and severe dehydration or diarrhoea with danger sings (IV ringers solution) Use of zinc and other micronutrient supplement, encouragement of increased frequency of feeding during and post diarrhoea		✓	✓	✓
Algorithm guided treatment of pneumonia Counting number of breaths per minute and in chest in-drawing nasal flaring with parenteral antibiotics- amoxicillin and provision of moist oxygen		✓	✓	✓
Epidemic and outbreak management - cholera and meningitis, measles, whooping cough, polio yellow fever, RV fever etc		✓	✓	✓
Reporting	✓	✓	✓	✓
Monitoring and supervision			✓	✓

Most Common Diseases and Public Health Risks

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
MOST COMMON DISEASES AND PUBLIC HEALTH RISKS				
Prevention and Control of Communicable and other Endemic Diseases				
Malaria				
IEC	✓	✓	✓	✓
Clinical diagnosis		✓	✓	✓
Microscope diagnosis			✓	✓
Treatment of uncomplicated cases – first line treatment		✓	✓	✓
Treatment of uncomplicated cases not responding to first line		refer	✓	✓
Treatment of severe and complicated cases		refer	✓+ refer	✓+ refer
Promote use of insecticide-treated mosquito nets	✓	✓	✓	✓
Intermittent therapy (pregnant women)		✓	✓	✓
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
Tuberculosis				
IEC	✓	✓	✓	✓
Case detection among self-reporting patients using sputum smear	refer	refer	✓	✓
Short course chemotherapy, incl. DOTS		follow up	follow up	diagnose and treat
Defaulter tracing	✓	✓	✓	✓
BCG vaccination	assist	assist	✓	✓
X ray for smear negative patients				✓
Algorithms of treatment for AFP (-)			✓	✓
Preventative therapy for children contact of TB patients	refer	refer	✓	✓
DOTS-plus in muti-drug resistant TB		follow up	✓	✓
Inpatient management of severe cases			refer	✓+ refer
Management of complicated cases				✓+ refer
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
STI, HIV/AIDS				
IEC on STI and HIV including – promotion of safer sexual behaviour including condom promotion, procurement and distribution; – encouragement of prompt health care-seeking behaviour in case of experiencing symptoms and signs of STI – referral for VCT	✓	✓	✓	
VCT and provider initiated counselling and testing (PITC)			✓	✓
HIV/AIDS treatment and care including PMTCT	refer	refer	✓	✓

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
Comprehensive case management of STI		✓	✓	
Prevention and care of congenital syphilis and neonatal conjunctivitis	✓	✓	✓	✓
Home based care and adherence counselling for PLWHA already on treatment	✓	✓	✓	
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
Diarrheal, Enteric Infections and Infestations				
IEC on the causes of diarrhoea and its prevention and – encouragement of mothers to continue with the healthy infant feeding and weaning practices – safe use of potable water – promotion of hand washing before and after handling food, after toilet including after cleaning or handling children's faeces – recognition of other enteric infections (esp. abdominal pain, progressive fever, generalised weakness, constipation or small loose stool) – early recognition of outbreaks of diarrhoea and immediately alert staff at PHCU or PHCC – safe disposal of faeces including those of children	✓	✓		
Creation of awareness among village development committees on participatory health and sanitation (PHAST)	✓	✓		
Facilitation for practical identification of water points – protection of water points – discouragement of risky sanitary practices	✓	✓		
Construction of demonstration toilets protection of water sources in schools, market places and administration centres, community gathering venues	✓	✓		
Promotion of immunisation especially against measles	assist	assist	✓	
Regular administration of vitamin A (every six months) for all children under the age of five	✓	✓		
Regularly de-worming of children – mass campaigns, school health programs	✓	✓		
Refer suspected typhoid fever cases to PHCC/CH for laboratory investigation, diagnosis, treatment with antibiotics and report to Payam and county health authorities		refer✓	✓	✓
Emergency preparedness by identifying early warning signs for outbreaks of diarrhoea, developing responses and reporting	✓	✓	✓	✓
Treatment of mild cases of dehydration (ORS)		✓	✓	
Treatment of severe cases of dehydration (IV) and cases requiring			✓	✓

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
antibiotics				
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
Acute Respiratory Infection				
IEC on early signs of respiratory infection among children and adults	✓	✓		
Refer cases of suspected pneumonia promptly to the PHCC to start treatment with oral antibiotics immediately		refer	✓	✓
Refer older people and/or severe cases of suspected pneumonia promptly to the CH to start treatment with antibiotics injections and oxygen if respiratory failure sets in.		refer	refer	✓
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
Neglected and Tropical Diseases				
Schistosomiasis (snails fever), trypanosomiasis (sleeping sickness), visceral leishmaniasis (Kalar Azar), lymphatic filariasis (elephantiasis), river blindness (onchocerciasis), guinea worm infections, trachoma				
IEC to create awareness on the causes, dangers and impact and means of prevention of the diseases	✓	✓	✓	
Promotion of interventions to reduce the contact of people with the parasites or their vectors (carrying agents) Provision of protected water sources, provision of fuel wood away from known breeding sites of vectors, encouragement of construction and proper use of toilets or avoidance of water sources by all especially those who are infected and	✓	✓		
Preventive chemotherapy through mass drug administration (MDA) and other national control programmes	✓	✓	✓	
Schistosomiasis Control				
IEC to increase number and use of toilets	✓	✓	✓	
Annual dose of the drug praziquantel	assist	assist	✓	
Mass treatment with albendazole	assist	assist	✓	
Identification and treatment of cases with albendazole				✓
Onchocerciasis Control Initiatives				
Mass administration of ivermectin	assist	assist	✓	
Elimination of the blackfly through insecticide spraying	assist	assist	✓	
Community distribution of topical antibiotics for mass treatment	✓	✓	✓	
Community directed visual health programme	✓	✓	✓	
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓

Non-Communicable, High Priority Diseases and Conditions

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
Non-Communicable, High Priority Diseases and Conditions				
Diabetes and Hypertension				
Awareness, prevention and education	✓	✓	✓	✓
Case detection	✓	✓	✓	✓
Clinical diagnosis		✓	✓	✓
Laboratory diagnosis			✓	✓
Treatment of uncomplicated cases	follow	follow up	✓	✓
Treatment of complicated cases		refer	✓+ refer	✓+ refer
Defaulter tracing	✓	✓	✓	✓
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
Mental Health				
Mental health education and awareness	✓	✓	✓	✓
Case detection	✓	✓	✓	✓
Anxiety disorders (e.g. post-traumatic stress-; panic disorder)	refer	follow up	✓	✓
Depression: identification and bio-psychosocial management	refer	follow up	✓	✓
Epilepsy: identification and treatment	refer	follow up	✓	✓
Psychotic and psychiatric cases: bio-psychosocial management	refer	follow up	✓	✓
Mental retardation: identification, education to parents	✓	✓	✓	✓
Community based care and rehabilitation incl. support groups	✓	✓	✓	
Inpatient treatment			refer	✓+ refer
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓
Disability (physical)				
Awareness, prevention and education	✓	✓	✓	✓
War injuries	refer	refer	refer	✓+ refer
Traumatic amputations	refer	refer	refer	✓+ refer
Prosthesis	refer	refer	refer	✓ + refer
Assessment and treatment of physically impaired patient	refer	refer	refer	✓ + refer
Community based care and rehabilitation incl. support groups	✓	✓	✓	
Primary Eye Care				
IEC on the types and causes of eye diseases	✓	✓	✓	
Promotion of eye health/prevention of eye infections regular washing of face	✓	✓	✓	
Community based mass distribution campaigns for antibiotics for trachoma and OV preventions commodities (water filters)	✓	✓	✓	
Management of common and simple eye diseases		✓	✓	✓

SERVICES AND ACTIVITIES	Village	Boma PHCU	Payam PHCC	County Hospital
especially topical antibiotics for treatment of epidemic eye infection during outbreak seasons				
Detection and referral of treatable blindness including cataract and corneal opacities or trichiasis		refer	refer	✓ + refer
Visual activity by school teachers	✓	✓		
Mass testing in schools (refraction errors)	✓	✓		
Simple lid eversion and removal of sub-tarsal foreign bodies		✓	✓	
Irrigation of the eye for chemical injuries, (		✓	✓	
Referral of complicated treatment to CH and SRH		refer	refer	✓ + refer
Trachoma trichiasis surgeries		refer	refer	✓ + refer
Cataract extraction		refer	refer	✓ + refer
Provision of lenses				✓

7.2 Annex 2: Lot information sheets – indicative data January – December 2015[15]

#	Geographical Area	Health Facility Numbers per Category						Total Population	Antenatal client 1st visit	Antenatal client 4th or more visit	Consultation curative 5 years and older	Consultation curative under 5 years	Delivery in facility by skilled birth attendant	Delivery in facility total	DPT 3rd dose under 1 year total	Family planning new user
		Hospital			PHCC	PHCU	Total									
		State Hosp	County Hosp	FBO Hosp												
1	Torit County Magwi County Nimule County Hospital (Focus on CEMONC) Torit State Hospital (Focus on CEMONC)	1	1	0	18	67	87	413,948	10,478	6,061	78,744	95,994	4,009	5,231	256	786
2	Lopa-Lafon County Ikotos County Isohe Missing Hospital (St. Theresa) (Focus on CEMONC)	0	1	0	7	41	49	292,691	4,191	1,708	53,533	63,220	708	1,429	270	265
3	Budi County Kapoeta South County Kapoeta Mission Hospital (Focus on CEMONC) Kapoeta Civil Hospital (Focus on CEMONC)	0	2	0	6	21	29	275,965	7,453	3,376	57,183	50,815	953	1,344	161	20

[15] Data is indicative only, for guidance and planning purposes. This is only to be used for the RFP, and not quoted for other documentation as HPF data. Official data has not been released for 2015.

	Chukudum Hospital (Focus on CEMONC)															
4	Kapoeta North County Kapoeta East County	0	1	0	6	25	32	411,160	7,328	2,510	52,812	43,149	692	888	12	6
5	Jur River County Wau County St Daniel Comboni Hospital, Wau (Focus on CEMONC) Wau Teaching Hospital (Focus on CEMONC)	1	1	0	17	53	72	396,433	14,287	6,345	229,194	131,722	4,143	5,460	3,997	1,561
6	Raja County Aweil North County Aweil West County Raja County Hospital (Focus on CEMONC)	1	0		10	64	75	496,791	34,170	13,313	338,974	236,490	6,614	8,802	5,783	1,653
7	Rumbek North County Rumbek Centre County Rumbek East County Cueibet County Wulu County Cueibet County Hospital (Focus on CEMONC) Rumbek State Hospital (Focus on CEMONC)	1	1	0	15	43	60	723,532	26,843	11,925	315,464	176,248	2,988	5,892	2,392	297
8	Yirol West County Yirol East County Awerial County Mapuordit Mission Hospital (Focus on CEMONC) Yirol County Hospital (Focus	0	1	1	8	24	34	329,644	20,406	6,488	217,015	139,320	2,805	4,266	3,540	45

	on CEMONC)															
9	Twic County Gogrial West County Gogrial East County Turalei Mother Teresa (Focus on CEMONC) Kwajok State Hospital (Focus on CEMONC)	1	1	0	14	43	59	783,817	32,491	14,760	327,048	186,231	2,814	5,540	1,554	296
10	Tonj North County Tonj East County Tonj South County Marial Lou Hospital (Focus on CEMONC) Tonj County Hospital (Focus on CEMONC)	1	1	1	9	27	39	521,624	19,475	7,070	210,301	144,199	1,401	3,436	767	259
11	Aweil East County Aweil South County Aweil Centre County Aweil State Hospital (Focus on CEMONC)	1	1	1	12	49	64	603,796	18,076	9,794	282,164	169,570	1,329	2,486	9,902	1,021
12	Mayom County Abiemnom County	0	0	0	4	9	13	205,493	9,301	4,016	135,697	63,341	236	1,274	114	154
13	Pariang County	0		0	4	3	7	123,296	1,116	549	38,297	16,065	353	402	858	17
14	Bentiu State Hospital Rubkona County Guit County	1	1	0	7	5	14	198,498	4,999	1,502	118,142	53,340	1,436	1,601	303	102
15	Leer County	0	1	0	3	14	18	160,022	1,360	591	38,665	28,622	119	360	-	224

	Mayendit County															
16	Koch County	0	1	0	2	4	7	111,928	473	144	11,940	7,412	10	119	-	0
17	Panyijiar County	0	0	0	3	11	14	65,117	2,199	516	53,417	30,993	351	357	75	3
18	Terekeka County		1	0	6	35	42	206,287	5,261	2,417	26,508	32,193	473	633	_	369
19	Juba County El-Shabah Children Hospital (Focus on referral) Juba Teaching Hospital (Focus on referral)	4			20	73	97	525,953	21,071	10,038	54,476	113,881	4,226	6,819	3,154	745
20	Lainya County Lainya County Hospital (Focus on CEMONC) Yei County Yei Civil Hospital (Focus on CEMONC) Morobo County Morobo County Hospital (Focus on CEMONC) Kajo Keji County Kajo Keji County Hospital (Focus on CEMONC)		3	0	19	92	114	844,046	21,944	10,844	156,286	93,742	6,209	8,460	5,152	2,477
21	Mvolo County Maridi County Maridi County Hospital (Focus on CEMONC)	0	4	0	10	50	64	276,323	8,308	4,084	36,751	20,526	1,397	2,276	4,040	1,290

	Mundri East County Mundri West County Lui Civil Hospital (Focus on CEMONC)															
22	Tambura County Tambura County Hospital (Focus on CEMONC) Nagero County	0	1	0	7	31	39	**84,342**	**4327**	**1,366**	**27,224**	**21,388**	**734**	**1,868**	**543**	**461**
23	Nzara County Nzara County Hospital (Focus on CEMONC) Ezo County Yambio County Yambio State Hospital (Focus on CEMONC) Ibba County	1	1	0	12	57	71	442,599	5918	3,681	27,421	13,206	1,665	3,407	4,254	2,512

7.3 Annex 3: Hospital Guidance on CEmONC and Referral

There are three categories of support: CEmONC support, referral support or specific one-off requirements identified by HPF (e.g for the faith based hospitals). This section is a guide for CeMONC and referral support. Please also refer to the additional lot specific support requirements per hospital in Annex 4.

Key CeMONC components		CEmONC	Referral
Staffing	- Adequate number of medical doctors, midwives, anaesthetists, theatre nurse and other staff for 24 hours CEmONC and critical support services - Retention of health workers - Staff management e.g. staff appraisal and job descriptions	X	
Medical equipment and furniture	- Equipment and furniture for Maternity ward, delivery room and Operation Theatre - Essential equipment for critical other/support services	X	
Medical consumables and supplies	- Complementary and supplementary essential drugs and medical supplies according to guidelines MOH - Essential Emergency drugs	X	
Infrastructure including renovation, minor construction and refurbishment	- Adequate infrastructure for maternity, delivery and neonatal services - Adequate infrastructure for Operating Theatre services and blood bank - Adequate infrastructure for critical support services (laboratory, sterilisation, pharmacy etc.) - Running water supply and sanitation in essential departments - Latrines for patients and staff - Power supply for 24 hour services - Waste management incl. incinerator	X	
Training and capacity building	- In-service training programs for relevant staff - On-site mentoring - Task-shifting including related training - Access to learning material - Staff exchange program and peer review - Placement and mentoring of pre-service students in the hospital	X	

Continuous Quality improvement	- Adequate supportive supervision (internal and external) - Regular clinical skills updates and continuous medical education programs - Use of clinical aids, partograph, treatment protocols	X	
Data collection and management	- Avail inpatient- and hospital department registers - Data collection, processing and reporting - Use of data in management and service improvements	X	
Countywide referral system from community level to PHC facilities up to hospital level in close collaboration with CHD and others health service providers	- Transport: Procure, repair and maintain ambulances or alternative means of transport where appropriate - Set up or scale up communication system from community level upwards - Referral feedback system - Maternity waiting space/home/facility	X	X
Key community components		**CEmONC**	**Referral**
Community governance structures	- Consult Village Health Committees and Boma Health Committees for feedback on perceived quality of care - Engage community governance structures in following up of maternal death, defaulters and referral	X	
Community involvement in Hospital governance	- Ensure representation of community leaders on the hospital board	X	
Appropriate community sensitization	- Support the CHD to develop and disseminate appropriate messages based on recognition of unique cultural and social norms	X	
Engagement of Community Based Resource Persons	- Engage Home Health Promoters and TBAs in effective referral - Engage and support TBAs in hospital based ANC and delivery services in the absence of sufficient skilled birth attendants, Community Midwives and MCHW	X	
Key Stewardship Components		**CEMOC**	**Referral**
Strengthening the hospital daily management	- Set up/support the daily hospital management structures (medical director, matron and administrator) - Ensure regular meetings of the daily management committee including action plans	X	

Strengthening the CHD or SMOH as stewards of the hospital health management	- Ensure joint planning (service provider and government), using the HMIS and HRIS data - Planning and recruitment of staff, retention and management of staff - Establish and update personnel records of each health worker based on training and capacity development activities (paper records and through the HRIS) - Establish the MOH approved hospital-based HMIS - Essential drugs, medical supplies and warehouse management - Support overall financial management and budgeting, using government approved forms - Build capacity to assess, monitor and account for government transfers,	X	
Engagement of SMOH in its support role to CHD and county health system	- Hospital support and review visits - Re-allocation of staff within the State	X	X

7.4 Annex 4 Hospital Specific Support Requirements

For CEmONC and Referral support, please also refer to Annex 3.

Faith Based Hospital Support is described below, and focuses on discreet and specific support as it is not HPF's intention to manage the hospital.

Lot number	Hospital Support Description
1	**Nimule Hospital (focus on CEmONC)** • Hospital receives support from HPF. • Service Provider should focus on increase quality of CEmONC services and support family planning clinic, as CEmONC services already established • Support should be provided to develop a well-functioning referral system **Torit State Hospital (focus on CEmONC)** • Hospital receives support from HPF already • Priority to increase quality of CEMONC services and support family planning clinic • Support to develop a well-functioning referral system
2	**Isohe Mission Hospital (St Teresa) (Faith Based Hospital Support)** • Hospital previously received support from HPF. Priority is to ensure availability of CEmONC services. Hospital is managed by Caritas Torit. • HPF2 funding should be used to make sure CEmONC services are available, support to develop a well-functioning referral system. • Support should focus on renovation, equipment and specific technical or systems training support. • HPF2 implementing partner support should ensure collaboration so that the mission hospital is linked with the overall government systems. • Caritas to remain the lead for the hospital
3	**Kapoeta Mission Hospital (Faith Based Hospital Support)** • Hospital previously received support from HPF. There isn't a need to support CEmONC because Kapoeta Civil Hospital is located nearby. It is referral for patients with TB and HIV/AIDS. According to the hospital's annual report, hospital is also referral centre for malnourished patients. • Support should focus on renovation, equipment and specific technical or systems training support. • HPF2 implementing partner support should ensure collaboration so that the mission hospital is linked with the overall government systems. **Kapoeta Civil Hospital (focus on CEmONC)** • Hospital receives support from HPF already. Priority is to increase quality of CeMONC services, support family planning clinic and support for well-functioning referral system **Chukudum Hospital (focus on CEmONC)** • Hospital receives support from HPF already. Priority is to increase quality of CeMONC services, support family planning clinic and support for well-functioning referral system
4	-

5	**Wau Comboni Hospital (Faith Based Hospital Support)** • Hospital received support from HPF already. Wau Teaching Hospital is nearby and greater focus on supporting Wau Teach Hospital for CEmONC. The hospital already has a good neonatal unit. • Support should focus on renovation, equipment and specific technical or systems training support. It may also require specific essential commodities outside of the national drug procurement plans. Support should also help reduce the patient burden on Wau Teaching Hospital. **Wau Teaching Hospital (focus on CEmONC)** • Hospital already receives support from HPF. Service Provider should focus on increase quality of CEmONC services and support family planning clinic, as CEmONC services already established • Support should be provided to develop a well-functioning referral system
6	**Raja Hospital (focus on CEmONC)** • Hospital already receives support from HPF. Service Provider should focus on increase quality of CEmONC services and support family planning clinic, as CEmONC services already established • Support should be provided to develop a well-functioning referral system
7	**Cuibet Hospital (focus on CEmONC)** • Hospital already receives support from HPF. Service Provider should focus on increase access to CEmONC services and support family planning clinic. Family planning uptake is very low, therefore service providers should describe how they will increase uptake • Support should be provided to develop a well-functioning referral system **Rumbek State Hospital (focus on CEmONC)** • Hospital already receives support from HPF. Service Provider should focus on increase quality of CEmONC services and support family planning clinic. • Support should be provided to develop a well-functioning referral system
8	**Mapuordit Mission Hospital (focus on CEmONC)** • Hospital already receives support from HPF. It is a referral hospital in Lakes State that receives patients from WES as well. • Service Provider should focus on increase access to CEmONC services and support family planning clinic. Family planning uptake is very low, therefore service providers should describe how they will increase uptake • Support should be provided to develop a well-functioning referral system **Yirol Hospital (focus on CEmONC)** • Hospital already receives support from HPF. Service Provider should focus on increase quality of CEmONC services and support family planning clinic. Family planning uptake is very low, therefore service providers should describe how they will increase uptake • Support should be provided to develop a well-functioning referral system
9	**Turalei Mother Teresa Hospital (focus on CEmONC)** • Hospital already receives support from HPF. It is the only county-level hospital in Twic County. Service Provider priority should be to ensure availability of CEMONC services. • Support should be provided to develop a well-functioning referral system

	Kwajok Hospital (focus on CEmONC) • Hospital already receives support from HPF. Service Provider should focus on increase quality of CEmONC services and support family planning clinic. • Support should be provided to develop a well-functioning referral system
10	**Marial Lou Hospital (focus on CEmONC)** • Hospital already receives support from HPF. • Service Provider should focus on increase quality of CEmONC services. • Support should be provided to develop a well-functioning referral system **Tonj Hospital (focus on CEmONC)** • Hospital already receives support from HPF. • Service Provider should focus on increase quality of CEmONC services and support family planning clinic. • Support should be provided to develop a well-functioning referral system
11	**Aweil State Hospital (focus on CEmONC)** • Hospital already receives support from HPF. Service provider priority should be to ensure access to CEMONC services and support family planning clinic, especially because MSF has plans to exit in 2017 • Service provider must support family planning clinic • Support should be provided to develop a well-functioning referral system
12	-
13	-
14	**Bentiu State Hospital (focus on CEmONC)** • Priority from Apr-Sep was on rehabilitation of hospital and providing equipment, supplies and staffing to start offering hospital level services • Priority for HPF2 should be to make sure CEmONC services are available in the hospital, and establish a referral system
15	-
16	-
17	-
18	-

19	**El-Sabah Children Hospital (focus on referral system)**
	• Establish a referral system.
	• Specifically ensure the following priorities:
	  ○ Provide missing equipment for newborn unit
	  ○ Provide solar power for units providing CEMONC services (e.g. newborn unit, lab, theatre)
	  ○ Provide water supply
	  ○ Maintain the ambulance
	Juba Teaching Hospital (focus on referral system)
	• Strengthen the referral system

	• Specifically ensure the following priorities: ○ Provide solar power for units providing CEmONC services (e.g. maternity, lab, theatre and neonatal unit) ○ Provide missing equipment for providing CEmONC services ○ Provide consumables, not limited to, anaesthetic drugs, suturing materials, spinal needles. ○ Provide water supply for units providing CEmONC services ○ Strengthen infection prevention and control across the hospital
20	**Lainya County Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority intervention areas are; ○ Support 1 medical doctor for CEmONC, 1 midwife, 2 nurses and 1 clinical officer ○ Refurbishment/ Renovation of a maternity ward / OPD/ drug store ○ Renovation and provide basic laboratory equipment ○ Establishment of a referral system ○ Management support planning, hospital management and hospital board **Yei Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority intervention areas are; ○ Good hospital management practices including space management and quality management ○ Equipment especially for theatre, theatre, maternity, x-ray, wards ○ Renovation of various wards medical , maternity, laboratory ○ Support for CEmONC services 1 medical doctor, I midwife, 2 nurses, I Clinical Officer **Morobo County Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority intervention areas are; ○ Support especially medical doctor for CEmONC, 1 midwife 1 nurses and 1 clinical officer ○ Establishment of a drug store ○ Renovate/Rehabilitate a room and provide basic Laboratory equipment ○ Strengthen the referral system **Kajokeji Civil Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority intervention areas are; ○ Infrastructural improvement especially for theatre ○ Renovation of laboratory, wards and maternity ○ Equipment especially for theatre, Laboratory and maternity ○ Support with 1 medical officer, 1 midwife and 2 nurses ○ Support referral services
21	**Maridi Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority interventions are: ○ Establish: Blood bank, including procurement of blood bank fridge ○ Provide solar power system in the ICU, maternity, surgical ward and theatre ○ Provide basic laboratory equipment ○ Provide the missing equipment (Oxygen concentrators, Anaesthetic machine, caesarian section pack, Neonatal equipment, including resuscitation table, Electric sterilizer, Water tank) ○ Provide support with referral protocol. ○ Establish and support to CEmONC by providing 1 medical doctor, I

	midwife, 2 nurses, 1 clinical officer **Lui Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority intervention areas are; o Strengthening of the referral system o Renovation of wards/ establishment of a minor theatre o Support with 1 medical doctor for CEmONC o Support midwifery training school by improving quality of tutors o Establishment of a proper drug store
22	**Tambura Hospital (focus on CEmONC)** • No previous support from HPF. The priority interventions are; o Renovation/equipping of the theatre o Renovation/ rehabilitation of all wards o Deployment of staff- 1 medical officer, 1 Clinical officers, 2 Nurses, 1 midwife o Improving power supply through additional generator/solar o Strengthening of the referral system o Improving supplies especially of essential drugs
23	**Nzara Hospital (Faith Based Hospital Support)** • HPF has not previously supported this hospital. It is a catholic-run hospital that has already secured funding support from other sources. • Support should focus on renovation, equipment and specific technical or systems training support. • Service Provider should strengthen the referral system and ensure better linkage with the government health services. **Ezo County Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The priority areas of support are; o Work with local authorities/community to improve the security of the hospital o Sensitization to encourage the community to seek services o Rehabilitation of destroyed installations in the hospital-generators, solar, borehole and water supply, broken doors and windows o Re equipping the maternity/theatre o Deployment of key staff (1 medical doctor, 1 midwife, 2 nurses, 1 clinical Officer) to support CEmONC services **Yambio State Hospital (focus on CEmONC)** • HPF has not previously supported this hospital. The hospital currently has multiple agencies providing support to different departments. • The hospital needs to be strengthened as a referral hospital for greater WES. • The recommended immediate interventions are; o Capacity strengthening with deployment of 4 specialists (OBS/Gynea, Surgeon, Paediatrician, Internal Medicine and Anaesthetic Nurse) and strengthening the skills of existing staff o Establishment of a referral system to support satellite facilities o Augmentation of supplies especially essential drugs o Renovation/ completion of renovation of medical/ surgical wards o Strengthening the hospital inpatient HIS

Appendices

8. Appendix A: Documents for Submission

Appendix A can be downloaded from the HPF website: www.hpfsouthsudan.org

Appendix A consists of:

Appendix A1	Technical bid submission letter
Appendix A2	Technical proposal outline
Appendix A3	Technical proposal work plan, target table and health facilities template
Appendix A4	List of consortium partners
Appendix A5	Financial bid submission letter
Appendix A6	Budget template and justification
Appendix A7	Business partner questionnaire

Appendix A should be submitted in accordance with instructions given in Section C of this RFP document.

9. Appendix B: Standard Form of contract for Service Providers

SOUTH SUDAN HEALTH POOLED FUND (HPF)

Agreement dated 2016

BETWEEN:

CROWN AGENTS LIMITED

AND

[Service Provider]

Locations-

:

Lot: [ ]

THIS AGREEMENT is made and entered into on this **[dd month year]** between:

Crown Agents Limited incorporated and registered in England under company number 03259922 whose registered office is at St. Nicholas House, St Nicholas Road, Sutton, Surrey, SMI 1EL (“Client”) and

[Service Provider, registration number and address]

Each a ‘’Party’’ and together the ‘’Parties’’

WHEREAS The Department for International Development of the UK Government (‘’DFID’’) awarded a contract to the Client to act as Fund Manager of the South Sudan Health Pooled Fund Project on 17 October 2012.

WHEREAS the Client now wishes to appoint the Service Provider to perform the Services as set out in Annex A.

WHEREAS the Service Provider, is willing to perform the Services on the terms and conditions set out below.

NOW THEREFORE the Parties in consideration of the mutual covenants contained herein agree to the following:

1. INTERPRETATION

1.1 Save where expressly stated otherwise, the following terms have the following meanings:

‘’Affiliate’’ means, with respect to any person, any entity which is a direct or indirect parent or subsidiary of such person or which directly or indirectly owns or control such person, is owned or controlled by such person or is under common ownership or control with such person and, for the purposes of this definition, ‘’control’’ shall mean the power to direct the management or policies of such entity, whether through the ownership of voting securities, by contract or otherwise.

‘’Agreement’’ means this agreement as originally executed or as may from time to time be amended by specific written instrument executed on behalf of both Parties, and this Agreement shall include the Annexes attached hereto, being:

Annex A: The Services including the Terms of Reference, Work plan and performance indicators

Annex B: Renumeration

Annex C: Key Personnel

Annex D: Due Diligence Questionnaire

Annex E: Minimum Required Capacities for Service Providers

‘’Confidential Information’’ means all Personal Data and any information however it is conveyed, that relates to business, affairs, developments, trade secrets, know-how, personnel and suppliers of either Party including all intellectual property, together with all information derived from any of the above, and any other information clearly being designated as being confidential (whether or not it is marked “confidential”) or which ought reasonably be considered to be confidential.

‘’Personnel’’ means in relation to a party, any person instructed to undertake any of that Party’s obligations under this Agreement including that Party’s directors, officers, employees, sub-contractors and/or consultants.

“Services” means the services set out in Annex A to this Agreement.

''Service Provider Materials'' means all documents, records, plans, equipment and software to be provided by the Service Provider in connection with this Agreement, including as more particularly described in Annex A.

1.2 In this Agreement, any reference to:

1.2.1. ''include'' or ''including'' shall be construed without limitation;

1.2.2 a ''person'' includes a reference to any individual, firm, company, corporation or other body corporate, government, state or agency of state or any joint venture, association or partnership, works council or employee representative body (whether or not having separate legal personality) and also includes a reference to that person's successors and permitted assigns;

1.2.3 a ''Party'' includes a reference to that Party's successors and permitted assigns; and

1.2.4 "written", "writing" or in "writing" shall include email.

1.3 Duration of this Agreement

This Agreement shall be deemed to have commenced on [xxxx] 20[xx] and shall expire on [XXXXX] 20[XX] ("Expiry Date") unless extended by the mutual written agreement of the Parties, or unless otherwise terminated by either Party in accordance with the provisions of this Agreement.

1.4 Maximum Value of this Agreement

The anticipated maximum funding that may be available under this Agreement is **GBP [insert amount] (amount in words).**

2. GENERAL

2.1 Where there is any inconsistency between the main body of this Agreement and/or between the Annexes, the following order of precedence shall apply:

The main body of this Agreement;

Annex A: The Services including the Terms of Reference, Work plan and Performance Indicators;

Annex B: Remuneration;

Annex C: Key Personnel;

Annex D: Due Diligence Questionnaire;

Annex E: Minimum Required Capacities for Service Providers

3. OBLIGATIONS OF THE PARTIES

3.1. The Service Provider shall start to provide the Services on the relevant date specified in Annex A and shall perform the Services in accordance with this Agreement.

3.2. The Service Provider shall provide all labour and Service Provider Materials required for the execution, completion and if relevant the maintenance of the Services.

3.3. The Service Provider agrees that it has full knowledge and understanding of the Services to be provided under this Agreement.

3.4 The Service Provider shall carry out the Services in a professional manner in every respect to the standards expected of an expert(s) experienced in the provision of the Services, and in accordance with the scope of work and specifications set forth in forth in Annex A. If, at any time, the Service Provider fails to perform the Services in the manner and at the times required pursuant to this Agreement then the Service Provider shall, immediately upon the request of the Client, at no additional cost to the Client, take all necessary steps, including the re-performance of the Services or part thereof, the substitution of defective Service Provider Materials, the provision of additional Service Provider materials and/ or labour, changes in the method and manner of performance of the Services, and other measures as required so as to perform in accordance with this

Agreement. The request by the Client for such measures shall be without prejudice to any other rights or remedies the Client may have under this Agreement or otherwise.

3.5. It shall be the responsibility of the Service Provider to inform and report to the Client immediately upon the occurrence of any event or circumstances that may, immediately or in the future, impede the proper and timely execution of the Services so that remedial action, as is appropriate under the circumstances, may be taken and relevant decisions made.

3.6. The Service Provider shall in relation to the Services comply promptly with all instructions and decisions that are notified and confirmed in writing to the Service Provider by the Client.

3.7 The Service Provider shall make such variations to the Services whether by way of addition, modification or omission ("Variations"), as may be:

a) Ordered by the Client and confirmed in writing to the Service Provider by the Client; or
b) Agreed to be made by the Client and Service Provider (which agreement shall not be made unless the Client has first secured the agreement of the Service Provider (which agreement shall not be unreasonably withheld) to such addition, modification or omission and the effect on price pursuant to Clause 3.8 below) and confirmed in writing to the Service Provider by the Client.

3.8. The value of all Variations which may be made under the provision of Clause 3.7 above shall be ascertained by reference to the rates and/or prices specified in Annex B for like or analogous work and/or services, but if there are no such rates and or prices or if they are not applicable, then the value shall be such as is fair and reasonable in all the circumstances.

3.9. The Service Provider shall comply at its own cost with all applicable health and safety requirements as may be required by its own policies and procedures and the law applicable in its place of domicile together with any applicable provisions in the locations where the Services are to be performed. For the avoidance of doubt, all of the Service Provider's Personnel engaged under this Agreement will come under the duty of care of the Service Provider:

a) The Service Provider will be responsible for providing suitable and adequate security arrangements for the Service Provider's Personnel and the Client accepts no responsibility for the health, safety and security of Service Provider personnel or property under this Agreement.

The Service Provider will be responsible for taking out and maintaining in place for a long as may be necessary, suitable and adequate insurance in respect of the death or personal injury and/or any damage to, or loss of property suffered by the Service Provider or any of the Service Provider's Personnel 3.10. Service Provider shall act as an independent contractor with respect to and in providing the Services and shall exercise control, supervision, management and direction as to the method and manner of performing the Services in accordance with this Agreement. It is expressly understood by the Parties that the Service Provider is an independent contractor and that neither the Service Provider nor any of the Service Provider's Personnel shall be deemed for any purpose to be employee, agent, partner, servant or representative of the Client.

3.11. The Service Provider shall cooperate fully (at its own cost) with any capacity assessments that the Client undertakes to ensure the Service Provider has sufficient systems and capacity to perform the Services as defined in Annex A. The Service Provider shall (at its own cost) comply with any additional reasonable measures or systems improvements required by the Client as a result of a capacity assessment.

3.12. The Service Provider shall keep accurate and systematic accounts files and records (''the Records'') in connection with the Services performed under this Agreement.

The Service Provider shall keep the Records throughout the period of the Agreement and for six years following its expiry or termination.

The Service Provider shall at its own cost upon request from the Client or its authorised representatives, provide unrestricted access to the Records in order that the Records may be inspected and copied. The Service Provider

shall co-operate fully in providing to the Client or its representatives, answers to such enquire as may be made about the Records.

4. LIABILITIES, INDEMNITIES AND INSURANCE

4.1 For the purpose of this Clause 4, the following definitions shall apply:

''Client Group'' shall mean the Client, its Affiliates and its sub-contractors Clients of any tier and their respective directors, officers, employees and agents but shall not include the Service Provider

4.2. The Service Provider shall indemnify and keep indemnified the Client Group against all liabilities, demands, costs, damages , expenses, claims, actions and proceedings (including all consequential, direct, indirect or special loss) and legal and other professional fees, costs and expenses suffered or incurred by the Client Group arising out of or in connection with:

a) The Service Provider's breach of this Agreement or any reckless or negligent act or omission by the Service Provider and/or the Service Provider's Personnel.
b) Any claim made against the Client Group for any actual or alleged infringement of a third party's intellectual property rights arising out of or in connection with the provision of the Services and the use by the Client of any Service Provider Materials supplied by the Service Provider in connection with this Agreement.
c) Any claim made against the Client Group by a third party arising out of or in connection with the provision of the Services to the extent that such claim arises out of the breach, negligent performance or failure or delay in performance of this Agreement by the Service Provider, its employees, agents or sub-contractor.
d) Any claim made against the Client Group by a third party for death, personal injury or damage to property arising out of or in connection with defective goods or services, to the extent that the defect in the goods or services is attributable to the acts or omissions of the Service Provider and its Personnel
e) Any breach of any warranty or representation provided by the Service Provider and/or its Personnel pursuant to and/or in connection with this Agreement.

4.3 Without limiting the Service Provider's liabilities under this Agreement, the Service Provider shall take out and maintain for the duration of this Agreement and for 6 years thereafter with a first class insurance company, policies of insurance which as a minimum shall cover its liabilities under this Agreement, including but not limited to, professional indemnity insurance, and employer's liability insurance in accordance with any legal requirements in the Service Provider's domicile and in the country in which the Services are to be delivered.

4.4. An insurance certificate showing compliance by the Service Provider with the Insurance requirements of this Agreement shall, upon request, be provided to the Client within seven days of such request being made.

5. PAYMENT

5.1. Subject to the Service Provider's performance of the Services in accordance with this Agreement and its submission of an invoice in accordance with this Agreement and the rates and/or prices stated in Annex B, the Client shall make payment within 30 days of receipt of the invoice for that part of the Services which relates to the Services as contained in the Service Provider's invoice.

5.2 The Service Provider acknowledges and agrees that payment of the Service Provider's invoices and other sums due to the Service Provider in accordance with this Agreement is conditional upon the prompt submission by the Service Provider to the Client of all relevant financial reports, invoices, expenses and financial claims in sufficient detail ("**Payment Data**"). Accordingly, the Service Provider shall submit all relevant Payment Data to the Client within 15 calendar days of the end of the relevant reporting period to which the Payment Data relates. Without prejudice to the Client's other rights and remedies, the Client reserves the right to unilaterally make the following

deductions from the sums owed to the Service Provider in respect of such Payment Data, to cover the Client's increased administrative costs and wasted expenditure relating to the late submission of Payment Data:

a) For Payment Data submitted 30 days or more after the end of the relevant reporting period – 5% deduction; and
b) For Payment Data submitted 60 days or more after the end of the relevant reporting period – 10% deduction,

and the Service Provider acknowledges and agrees that these deductions represent a genuine pre-estimate of the Client's additional costs of dealing with the consequences of the Service Provider's delay in submitting such Payment Data.

To the extent the Service Provider fails to submit the relevant Payment Data to the Client within a period of 90 days from the end of the relevant reporting period, then without prejudice to the Client's other rights and remedies, the Client shall not be obliged to pay any sums in respect of such Payment Data to the Service Provider.

The Service Provider shall address all queries raised by the Client within the aforesaid 90 day period, in default of which the Client shall not be required to pay the applicable invoice.

In exercising its discretion pursuant to this clause 5.2, the Client agrees to take into account any suitable justification for the Service Provider's delay in submitting the relevant Payment Data, and the Client may in its absolute discretion agree to an extension of any deadlines for submitting such Payment Data by notifying the Service Provider in writing.

5.3 The Service Provider is allowed to move up to a maximum of 10% of the funds in any one budget line to another budget line and/or from another major heading in the Project direct cost budget to another major heading in the Project direct cost budget provided at all times that the overall aggregate budgeted amount is not changed. If the Service Provider wishes to move in excess of 10% of funds to another budget line, or from another major heading in the Project direct cost budget to another similar major heading, it shall first obtain the Client's written consent. The Service Provider shall not move any funds from a direct cost budget to an indirect cost budget or vice versa. The Service Provider shall at all times ensure that indirect costs are minimised. If the Service Provider anticipates that indirect costs may exceed the agreed 30% limit, the Service Provider shall as soon as possible provide the Client with an explanation and a written proposal to reduce the indirect costs with a revised budget for its review. The Service Provider shall not implement any proposals or revised budget unless and until it authorised to do so by the Client.

5.4 Should the Client determine (acting reasonably) after paying for a particular Service that the Service has not been completed satisfactorily, the Client may recover and/or withhold from further payments, an amount not exceeding that previously charged for that Service until the unsatisfactory Service is remedied to its satisfaction.

5.5. All payments shall be made hereunder in British Pounds Sterling unless otherwise agreed in writing between the Parties.

5.6. The Service Provider warrants that the rates and/or prices set out in Annex B to this Agreement are correct and sufficient to support the performance of all of its obligation either expressed or implied in this Agreement or otherwise appropriate for the proper and timely performance of the Services, based on applicable laws and regulations in effect at the date of execution of this Agreement.

5.7. The Client reserves the right to withhold payment of appropriate sums from amounts otherwise due under this Agreement in the event of unsatisfactory work (in the reasonable opinion of the Client) by the Service Provider or other related queries until such time as such unsatisfactory work is remedied or such outstanding queries are resolved.

5.8. All funds must be invoiced in British Pounds Sterling. Whenever it is necessary to convert actual expenditure into British Pounds Sterling, the date and rate used for calculation of the exchange rate are those obtained on InforEuro website http://ec.europa.eu/budget/inforeuro/index.cfm? Language=en) using the

corresponding monthly rate for the date on which the purchase was made or the service acquired by the Service Provider.

5.9. Eligible expenses are expenses agreed in writing with the Client as detailed in Annex B,

5.10. Eligible expenses to be paid to the Service Provider under this Agreement will be invoiced monthly in arrears.

5.11. Each invoice must be accompanied by an introductory letter on the Service Provider's letter headed paper as follows:

> **'' certify all the amounts detailed above have been actually and necessary expended under the grant in accordance with terms and conditions outlined in the Agreement between Crown Agents and the Service Provider dated……..''**

5.12. The accompanying letter and the invoice must be sent to the Client's HPF Team Leader in Juba for authorisation.

5.13. The Client reserves the right to call for and examine documentary evidence of various payments made by the Service Provider. The Service Provider shall keep the payment records throughout the duration of this Agreement, and for six years following its termination.

5.14. The Client or its designated representatives may carry out field visits and interviews with beneficiaries into the economy, efficiency and effectiveness with which the Service Provider has used the resources under this Agreement.

5.15. No expenditure may be incurred by the Service Provider in excess of the budget limits set out in Annex B and no virements between components shown in the schedule of prices in Annex B are permitted without the prior written authority of the Client.

5.16. Payments shall be made to the Service Provider's bank account held at:

Bank	
Bank postal address	
Name of account	
Sort Code	
Currency of Bank account	
IBAN Number	
SWIFT number	
ABA or BIC Number	

6. PROCUREMENT TO BE UNDERTAKEN BY THE SERVICE PROVIDER

6.1 Prior to undertaking any procurement of equipment for the project, the Service Provider shall provide the Client with:

a) A procurement plan related to this Agreement and no procurement shall be undertaken without the prior written approval of the Client.
b) Curriculum vitae of the Key individual (s) who would be responsible for procurement under this Agreement.
c) The procurement policies and procedures that the Service Provider proposes to use to undertake the procurement.

6.2 The Client will assess the capacity of the Service Provider to undertake procurement based on the submissions in clause 6.1 and advise the Service Provider accordingly. No procurement shall be undertaken without the prior written approval of the Client.

6.3 In the event that the Service Provider is directed by the Client to undertake procurement, the Service Provider shall ensure that all procurement of equipment shall

a) Achieve value for money (meaning procuring at the optimum combination of whole-life cost and quality to meet requirements) and that the procurement be conducted in a transparent manner.

6.4 If procurement is not to be undertaken by the Service Provider, the Client shall advise the Service Provider of relevant details of the alternative arrangements.

7. USE OF AND RESPONSIBILITY FOR EQUIPMENT

7.1 Equipment may only be used in providing the Services and shall be safely kept and maintained. Personal use of Equipment by the Service Provider is not permitted unless the Client gives prior written consent.

7.2 The Service Provider shall keep an up to date inventory of the equipment in its condition and location and make such inventory available to the Client immediately on request.

7.3 The Service Provider shall be responsible for all loss or damage to Equipment other than that caused by fair wear and tear. The Service Provider shall notify the Client immediately the Service Provider becomes aware of any loss of or damage to equipment.

7.4 The Service Provider shall obtain the Client's instructions on the disposal of Equipment and comply with such instructions.

8. CONFIDENTIALITY

8.1 Each Party receiving Confidential Information from the other shall keep confidential and not use, or disclose to any third party, any information provided directly and indirectly by the divulging Party including, but not limited to, any technical information or operating data derived from the divulging Party's Work or Services hereunder or its related business operations.

8.2 The Parties agree that the confidentiality obligations do not apply when:

a) The information was part of the public domain or becomes part of the public domain other than through a breach of this Agreement.
b) The information was in the possession of either Party prior to the date of this Agreement or which was not received under an obligation of confidentiality.

c) The information was received lawfully from a third party without an obligation of confidentiality;
d) The information is required to be disclosed in compliance with the requirements of any law, rule or regulation of any government authority, regulatory body or stock exchange having jurisdiction over the work or the parties.
e) The information is developed by either Party independently of this Agreement; or
f) The information is disclosed following authorisation by the other Party or after five years from the date of completion of the Services.

8.3 Neither party shall publish or permit to be either alone or in conjunction with any other person any information, articles, photographs or other illustrations relating to the Services, the other Party or the Client without the prior written consent of the owner of such information and the other Party.

9. INTELLECTUAL PROPERTY RIGHTS

9.1 Intellectual property rights in all material produced solely by Personnel of the Client in the course of work called for by this Agreement shall belong exclusively to the Client. Intellectual property rights in all materials produced solely by Personnel of the Service Provider in the course of the work called for by this Agreement shall belong exclusively to the Service Provider. Each Party hereby grants to the other a non-exclusive royalty–free licence to use and sub-license its respective intellectual property rights in the aforementioned Material. Except as stated in the preceding paragraphs, nothing contained in this Agreement shall be deemed, by implication, estoppel or otherwise, to grant any right or license in respect of any intellectual property or technical information at any time owned by the other Party.

9.2 For the purpose of this Clause 9 ''Materials'' shall mean all material including proposals, reports, software, data and designs, whether or not electronically stored.

10. NON-SOLITICATION

In order to protect the Confidential information and business connections of both Parties as a result of activities undertaken in relation to this Agreement, both Parties agree that unless otherwise agreed in writing, they shall not any time during this Agreement or for **3 months** after termination of this Agreement, offer to employ or engage or otherwise endeavour to entice away from the Client or any of its Affiliates or the Service Provider any of its Personnel.

11. TERMINATION

11.1. The Agreement shall commence on the date first set out above and shall continue in force until the Expiry Date stated in clause 1.3 unless until terminated in accordance with clause 11.2.

11.2. Without prejudice to any other right or remedy the Client may have against the Service Provider, the Client may terminate this Agreement by giving no more than 7 (seven) calendar days' prior written notice to the Service Provider.

11.3. 11.5. Termination of this Agreement howsoever caused shall not prejudice the rights or obligations of either Party that have accrued prior to termination.

11.6. On reasonable notice at any point during the term of this Agreement the Service Provider shall (at its own cost) provide all reasonable assistance, materials, documentation and information to the Client and/or potential replacement service providers (subject to the potential replacement service providers entering into reasonable written confidentiality undertakings) in order to facilitate the transfer of the Services to a replacement service provider.

11.7 On the expiry or earlier termination of this Agreement the Service Provider shall:

(i) promptly deliver to the Client (or destroy at the Client's request) all documents, papers, books of account, disks, drawings, technical plans, software, reports, keys, equipment and property of any sort (including copies, duplicates, extracts or reproductions of the same) belonging to the Client and/or produced by the Service Provider in the course of providing the Services which may be in the Service Provider's possession or under its control;

(ii) promptly vacate any Client and/or project premises and hand back any security or other access pass;

(iii) (if directed to do so by the Client) irretrievably delete any information relating to the business of the Client stored on any magnetic or optical disk or memory and all matter derived from such sources which is in his possession or control outside the premises of the Client; and

(iv) The Service Provider shall not at any time after the expiry or earlier termination of this Agreement represent himself or permit himself to be held out by any person, firm or company as being in any way connected with or interested in the Client and/or project.

11.8 Clauses 1, 2,4,8,9,10, 11, 16 and 21 shall survive termination of this Agreement.

12. FORCE MAJEURE

Where the performance by the Service Provider of their obligations under this Agreement is delayed hindered or prevented by the events beyond the reasonable control of the Service Provider and against which an experienced Service Provider could not reasonably have been expected to take precautions, the Service Provider shall promptly notify the Client in writing, specifying the nature of the force majeure event and stating the anticipated delay in the performance of this Agreement.

From the date of receipt of notice given in accordance with this Clause the Client may, at its sole discretion, either suspend this Agreement ('' the suspension period") or terminate this Agreement forthwith.

If by the end of the suspension period the Parties have not agreed a further period of suspension or re-instatement of the Agreement, the Agreement shall terminate automatically.

13. PROJECT MANAGEMENT

13.1 No later than five days after the date on which this Agreement is executed by the Parties:

a) the Client shall notify the Service Provider of the name and qualifications of the person appointed as its representative (the ''Client Representative") and
b) The Service Provider shall notify the Client of the name and qualifications of the person appointed as its representative who has responsibility for the overall progress of the delivery of the Services (the "Service Provider Representative")

13.2 The Service Provider Representative shall participate as required by the Client Representative in meetings with the Client and will assist as required by the Client.

13.3 The Service Provider shall permit the Client and the Client to freely inspect, access, test and review the Services and Service Provider Materials as well as the activities of the Service Provider and comply with all the rights of the Client to inspect and audit.

13.4 The Service Provider Representative shall co-operate with the Client Representative and shall attend meetings scheduled by the Client Representative at reasonable intervals, as required by the Client, to advise and assist the Client Representative on all matters relating to the Services.

14. REPORTING

a) The Service Provider shall submit reports to the Client as described below. The exact format for preparation of and timing for submission of all reports will be determined by the Client.
b) Monthly technical report using a template to be provided by the Client.
c) The Service Provider will update the Client on the progress of agreed targets on a monthly basis. This shall form the basis of performance measure of the Service Provider's project.
d) DHIS monthly report.
e) The Service Provider is expected to submit monthly DHIS reports to the Client (HPF) and also provide necessary information on integrated disease surveillance.
f) Monthly Invoice
g) Without prejudice to clause 5 (Payments) of this Agreement, the Service Provider shall submit monthly invoices to the HPF with Statements verifying and certifying the accuracy of the invoiced costs.
h) Final Report following the template provided by the client
i) The Service Provider shall submit an electronic copy of the final narrative report no later than 30 days past the end date of the Agreement and HPF will provide the Service Provider with the necessary template for this final report.
j) Service Provider will be expected to utilise the services of an independent audit firm, approved by the HPF, to conduct an independent examination of expenditure at the close of this agreement.
k) The Client has the right to terminate the contract if the reports are not submitted within the required time periods stated above.

15. KEY PERSONNEL

15.1 All members of the Service Provider's Personnel identified in Annex C as ''Key Personnel" shall have the qualifications and experience that would normally be expected of personnel engaged by reputable and experienced providers of Services that are the same as or similar to the Services.

15.2 Except in the case of sickness, resignation or other similar events outside the Service Provider's reasonable control, no changes or substitutions may be made to the Key Personnel without the Client's prior written consent. Any request by the Service Provider for such written consent must be accompanied by the CV of the proposed substitute and the Client shall have the right to interview any such proposed substitute at the Client's premises or via telephone.

15.3 if the Client has reasonable grounds to consider any of the Service Provider's Key Personnel unsuitable to provide the Services, the Client shall give the Service Provider written notice of its decision (Including adequate reasoning to support such decision) and the Service Provider shall be given 15 days to resolve such issue (and the Client shall make itself available as required to discuss the issue). If the issue is still unresolved after 15 days, the Service Provider shall substitute such Key Personnel as quickly as reasonably possible without charge to the Client with a replacement who is acceptable to the Client.

16. LIENS, ATTACHMENT LIENS, ATTACHEMENTS AND ENCUMBRANCES

The Service Provider shall be responsible for all claims in respect of labour, equipment, supplies and materials, including the Service Provider Materials, to be furnished by or on behalf of the Service Provider hereunder, and the Service Provider shall not permit liens, attachments or encumbrances to be imposed by any person, firm or government authority upon the Client's or the Client's property by reason of any claim or demand against the Service Provider. Any such lien, attachment, or other encumbrance shall until the Service Provider has secured the release thereof, preclude any claims or demands by the Service Provider for payment under this Agreement, and in the event that the same shall not have been removed within a reasonable amount of time after receipt by the Service Provider of written notice from the Client, then the Client may cause the same to be removed and withhold and/or recover the cost of removal, including legal and other fees and expenses, from the Service Provider hereunder.

17. ANTI-CORRUPTION, FRAUD AND BRIBERY

17.1 Each Party shall:

17.1.2 comply with all anti-bribery and anti-corruption laws, regulations and codes applicable in the countries in which they operate and where those laws, regulations and codes apply outside those countries (for example the UK Bribery Act 2010 and the US Foreign Corrupt Practices Act 1977), in all those other countries to which such anti-bribery and corruption laws, regulations and codes apply;

17.1.3 not engage in any activity, practice or conduct which would constitute an offence under sections 1, 2 or 6 of the UK's Bribery Act 2010 if such activity, practice or conduct had been carried out in the UK;

17.1.4 uphold the highest standards of ethics in the performance of this Agreement and shall comply with the obligations contained in the Ethical Code for Business Partners which is available as a download from Crown Agents website http://www.crownagents.com/about-us/ethics-and-compliance as it may be updated from time to time. Any breach of those obligations shall constitute a breach of this Agreement which is not capable of remedy and shall entitle the non-defaulting Party to terminate this Agreement.

17.2 The Service Provider warrants and represents that the information supplied in Annex D is accurate and if found to be inaccurate the Client reserves the right at its absolute discretion to consider this a breach of this Agreement.

18. GENERAL

18.1 This Agreement relates solely and exclusively to the activities and purpose set out here in and does not apply to any other activity, transaction, relationship, contract, project or work of the Parties, Accordingly, no Party shall be restricted in any of its activities outside the scope of this Agreement.

18.2 This Agreement contains the entire agreement of the Parties and cancels and supersedes any previous understanding or agreement related to the Services, whether written or oral.

18.3 No variation of this Agreement shall be valid unless it is in writing and signed by or on behalf of each of the Party.

18.4 The failure to exercise or delay in exercising a right or remedy under this Agreement shall not constitute a waiver of the of rights or remedy or a waiver of any other rights or remedies and no single or partial exercise of any right or remedy under this Agreement shall prevent any further exercise of the right or remedy or the exercise of any other right or remedy.

18.5 The rights and remedies contained in this Agreement are cumulative and not exclusive of any rights or remedies provided by law.

18.6 A person who is not a party has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Agreement except where such rights are expressly granted in this Agreement but this does not affect any right or remedy of a third party which exists or is available apart from that act except where such rights are expressly granted in this Agreement.

18.7 The Service Provider shall not, without the prior written consent of the Client, assign, and transfer or create any trust in respect of, or purport to assign, transfer or create any trust in respect of, any of its right obligation under this Agreement.

18.8 This Agreement may be executed in any number of counter parts each of which when executed and delivered shall be an original, but all the counterparts together shall constitute one and the same instrument.

19. NOTICE

19.1 A notice given to a party under or in connection with this Agreement;

a) Shall be in writing and in English
b) Shall be signed by or on behalf of the Party giving it;
c) Shall be sent to the Party for the attention of the person at the address, or fax number specified in this clause (or to such other person or to such other address or fax number as that Party may notify to the others, in accordance with the provisions of this clause); and
d) Shall be:
e) Delivered personally; or
f) Sent by commercial courier; or
g) Sent by e-mail.

19.2 The address for delivery of a notice are as follows;

Client:

Address: Crown Agents, St Nicholas House, St Nicholas Road, Sutton, Surrey, SM1 1EL, United Kingdom

Email: **Maria.Guerra@crownagents.co.uk**

For the attention of: **Guerra, Maria**,

HPF Project Director

Service Provider

Address:

Fax number:

Email:

For the attention of:

19.3 If a notice has been properly sent to or delivered in accordance with this clause, it will be deemed to have been received as follows;

a) If delivered personally, at the time of delivery; or
b) If sent by commercial courier, on the date and the time of signature of the courier's delivery receipt; or
c) If sent by e-mail the burden of proving receipt will be met by the sender receiving confirmation in writing (by '' return receipt'' or e-mail or otherwise) from the receipt that the receipt has received the relevant e-mail. Any copy of a notice sent by e-mail shall be deemed to have been duly received on the day of the ''return receipt'' in respect of the relevant email or other written confirmation of receipt from the recipient.

19.4 For the purpose of this clause;

a) All times are to be read as local time in the place of deemed receipt; and
b) If deemed receipt under this clause is not within business hours (meaning 9.00am to 5.30pm Monday to Friday on a day that is not a public holiday in the place of receipt), the notice is deemed to have been received when the business next starts in the place of receipt.

19.5 The provisions of this clause shall not apply to the service of any proceedings or other documents in any legal action.

20. GOVERNANCE LAW AND JURIDICTION

20.1 This Agreement, and any dispute, question, matter, issue or claim arising out of or in connection with it or its subject matter of formation (including non-contractual dispute or claims), shall be governed by, and construed in accordance with, the law of England and Wales.

20.2 Any dispute arising out of or in connection with this Agreement, including any question regarding its existence, validity or termination, which cannot be resolved amicably shall be referred to and finally resolved by arbitration under the LCIA (London Court of International Arbitration) Rules, which Rules are deemed to be incorporated by reference into this clause and on the following basis:

a) The number of arbitrators shall be three;
b) The seat, or legal place, of arbitration shall be London; and
c) The language to be used in the arbitral proceedings shall be English

In witness whereof this Agreement has been entered into on the date first written above.

For and on behalf Crown Agents Limited

…….

PRINTED NAME:

DATE:

Duly authorised.

For and on behalf of The Service Provider

……

PRINTED NAME:

DATE:

Duly authorised.