Department for International Development

UKaid from the British people

Section 4 Appendix A

CALLDOWN CONTRACT

Framework Agreement with: **Oxford Policy Management**

Framework Agreement for: **Professional Evidence and Applied Knowledge Services – Health (including Nutrition) and Education**

Framework Agreement Purchase Order Number: 5752

Call-down Contract For: **Implant Training Plan for Ghana Health Service 2016**

Contract Purchase Order Number: 7570

I refer to the following:

1. The above mentioned Framework Agreement dated 11th July 2012

2. Your proposal submitted to the Contract Manager on 23rd May 2016

and I confirm that DFID requires you to provide the Services (Annex A), under the Terms and Conditions of the Framework Agreement which shall apply to this Call-down Contract as if expressly incorporated herein.

1. Commencement and Duration of the Services

1.1 The Supplier shall start the Services no later than **23rd May 2016** ("the Start Date") and the Services shall be completed by **31 July 2016** ("the End Date") unless the Call-down Contract is terminated earlier in accordance with the Terms and Conditions of the Framework Agreement.

2. Recipient

2.1 DFID requires the Supplier to provide the Services to the DFID Ghana acting on behalf of the Ghana Minsitry of Health ("the Recipient").

3. Financial Limit

3.1 Payments under this Call-down Contract shall not, exceed **£796,850** ("the Financial Limit") and is exclusive of any government tax, if applicable as detailed in Annex B**.**

4. DFID Officials

4.1 The Project Officer is:

4.2 The Contract Officer is:

5. Key Personnel

The following of the Supplier's Personnel cannot be substituted by the Supplier without DFID's prior written consent:

6. Reports

6.1 The Supplier shall submit project reports in accordance with the Terms of Reference/Scope of Work at Annex A.

7. Duty of Care

All Supplier Personnel (as defined in Section 2 of the Agreement) engaged under this Call-down Contract will come under the duty of care of the Supplier:

I. The Supplier will be responsible for all security arrangements and Her Majesty's Government accepts no responsibility for the health, safety and security of individuals or property whilst travelling.

II. The Supplier will be responsible for taking out insurance in respect of death or personal injury, damage to or loss of property, and will indemnify and keep indemnified DFID in respect of:

II.1. Any loss, damage or claim, howsoever arising out of, or relating to negligence by the Supplier, the Supplier's Personnel, or by any person employed or otherwise engaged by the Supplier, in connection with the performance of the Call-down Contract;

II.2. Any claim, howsoever arising, by the Supplier's Personnel or any person employed or otherwise engaged by the Supplier, in connection with their performance under this Call-down Contract.

III. The Supplier will ensure that such insurance arrangements as are made in respect of the Supplier's Personnel, or any person employed or otherwise engaged by the Supplier are reasonable and prudent in all circumstances, including in respect of death, injury or disablement, and emergency medical expenses.

IV. The costs of any insurance specifically taken out by the Supplier to support the performance of this Call-down Contract in relation to Duty of Care may be included as part of the management costs of the project, and must be separately identified in all financial reporting relating to the project.

V. Where DFID is providing any specific security arrangements for Suppliers in relation to the Call-down Contract, these will be detailed in the Terms of Reference.

8. Call-down Contract Signature

8.1 If the original Form of Call-down Contract is not returned to the Contract Officer (as identified at clause 4 above) duly completed, signed and dated on behalf of the Supplier within 15 working days of the date of signature on behalf of DFID, DFID will be entitled, at its sole discretion, to declare this Call-down Contract void.

Department for International Development

UKaid from the British people

For and on behalf of
The Secretary of State for
International Development

Name:

Position: Procurement Manager

Signature:

Date: 23/05/16

For and on behalf of

Oxford Policy Management
Level 3, Clarendon House
52 Cornmarket St
Oxford
OX1 3HJ

Name:

Position:

Signature:

Date:

Department for International Development

UKaid from the British people

ANNEX A

TERMS OF REFERENCE
Implant Training for Ghana Health Service 2016

Introduction

The UK Government is supporting the Government of Ghana to implement an Adolescent Reproductive Health (ARH) programme aimed at contributing to the achievement of former MDG 5 and their replacement with the Sustainable Development Goals (SDGs). Specifically, the programme will improve reproductive knowledge and will also strengthen the national family planning (FP) programme through improved management and coordination of inputs as well as the procurement of contraceptives.

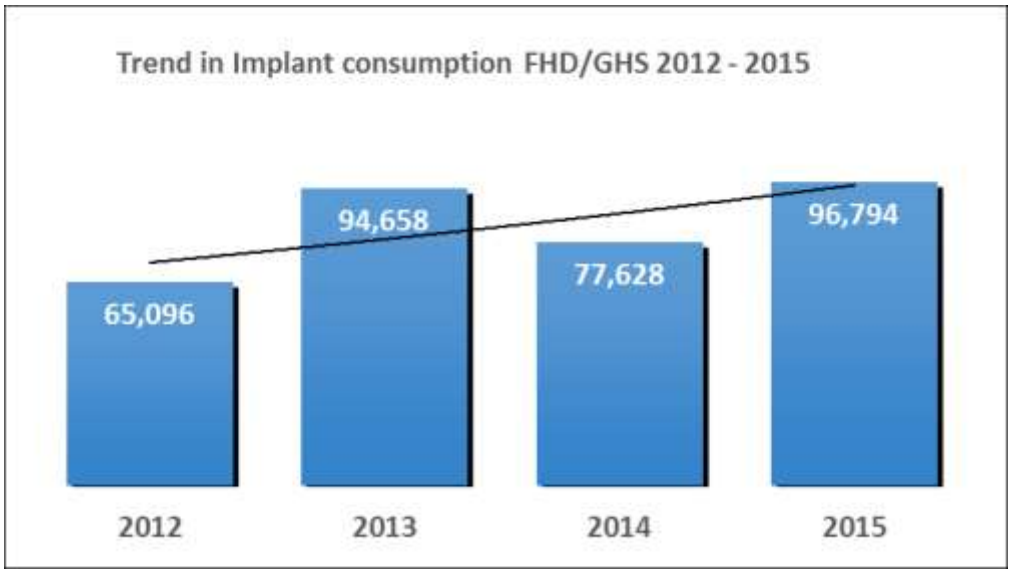
Ghana has made significant progress towards reducing the MMR of 760 per 100,000 live births recorded in the 1990s to 319 per 100,000 live births in 2015 (WHO *et al*., 2016). The rate is still high compared with other lower and middle income countries, and following the end of the MDGs and their replacement with the Sustainable Development Goals, more effort is needed if Ghana is to meet the new goals. Among the key strategies for reaching the newly set targets is to improve access to long-acting reversible contraceptives (LARCs), consequently increasing the modern contraceptive prevalence rate (mCPR), which is 22% (Ghana Statistical Service (GSS), Ghana Health Service (GHS), and ICF International, 2015) and by so doing reducing the unmet need for family planning (FP). According to WHO et al. (2014) satisfying the unmet need for FP alone could cut the number of maternal deaths by almost a third.

The contraceptive prevalence rate (CPR) for modern methods has fluctuated, falling from 19% in 2003 to 17% in 2008 and increasing to 22% in 2014 (GSS, GHS and ICF International, 2015), indicating that even after a decade, still less than a quarter of married women are current users of modern contraception in Ghana. Similarly, up to 30% of married women and an additional 62% of adolescents in Ghana have an unmet need for FP (GSS, GHS and ICF International, 2015).

To improve the prevalence rate and reduce unmet need for FP, the country also made key commitments at the London FP summit in 2012 aimed at improving access to quality FP services. These commitments included:

- expanding contraceptive choices to include a wider range of long-acting and permanent methods, along with including task-shifting options and improvement of post-partum and post-abortion FP services;
- ensuring that services will be available for sexually active young people through youth promoters and adolescent friendly services;
- prioritizing improved counselling and customer care; and
- making FP free in the public sector and supporting the private sector in relation to providing services.

One factor contributing to low usage of modern methods is a shortage of trained staff skilled in providing effective long-acting reversible and permanent methods. In response Ghana Health Service came out with a task shifting policy in February 2013 to train Community Health Nurses and Auxiliary nurses to provide contraceptive implant service.
Presently the fastest growing FP method is the implants; Jadelle and Implanon NXT in the last few years as illustrated below.



Currently, about 2,500 community nurses have been trained since the policy change. Development partners, such as DFID, Marie Stopes International, Ghana (MSIG), USAID, the UN Population Fund (UNFPA) and West African Health Organisation (WAHO) have supported these trainings. These trainings have increased access to implants and other modern contraceptives like condoms, pills, intra-uterine devices (IUD) in rural areas, where the majority of CHNs are found. Findings from the 2014 Ghana Demographic and Health Survey (GDHS) indicate that, currently, use of modern methods is higher in rural areas. 25% of married women in rural areas use modern methods, compared with 20% of women in urban areas (GSS, GHS and ICF International, 2015).

Rationale

Community Health Nurses (CHNs) are the largest cadre of auxiliary nurses to provide communities with basic preventive health care and health education services. Their tasks under Ghana's Community-Based Health Planning and Services (CHPS) program include: the provision of quality health information; minor curative services; counselling on all contraceptive methods, including the lactational amenorrhea method (LAM); provision of pills, injectable, condoms, and emergency contraceptive pills; and referrals for IUDs, implants, and sterilization services. Following the task shifting policy, their tasks have now been extended to include provision of implants.

Consistently, DFID Ghana has met its commitment of providing implants to Ghana through the Ministry of Health as part of its reproductive health programmes in the country. In 2014 and 2015, DFID supported Ghana to train 299 and 611 service providers respectively, and this has contributed significantly to the surge in the implant uptake. In addition, there were trainings held in 2015 for managers, supervisors and trainers to offer technical support in the areas of quality assurance, monitoring and supportive supervision.

Following both trainings, the consultants, who report primarily to the Ghana Health Sevice and the Ministry of Health agreed that the scale-up of the training of CHNs will help Ghana fill in the gap for the unmet target of 4,000 CHNs trained by the end of 2015, assist service providers to meet the increasing demand and further improve the uptake of implants. With the introduction of Implanon NXT the need to scale up the training of more service providers has become increasingly urgent to meet the increasing demand and orientate service providers who are already offering implants

services on the NXT insertion and removal. The training of more service providers, especially the community health nurses and enrolled nurses is key because these cadres of service providers are more widely distributed in the rural and the peri-urban areas where access is poor.

Goal

The overall goal is to improve service provider capacity to offer contraceptive implants services in the communities and increase contraceptive prevalence in the country.

Objective and Scope of work

Despite these significant supported inputs, there are still further inputs required to ensure sustainability of this through DFID support.

Key Objectives

Ensuring that by end of July 2016,

- 675 community health nurses receive knowledge and skills on implants through a competency based training approach involving practice on humanistic models and actual clients
- To train 675 community health nurses and enrolled nurses to offer implant insertion and removal
- To train 675 community health nurses and enrolled nurses to improve FP counselling skills
- Ensure that all in-service and pre-service Family Planning trainings include implants
- Conduct regular supervision/follow up and feedback meetings to ensure quality downstream training for service providers on contraceptive implant services
- Ensure appropriate coordination of training activities and supply chain management that makes commodities available to all trained providers.

Methodology

Some regions will be allocated more trainees based on the geographical size and number of service delivery points. Where client load for practical sessions in the region is high enough to support, trainings sessions will take place in the regions to avoid transporting large numbers of staff to different sites. The allocation in based solely on the geographical size and facilities where family planning services can be accessed. This is information the Ministry of Health and Ghana Health Service use. Some areas have greater family planning caseload than others so, it is more reasonable that such areas manage larger numbers. Sessions in the different region will be held concurrently, and depending on the number of participants, one or two sessions will be held per region. Each session will last 5 days; comprising 2 days didactic and practice on models followed by 3 days of practical sessions in selected health facilities. Facilitators from national level will supervise the training; and will be supported by trainers in the regions.

The programme will compliment similar activities under the Millennium Development Goals Accelerated Framework project, UNFPA, USAID and WAHO support and contribute to increase in contraceptive prevalence in the country.

Department for International Development

UKaid from the British people

Monitoring Plan

Monitoring and supervision are key essentials for ensuring success in programme activity implementation. With support from supervisors from the national level, managers, trainers and mentors from the regional level trained in monitoring and supportive supervision in 2015 will follow up on the people trained every quarter. This will help to assess effectiveness of the training, the performance of the staff and identify and address any challenges. The health sub-team, the Ghana Health Service and the Ministry of Health keep copies of previous reports, especially the annexes containing lists of participants for monitoring purposes in order to avoid training the same people more than once.

Timeframe

The lead consultant working together with the other consultant in collaboration with the Ghana Health Service must be able to mobilise service providers in each region in the 1st week of the contract being signed in order to put in place necessary arrangements for the various training events throughout the period.

DFID's support in the area of implant training last for 10 weeks after contract is signed. We will seek to ensure continuity and sustainability by working closely with other partners over this period.

Reporting

The consultants should liaise closely with DFID staff and Family Health Division (FHD) of the Ghana Health Service at all times to ensure a common understanding of the implant training programme and this assignment.

A mid-term report will be presented to demonstrate progress of the trainings conducted (less than 10 pages) report.
All reports must be routed through the Family Health Division and sent in parallel to DFID Ghana.

The key relevant stakeholders within government bodies are:

Ministry of Health – overall responsibility to improve the health status of all people living in Ghana through exercising responsibility for effective and efficient policy formulation, resource mobilisation, monitoring and regulation of delivery of health care by different health agencies.

Ghana Health Service – responsibility for the implementation of health services in the public sector, including family planning and adolescent health services.

Duty of Care

The Supplier is responsible for all acts and omissions of the Supplier's Personnel and for the health, safety and security of such persons and their property. The provision of information by DFID shall not in any respect relieve the Supplier from responsibility for its obligations under this Contract. Positive evaluation of proposals and award of this Contract (or any future Contract Amendments) is not an endorsement by DFID of the Supplier's security arrangements. Note that the term "Supplier's Personnel" is defined under the Contract as "any person instructed pursuant to this Contract to undertake any of the Supplier's obligations under this Contract, including the Supplier's employees, agents and sub-contractors."

DFID Ghana