



Department  
for International  
Development

NOT PROTECTIVELY MARKED



██████████  
Population Services International  
1120 19<sup>th</sup> Street,  
NW Suite 600  
Washington, DC 20036  
USA,

Our ref: PO 7891

Email: ██████████@dfid.gov.uk

Tel: 01352 84 3429

Date: 16 Aug 2018

e-mail: ██████████

Dear ██████████

**Contract Reference: PO 7891 – To increase demand for family planning through interventions to change shared behaviours and beliefs**

**OJEU publication reference number: 2017/S 022-038521**

I refer to the contract advertised by the Department for International Development for the supply of services under the above OJEU reference number.

The mandatory 'standstill period' has now expired and the Department for International Development acting for and on behalf of the Secretary of State for International Development, is now pleased to advise you that we will be making a formal award of contract for the above mentioned services to **Population Services International** for the above Contract to those parties as described in the Terms of Reference and contract tender documents.

Please review the enclosed contract documents and confirm that you accept this contract award by signing and returning via our e-sign tool.

As per the DFID Supply Partner Code of Conduct, if this contract qualifies for internal compliance procedures, a member of the PCD Compliance Team will contact you to discuss your compliance requirements.

Yours sincerely

██████████  
Senior Manager  
Programme Sourcing - Procurement and Commercial Department

cc. [suppliercompliance@dfid.gov.uk](mailto:suppliercompliance@dfid.gov.uk); Commercial Delivery Manager (CDM); Senior Responsible Officer (SRO); Strategy and Stakeholder Engagement Team

Final Contract Award Covering Letter – June'18 v1.2

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**CONTRACT FOR SUPPLIER SERVICES**

**Section 1 - FORM OF CONTRACT**

**CONTRACT FOR:** To increase demand for family planning through interventions to change shared behaviours and beliefs

**PURCHASE ORDER NUMBER:** PO 7891

**THIS CONTRACT is made**

**BETWEEN :** The Secretary of State for International Development at the Department for International Development, Abercrombie House, Eaglesham Road, Hairmyers, East Kilbride, Glasgow, G75 8EA ("DFID");

**AND :** Population Services International ("Supplier"), whose registered office is situate at 1120 19<sup>th</sup> Street, NW Suite 600, Washington, DC 20036, USA,

(and DFID and the Supplier together shall be the "Parties").

**WHEREAS:**

- A. DFID requires the Supplier to provide the Services in the people of Mozambique's Maputo, Gaza and Nampula provinces) (the "Recipient"); and
- B. the Supplier has agreed to provide the Services on the terms and conditions set out in this Contract.

**IT IS HEREBY AGREED** as follows:

**1. Documents**

This Contract shall be comprised of the following documents:

- Section 1 Form of Contract
- Section 2 Standard Terms and Conditions - **REDACTED.**
- Section 3 Terms of Reference
- Section 4 Special Conditions - **REDACTED.**
- Section 5 Schedule of Prices - **REDACTED.**

**2. Contract Signature**

If the original Form of Contract is not returned to the DFID Contract Officer (as identified in Section 4) duly completed (including the applicable Purchase Order Number at the top of Section 1), and 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 Contract void.

**No payment will be made to the Supplier under this Contract until a copy of the Form of Contract, signed on behalf of the Supplier, is returned to the DFID Contract Officer.**

**3. Commencement Date and End Date of Initial Period**

The Services shall commence on 1st September 2018 and the end date of the Period shall

be 28th February 2021.

**4. Financial Limit**

Payments under this Contract shall not, in any circumstances, exceed £5,500,000 exclusive of any government tax, if applicable.

**5. Time of the Essence**

Time shall be of the essence as regards the performance by the Supplier of its obligations under this Contract.

Signed by an authorised signatory  
for and on behalf of  
**The Secretary of State for  
International Development**

Name:

Position:

Signature:

Date:

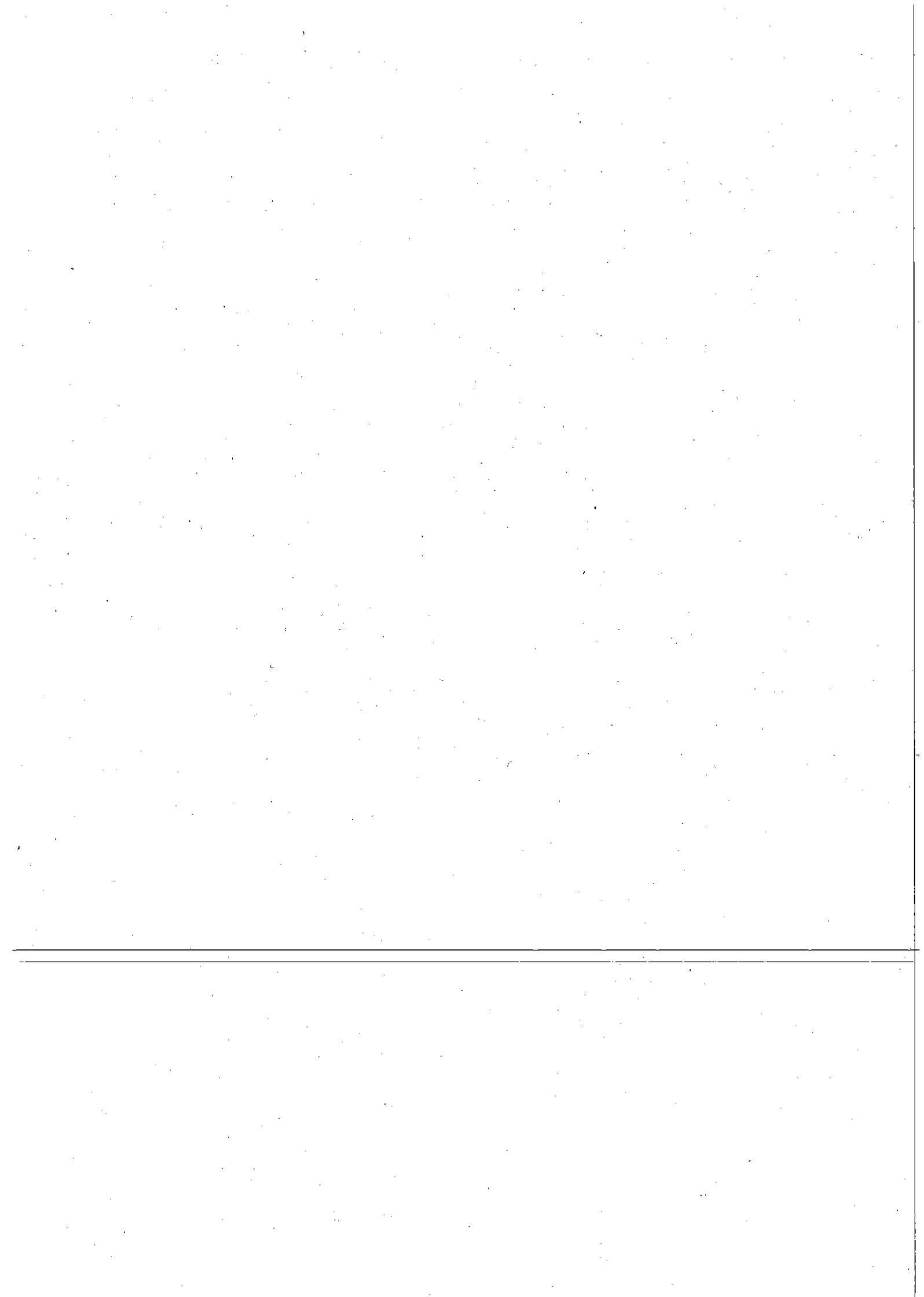
Signed by an authorised signatory  
for and on behalf of the Supplier  
**Population Services International**

Name:

Position:

Signature:

Date:



## Section 3

### Terms of Reference

**To increase demand for family planning through interventions to change shared behaviours and beliefs**

#### 1. Introduction

In September 2016, a new DFID Mozambique programme "Health Transitions" was approved. The purpose of the programme will be to support health system reforms for improved reproductive, maternal, neonatal, child and adolescent health (RMNCAH) in Mozambique. The programme will achieve this through three main components:

- a) **Supply side support to strengthen health policy and service delivery**  
Provide technical and financial support through a UN Consortium (consisting of UNFPA, UNICEF and WHO) to strengthen health systems for improved RMNCAH delivery. Management and policy support will be provided at the central level while at the sub-national level up to three provinces will be supported to deliver quality health services in communities and health centres. The support which should not be any larger than £23.5m should complement the Global Financing Facility, a new global financing platform for RMNCAH for which Mozambique becomes eligible in June 2017.
- b) **Demand side support to generate demand for family planning**  
Provide up to £5.5m to create an enabling environment for adolescents in rural areas to be able to delay or space pregnancy. This is likely to include innovative approaches such as work on social communications to address behaviours around sexual and reproductive health as well as engaging with the market on family planning services. This second component is the focus of these terms of reference and this contract opportunity.
- c) **Coordination and oversight of UK investments in the health sector**  
The total UK footprint in the sector is bigger than our bilateral programme. We will work to ensure that there is increased coordination across UK investments in health whenever possible. We also want to align better with other stakeholders in the sector to reduce duplication and ensure that we get the most out of our investments. This component which will be up to £3.3m will include an independent assessment of the overall programme to ensure that lessons feed into ongoing implementation.

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This Terms of Reference focuses exclusively on component 2: Demand side support to generate demand for family planning.

2. The Service Provider (SP) will take forward component (ii) above on support to building demand for and access to family planning especially for adolescents. Given that this component is framed within a wider three-year (therefore short term) health sector programme and UK spending round (until March 2020), we expect this FP component to pilot innovative and, or catalytic approach/es with

potential for scale up and integration into longer term programming in future. Therefore the SP shall commit to being fully prepared in the event any decision is made to scale up (increase) or scale down (decrease) the scope of the programme.

### 3. Evidence and underlying assumptions

There are therefore some evidence and assumptions involving socio-cultural norms and family planning in Mozambique that underlie our approach to the programme:

- i. Initial gains in family planning uptake can be made by satisfying the 23%<sup>1</sup> unmet need.
- ii. However, this is unlikely to provide a steady 1.5% annual increase in the contraceptive prevalence rate for modern methods, which is needed to reduce the fertility rate in the country. The total fertility rate increased from 5.5 to 5.9 children per woman between 2003 and 2011<sup>2</sup>.
- iii. There are social norms around fertility that drive early sexual debut, early marriage, and as a result early pregnancy. In some instances fertility is perceived to be a way to escape poverty through transactional sex, the dowry in Southern Mozambique or marrying a girl to a man that is perceived to be wealthy. These socio-cultural beliefs tend to vary across the country, according to socio-economic status and between urban and rural areas.
- iv. A woman's status is often linked to her ability to bear children, implying that long acting contraceptive methods are often perceived to negatively affect fertility and therefore less likely to be used.
- v. There are disparities throughout Mozambique in accessing family planning. Rural areas, the Central and Northern Regions have higher fertility rates compared to urban areas and the Southern Region where these are lower.
- vi. The youth in particular face huge challenges in accessing family planning information and services both in their communities and in health facilities. Challenges include norms and expectations from influential members of the community and *service providers* that discourage family planning /use of contraceptives. This coupled with early sexual debut and early marriage means that, 40% of adolescents on average are mothers or pregnant.<sup>3</sup> Successful interventions targeting the youth have included them in family planning provision.
- vii. Key influencers or "societal gatekeepers" can either prevent or facilitate an enabling environment for women and adolescents to access family planning information and services. Without the support of the societal gatekeepers messages and services targeting adolescents are less likely to result in increased contraceptive use.
- viii. Misleading information / information of poor quality can also create barriers and reinforce negative beliefs around contraception.
- ix. Supply also affects demand. Low access to preferred methods of contraceptives due to an unreliable supply distribution system and inconsistent information implies that although awareness of contraception has been increasing, women prefer to not use contraceptives where their preferred method is not available.

<sup>1</sup> MISAU (2015) Survey on Immunisation, Malaria, HIV& AIDS in Mozambique (IMASIDA)

<sup>2</sup> 2015 IMASIDA

<sup>3</sup> 2011 Demographic Health Survey (DHS)

<sup>3</sup> World Bank (2015) Searching for the demographic dividend in Mozambique: An urgent Agenda (draft report).

This means that actual use of contraception on average remains low and inconsistent. Innovative supply interventions are needed to reach people who are being excluded by the current approach.

These pieces of evidence and underlying assumptions need to be further explored and refined during the inception phase of the programme.

#### **4. Impact level statement**

The proposed objective of the programme is: To create an enabling environment that increases demand for family planning and results in at least 24,000 additional family planning users in rural areas

#### **5. Outcomes**

The proposed outcomes for this component of the programme are:

- i. Young women and men with improved knowledge and more positive attitudes towards family planning
- ii. Key influencers, are taking action that improves access to family planning for women and adolescents
- iii. Adolescents included in decision making processes and interventions to generate demand for family planning
- iv. Community of people with improved knowledge and positive attitudes that challenges gender discrimination and exclusion of adolescents in decision - making.
- v. Evidence of what works with similar interventions and in the programme is systematically used to inform policy and link with programming in the health sector including the supply-side support being undertaken by the UN agencies.
- vi. Increase family planning uptake among the population adolescents (younger than 20 years) including 16,080 new users of contraceptives.

The pilot should test an approach that if successful should lead to an additional 24,000 people in rural areas using contraceptives as a result of supply-side interventions. We expect two thirds of these to be adolescents, which is why one of the outcomes is that 16,080 additional users will be less than 20 years of age.

#### **6. Methods**

This is an innovative programme which will create an environment that (i) supports women and adolescents to make more use of family planning services, and, (ii) promotes alternative models, to deliver family planning services and information to groups that are currently excluded particularly adolescents.

- i. **Operational research**, leading to evidence based and locally tailored communication campaigns designed to improve knowledge and shift attitudes and behaviours towards fertility among potential users and gatekeepers including boys and men. Research should establish a baseline for monitoring

the programme and indicators for assessing shifts on individual attitudes and changing social expectations around family planning.

- ii. **Behaviour change communication interventions** based on social research as above and targeting potential users, gatekeepers and *service providers* to shift social expectations towards family planning uptake. These should promote family planning by dispelling misconceptions, shifting attitudes towards barriers and promote the benefits to access.
- iii. **Pilot market-led model(s)** to increase access to short and long acting reversible contraception (LARC) in areas that are currently underserved and to reach currently excluded groups such as adolescents. These models will have to deliver family planning services where necessary and are therefore the supply-side referred to below. It should also unpack the link between fertility and poverty by providing alternative sources of income to young people to reduce sexual health risks.

These activities should complement and be coordinated with those delivered by the National Health Service at the national and provincial levels. The SP delivering this component should directly involve adolescents where appropriate.

7. The work is divided into two stages: (a) an inception phase which will last no longer than six months and (b) an implementation phase which should initially last 24 months. Progression to the implementation stage will be contingent on DFID approval of the satisfactory completion of the inception phase. The initial contract will be 6 months inception and 24 months for implementation. DFID are aware that the nature of the contract may require longer and there may therefore be the possibility of extending the duration of the programme beyond the 30 month period to December 2022. This will be assessed in the medium-term review following Year 1 of implementation.

## 8. Geographical Focus

DFID are not prescriptive about the geographical location of the pilot as long as the pilot is implemented in at least one province where the supply side will be delivered. This should ensure that there will be complementarity between the demand and supply sides of the business case. We are therefore not specific about the coverage of interventions as long as the overall objective is achieved of increasing new users of family planning in rural areas by 24,000, of which two thirds will be adolescents by March 2020.

We expect a strong focus on rural areas where the contraceptive prevalence rate is significantly lower than in urban areas. However, the SP may also work in urban areas as a way to deliver quicker results while the rest of the programme rolls out. The largest share of interventions should be in rural areas. As long as these conditions are met, the SP is free to advise and ensure that the costs reflect their choice.

## **9. Break Clause**

There will be a break clause at the end of the inception, mid-term reviews and at March 2020. These will allow for reflection on progress and continuation of the services after these periods will be based on agreement of deliverables and on satisfactory performance and the progress of the Supplier against the specified outputs. At these points a decision will be made by DFID whether to continue with the programme approach and SP until March 2020, beyond 2020 or to change either one of them.

## **10. Programme Budget**

The total budget available for this component of the programme is no more than £5.5m. This should cover all costs associated with the delivery of this programme.

The supplier will make plans to mitigate the risk of contraceptive stock-outs or unreliable supply of contraceptives. If any purchase of contraceptives will be necessary these should not undermine the programme deliverables.

## **11. Implementation Process**

### **a) Inception Phase – Up to six months**

The inception phase will start with a kick-off meeting to establish expectations and end with an inception report. On the basis of the inception phase including the final report DFID will decide whether or not to move ahead into full implementation. During the inception phase the SP will be expected to:

- i. Prepare implementation arrangements for the project
- ii. Set up governance arrangements such as a National Steering Committee and finalise an agreement on ways of working with the UN Consortia.
- iii. Outline the approach to increasing family planning uptake including addressing behaviours and beliefs around fertility.
- iv. Undertaken at least a part of the operational research to guide the next phase of programming.
- v. Agree on target provinces for the pilot with DFID.
- vi. Finalise the programme Value for Money (VfM) and key performance indicators. A copy of our sample KPI's has been included within Annex 3 these are for information and to help the SP plan their indicators which should be adapted to suit this requirement.

### **b) Implementation phase**

The main tasks of the SP will be to deliver the outputs set up above in the target areas. Progress to implementation will be subject to approval by DFID Mozambique. ~~The duration of the implementation phase will be agreed based on the detailed work plan and budget developed and discussed during the inception phase.~~ The duration will be sufficient to generate robust evidence of pilot project outputs.

Indicative activities and deliverables of the implementation phase will include but not be exclusive to the following:

- i. Roll out of the approach in agreed provinces, districts, communities and facilities.

- ii. Quarterly management meetings with the National Steering Committee to review progress identify challenges and assess possible programme adjustment as required;
- iii. A programme logframe that will include key performance indicators and identification of the Vfm indicators.
- iv. Annual work plans and budgets;
- v. Coordination with DFID contracted independent evaluator, who will be responsible for a mid-term review as well as final assessment of the overall health programme including the pilot;
- vi. Supply side interventions to reach under-served populations such as adolescents with appropriate family planning information and services;
- vii. Ensure complementarity between the supply side implemented by the SP (in vi), the supply side from the UN Consortia and the demand-side which will be implemented by the SP;
- viii. Participation in the six month Steering Committee for the health system strengthening component being implemented by the UN Consortia and chaired by the Ministry of Health. Findings from the Baseline, Mid-Term Review and Final assessments will be presented at the Steering Committee meetings by the independent evaluator;
- ix. Production and submission of written reports to the DFID Mozambique Project Team on a quarterly basis. This will include, but not be limited to, periodic management reports, annual reviews that report against the programme logframe, and final report.

#### **c) Monitoring and Learning**

This project will invest in learning to ensure the lessons feed into implementation and influence wider policies in the health sector. However, it is not anticipated that it will undertake a full and formal evaluation. DFID will commission an Independent Evaluation that will use existing programme data to undertake an external mid-term and end line review. Annual Reviews may also regularly include the SP to contract external consultants on specific areas under review. Learning will include different approaches to disseminate lessons from the programme to different stakeholders including community members, health providers and policy makers. Lessons should also feed into the supply side which will be implemented by the UN Consortia.

#### **12. Collaboration with other components**

The demand side component should collaborate with the supply side. This should happen as the service provider participates in the six-monthly Steering Committee for the supply side component of the programme chaired by the MoH. A summary of the lessons, progress and challenges from the pilot are expected to be shared at these meetings.

DFID Mozambique is also in the process of setting up a youth multi-media platform focusing largely on behaviour change communication. This will be a key opportunity for collaboration with details of collaboration to be agreed during the inception phase in conjunction with DFID. DFID Mozambique will allocate an internal budget for the use of this platform. Therefore, while the SP did not include any costs for any other external communication costs if during the Inception Phase, it is deemed that other media/communication means are appropriate then the SP will agree with DFID the appropriate allocation of programme budget within the £5.5m for this purpose.

However, proposals have planned for other projected 'behaviour change' intervention costs.

### **13. UK Aid Branding**

Partners that receive funding from DFID must use the UK aid logo on their development and humanitarian programmes to be transparent and acknowledge that they are funded by UK taxpayers. Partners should also acknowledge funding from the UK government in broader communications but no publicity is to be given to this Contract without the prior written consent of DFID.

### **14. Digital**

If the delivery of this requirement results in the use of digital elements (either directly created by DFID or by a partner using DFID funding), approval of the spend for this must get be approved by DFID's Digital Service Team. Therefore please ensure all costs related to this are clearly outlined within your proposals.

### **15. Transparency**

DFID has transformed its approach to transparency, reshaping our own working practices and pressuring others across the world to do the same. DFID requires Suppliers receiving and managing funds, to release open data on how this money is spent, in a common, standard, re-usable format and to require this level of information from immediate sub-contractors, sub-agencies and partners.

It is a contractual requirement for all Suppliers to comply with this, and to ensure they have the appropriate tools to enable routine financial reporting, publishing of accurate data and providing evidence of this DFID – further IATI information is available from; <http://www.aidtransparency.net/>

### **16. Do No Harm**

The programme is targeting a highly sensitive area of work. The SP should demonstrate a sound understanding of the ethics in working in this area and applying these principles throughout the lifetime of the programme to avoid doing harm to beneficiaries. In particular, the design of interventions including research and programme evaluations should recognise and mitigate the risk of negative consequence for women, children and other vulnerable groups. The SP will be required to include a statement that they have duty of care to informants, other programme stakeholders and their own staff, and that they will comply with the ethics principles in all programme activities. Their adherence to this duty of care, including reporting and addressing incidences, should be included in both regular and annual reporting to DFID, an ethical commitment to the design and delivery of evaluations including the duty of care to informants, other programme stakeholders and their own staff should be demonstrated. DFID does not envisage the necessity to conduct any environmental impact assessment for the implementation of the programme. However, it is important to adhere to principles of "Do No Harm" to the environment.

### **17. Labour Law in Mozambique**

On December 1st 2016, a new regulation providing the mechanisms and procedures to apply to the hiring of Foreign Citizens in Mozambique will come into effect. It is important that the SP is aware of the implications of this regulation.

## 18. Background

The coverage of health services has increased significantly since the end of the civil war in 1992, albeit from a low base. While child health indicators have improved and the target for 2015 was achieved, maternal mortality is lagging behind with 408 deaths per 100,000 live births over the last decade. Communicable diseases are still the biggest cause of death particularly malaria and HIV & AIDS which is responsible for 107 deaths per day. These two diseases are also the largest indirect cause of maternal mortality which kills 31 women a days. Key health indicators in Mozambique are therefore below the regional average:

Indicators	Mozambique <sup>4</sup>	Sub-Saharan Africa <sup>5</sup>
Maternal mortality rate(per 100,000 live births)	408	550
Births attended by skilled health staff	70% <sup>6</sup>	46%
Contraceptive Prevalence rate	25% <sup>7</sup>	42%
Chronic Malnutrition in children under five years	43%	40%
Under five mortality rate (per 1,000 live births)	78.5%	86%
Doctors per 10,000 population	4.5	2
Government health expenditure as a proportion of total health expenditure	8.8%	10.3%

The population dynamics are of a young population with a high fertility rate. In 2015, 45% of the population were younger than 15 years, with only 3% of the population over 65 years. Life expectancy was an average of 51 years. The fertility rate has increased from 5.5 children per woman in 2003 to 5.9 in 2011. Mortality and fertility rates vary across the country, reflecting socioeconomic differences. Young people face enormous barriers in communities and in health facilities to access family planning. Although the Ministry of Health has Youth Friendly Services these are insufficient and cater largely to pregnant adolescents, excluding those who want to prevent or space births. As a result 40% of girls have at least two children by the time they are 18 years. The consequences of early pregnancy are contributing to the large numbers of girls dropping out of secondary school and a quarter of all maternal deaths among women younger than 20 years.

The National Health Service in Mozambique consists largely of the public sector particularly for reproductive and maternal health services which are free. The Ministry of Health is the implementer, financer and regulator of services. The private sector caters largely to the urban middle class, reaching less than 10% of the population.

<sup>4</sup> 2011 DHS

<sup>5</sup> WHO (2016) Africa data report: Health financing, outcomes and inequality in Sub-Saharan Africa.

<sup>6</sup> 2015 IMASIDA

<sup>7</sup> 2015 IMASIDA

There is a small but growing number of NGOs working in health promotion and prevention services, in partnership with the public sector.

**The Ministry of Health is committed to increasing family planning uptake, and has set a target of 34% contraceptive prevalence rate (CPR) by 2020.** Despite rapid progress from 11% CPR in 2011 to 25% in 2015, there are concerns that the target will not be achieved. Factors contributing to this include unreliable distribution of contraceptives and socio-cultural beliefs of *service providers* about fertility which undermine the delivery of family planning. On the demand side there are structural factors around fertility and marriage that influence the demand and use of family planning including unequal gender relations and the perception that fertility can be used to escape poverty. These factors drive the high prevalence of child marriage in the country<sup>8</sup>.

**Since 2007, DFID Mozambique has been investing in health systems as a means to improve health indicators.** From 2007- 2014 most of this support (£7million per year) was channelled with those of 10 other partners, through the Health Common Fund. The Common Fund supported the Government's Annual Health Plan. The lack of earmarking of the Common Fund meant that it was valued by the MoH because it allowed it to compliment significant vertical funding from large programmes including the Global Funds. Results included an increased coverage of health services with one doctor being available in each district by 2010. The DFID Mozambique health portfolio evolved to focus on alternative delivery mechanisms and pilots to address areas of weakness such as family planning, institutional deliveries and supply chain distribution. Lessons from these initiatives fed into the new £34.3 million health business case which was approved by Ministers in early September 2016.

#### 19. Duty of Care

The Supplier is responsible for the safety and well-being of their Personnel and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property. DFID will share available information with the Supplier on security status and developments in-country where appropriate.

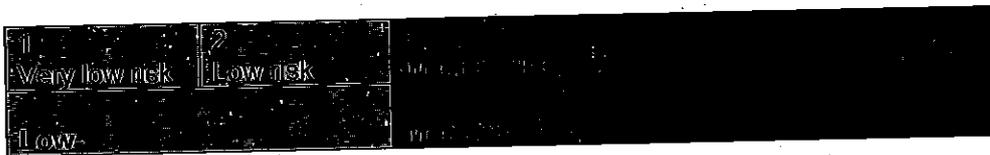
The Supplier is responsible for ensuring appropriate safety and security briefings for all of their Personnel working under this contract. Travel advice is also available on the FCO website and the Supplier must ensure they (and their Personnel) are up to date with the latest position.

Date of assessment – April 2016:

Theme	DFID Risk score
OVERALL RATING	3
FCO travel advice	3
Host nation travel advice	Not available
Transportation	3

<sup>8</sup> Mozambique has the 4<sup>th</sup> highest prevalence of teenage marriage in the world.

Security	3
Civil unrest	3
Violence/crime	3*
Espionage	2
Terrorism	2
War	3**
Hurricane	1
Earthquake	1
Flood	2***
Medical Services	4****
Nature of Project/	



For further information please consult the FCO travel advice:  
<https://www.gov.uk/foreign-travel-advice>

**20. Additional information:**

**Annex 1:** Final Report - Situation analysis and recommendations for addressing social and behavioural barriers to reproductive health 31<sup>st</sup> March 2016 (document released on the DFID Portal).

**Annex 2:**

In identifying options for DFID intervention, the study should give critical consideration to:

- A focus on reaching adolescent girls (which will need to include targeting behaviours of boys and men)
- Distinguishing between different socioeconomic groups and cultures (see above) and appropriate targeting to relevant actors, including specific social groups, health workers and other actors involved in delivery of health services and commodities;
- Ensuring an approach to communications and behaviour change that is locally appropriate and sustainable;
- Complement DFID support to the Ministry of Health through the UN Consortium (UNFPA, UNICEF and WHO) for reproductive, maternal and child health.
- Complements DFID's other emerging work on social norms on related issues, e.g. the Ligada programme to promote economic opportunity for women and girls and new work with men and boys to support nutrition outcomes
- Demonstrate considerations on achieving the best results within reasonable costs

**Section 5**

**SCHEDULE OF PRICES**

1. It is a requirement that all invoices are presented in the format of the payment basis, and in the case of Fees and Expenses only those categories defined are separately identified. Only one invoice per period, as defined in Section 2, paragraph 21, should be submitted.

Optional paragraphs, either 2 or 3.

**2. Fees and Expenses**

The amount of fees and expenses are shown separately and reflects the financial ceilings within each category. Only expenditure actually incurred for expenses will be reimbursed. Fees are tied to milestone payments, with payment made in accordance with paragraph 3 below. Receipts for all expenditure incurred may be required before any payment is made under this contract.

**3. Milestone Payments**

The amount to be paid for the completion of the services is fixed at [REDACTED].

Payment will be made on satisfactory performance of the services, at the payment points defined below (schedule of payments):

- (i) At relevant points throughout the contract period.

At each payment point set criteria will be defined as part of the schedule of payments. Payment will be made if the criteria are met to the satisfaction of DFID.

(September 2017)

