PART I - THE SCHEDULE

SECTION B - SUPPLIES OR SERVICES AND PRICE/COSTS

B.1 PURPOSE

The purpose of the USAID Health System Strengthening (HSS) contract is to help protect human health, promote development, and ensure stability in the event of a conflict in Iraq by supporting efforts to strengthen the overall health system and ensure the rapid normalization of specific health services.

B.2 CONTRACT TYPE

This is a Cost-Plus-Fixed-Fee (CPFF) completion contract. For the consideration set forth in B.3, the Contractor will complete the scope of work set forth in Section C in accordance with the terms and conditions of this contract during a 12-month performance period.

B.3 ESTIMATED COST, FIXED FEE, AND OBLIGATED AMOUNT

(a) The estimated cost for the performance of the work required hereunder, exclusive of fixed fee, if any, is (b)(4) . The fixed fee, if any, is (b)(4) The fixed fee is applied to total estimated costs, less grants ($6 million), less medical equipment and supplies and not to exceed the amount specified herein. The estimated cost plus fixed fee, if any, is $43,818,278.

(b) Within the estimated cost plus fixed fee (if any) specified in paragraph (a) above, the amount currently obligated and available for reimbursement of allowable costs incurred by the Contractor (and payment of fee, if any) for performance hereunder is $10,000,000.

(c) Funds obligated hereunder are anticipated to be sufficient through Phase I – Planning/Assessment (approximately two months from the effective date) and partial activities in Phase II-Health Systems Strengthening.

B.4 INDIRECT COSTS (DEC 1997)

Pending establishment of revised provisional or final indirect cost rates, allowable indirect costs shall be reimbursed on the basis of the following negotiated provisional or predetermined rates and the appropriate bases:

| Description | Rate | Base | Type |
|---|---|---|---|
| Fringe Benefits | (b)(4) | 1/ | 1/ |
| Overhead (Home Office) | | 2/ | 2/ |
| Overhead (Site Office) | | 3/ | 3/ |
| Handling Charge | | 4/ | 4/ |
| G&A | | 5/ | 5/ |

1/ Base of Application: (b)(4)
Type of Rate (Provisional/Predetermined): (b)(4)

2/ Base of Application: (b)(4)
Type of Rate (Provisional/Predetermined): (b)(4)

3/ Base of Application: (b)(4)

4/ Base of Application: (b)(4)
(b)(4)

Type of Rate (Provisional/Predetermined): (b)(4)

5/ Base of Application: (b)(4)
(b)(4)

Type of Rate (Provisional/Predetermined): (b)(4)

B.5 CEILING ON INDIRECT COST RATES

(1) Reimbursement for indirect costs shall be at the lower of the negotiated final predetermined rates or the following ceiling rates:

Aggregate Cap

Fringe Benefits
Overhead (Home Office) (b)(4)
G&A

(b)(4)

Same base and period applies as specified in B.4.

Separate Ceiling Caps:

| Description | Rate |
|---|---|
| Fringe (Site Office) | |
| G&A | (b)(4) |
| Handling Charge | |

Same base and period applies as specified in B.4.

(2) The Government will not be obligated to pay any additional amount should the final indirect cost rates exceed the negotiated ceiling rates. If the final indirect cost rates are less than the negotiated ceiling rates, the negotiated rates will be reduced to conform with the lower rates.

(3) This understanding shall not change any monetary ceiling, obligation, or specific cost allowance or disallowance. Any changes in classifying or allocating indirect costs requires the prior written approval of the Contracting Officer.

B.6 COST REIMBURSABLE

The U.S. dollar costs allowable shall be limited to reasonable, allocable and necessary costs determined in accordance with FAR 52.216-7, Allowable Cost and Payment, FAR 52.216-8, Fixed Fee, if applicable, and AIDAR 752.7003, Documentation for Payment.

B.7 LABOR

Compensation of personnel under this contract or any resulting subcontract must be in accordance with AIDAR 752.7007 Personnel Compensation (July 1996). See further guidance in AIDAR 722.170 Employment of Third Country Nationals (TCN's) and Cooperating Country Nationals (CCN's).

## SECTION C – STATEMENT OF WORK

## HEALTH SYSTEM STRENGTHENING IN A POST-CONFLICT IRAQ

The objective of this Contract is to help facilitate rapid, universal health service delivery to the Iraqi population and strengthen the overall health sector to ensure medium- to long-term viability. The implementation of this program shall not take place until a permissive environment exists and USAID instructs the contractor to proceed. See special provision in Section H.15.

C.1 BACKGROUND

Compared to many other developing countries in the Middle East and the rest of the world, Iraq has relatively poor health and demographic indicators. For example, in Iraq the total fertility rate is 5.4 (average for least developed countries is 3.1), the infant mortality rate is 103 (LDC average is 60), and the life expectancy at birth is only 58 years (LDC average is 65) (Population Reference Bureau, 2002). In addition, child malnutrition remains a major concern with almost one-third of all children in the southern and central regions of Iraq suffering from chronic malnutrition (UNICEF Emergency Update, October 7, 2002). Low exclusive breastfeeding rates, high prevalence of anemia among women, and a high incidence of low birth weight contributes to Iraq's very high child mortality rate (131 for children under 5 years) which has more than doubled from the previous decade with diarrhea and acute respiratory infections accounting for 70% of child deaths (UNICEF Emergency Update, October 7, 2002). The total expenditure on health as a percentage of GDP was only 3.7% in 2000, suggesting a limited national investment in protecting the health of Iraqis (2002 World Health Report). The fact that water-borne infectious diseases are a major killer of children suggests that investments in water and sanitation have also been limited.

The current humanitarian (and health) crisis in Iraq follows two devastating international wars--the Iran-Iraq war of 1980 and the Persian Gulf War of 1991--and the adoption of UN sanctions following the latter. The initiation of the UN Oil-for-Food program in 1995 as a "temporary" measure to provide for the humanitarian needs of the Iraqi people (UNSC Resolution 986) has only partly mitigated the very grave humanitarian crisis in the country. The severe deterioration of Iraq's infrastructure and basic public services (including health, water/sanitation, and electricity) has only added to the suffering of a rapidly increasing Iraqi population. Against this backdrop, the livelihood and coping capacity of the Iraq population have been severely strained.

The current international political focus on the Middle East and the possibility of conflict have highlighted existing gaps in basic services and infrastructure in Iraq, as well as the vulnerability of populations to further deterioration of health status if there is a disruption of basic services. The Iraqi health system continues to