

Republic of the Philippines
Department of Health

METRO MANILA CENTER FOR HEALTH DEVELOPMENT

SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 027

PROCUREMENT OF 20,060 PCS OVITRAP WITH PADDLE

This Supplemental/Bid Bulletin No. 1 is being issued to revise provisions/specifications in the Bidding Documents for a forecited project:

Revision and clarification to provisions/specifications in the Bidding Documents:
Additional Specifications: *Size of cup = 375ml PS Black cup *Height = 10-11cm *Diameter = 9cm *Thickness of Plastic Container = 3.2 mm Ovipaddle *Material = LAWANIT *Thickness = ¼ inch * Paddle Size: 1 x 6 inches *Delivery Schedule: 60 Calendar Days upon receipt of NTP * Delivery Area: DOH-MMCHD Pasig Warehouse

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This Supplemental/Bid Bulletin No. 1 shall form an integral part of the Bidding Documents. All other provisions indicated in the bidding documents which are not affected by this Supplemental/Bid Bulletin No. 1 shall remain in effect.

For guidance and information of all concerned.

Issued this 8th day of January, 2022 in MMCHD

Approved by:

ALELI ANNIE GRACE P. SUDIACAL, MD, MPH
Director III / BAC Chairperson



Republic of the Philippines
Department of Health

METRO MANILA CENTER FOR HEALTH DEVELOPMENT

SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 028

PROCUREMENT OF 5,848 BOXES MULTIVITAMINS FOR ADULTS CAP/TAB (100'S/BOX)

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METRO MANILA CENTER FOR HEALTH DEVELOPMENT

SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 029

PROCUREMENT OF 898,000 PCS DISPOSABLE STERILE SYRINGE 3cc, 22G x 1"
(100'S PER BOX)

This Supplemental/Bid Bulletin No. 1 is being issued to revise provisions/specifications in the Bidding Documents for a forecited project:

Revision and clarification to provisions/specifications in the Bidding Documents:	
*Delivery Area: DOH-MMCHD Pasig Warehouse	
From	To
Technical Specification: 3ml, with needle 22G x 1 inch long needle 0.7 x 25mm / 23G x 1 1/2" (0.60x38mm)	Technical Specification: 3ml, with needle 22G x 1 inch long needle 0.7 x 25mm
Technical Specification: Needle- G22 /g23 stainless steel	Technical Specification: Needle- G22 stainless steel

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SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 030

PROCUREMENT OF 898,000 VIALS OF MEDROXYPROGESTERONE ACETATE SUSPENSION 150mg/1ml VIAL INJECTABLE

This Supplemental/Bid Bulletin No. 1 is being issued to revise provisions/specifications in the Bidding Documents for a forecited project:

Revision and clarification to provisions/specifications in the Bidding Documents:
*Delivery Area: DOH-MMCHD Pasig Warehouse
*Delivery Schedule: 60 – 90 Calendar Days upon receipt of NTP

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SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 031

PROCUREMENT OF 217,861 CYCLES LEVONORGESTREL + ETHINYLESTRADIOL ORAL TABLETS

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*Delivery Schedule: 60 – 90 Calendar Days upon receipt of NTP

Bidders are advised to use the following attached forms and submit together with all required documents for the submission of bids on 17th day of January 2022, 9:00 AM:

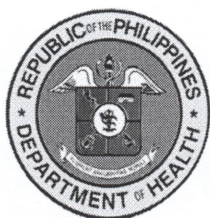
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SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 032

PROCUREMENT OF 632,553 PACKS OF MALE CONDOM ASSORTED FLAVORS "3 SACHETS/PACK

This Supplemental/Bid Bulletin No. 1 is being issued to revise provisions/specifications in the Bidding Documents for a forecited project:

Revision and clarification to provisions/specifications in the Bidding Documents:	
*Delivery Area: DOH-MMCHD Pasig Warehouse	
*Delivery Schedule: 60 – 90 Calendar Days upon receipt of NTP	
From	To
PROCUREMENT OF 632,553 PACKS OF MALE CONDOM ASSORTED FLAVORS "3 SACHETS/PACK	PROCUREMENT OF 632,553 PACKS OF MALE CONDOM ASSORTED FLAVORS "3 SACHETS/PACK"
Specification: Straight/dotted and paraallel sided with reservoir tip	Specification: Straight/dotted and parallel sided with reservoir tip
Secondary Packaging: 24 packs/box or 72 pcs/box	Secondary Packaging: 24 packs/box or 72 pcs/box or 40 packs/box or 120 pcs/box
Tertiary Packaging: 50 bxs in a carton/large box	Tertiary Packaging: 50 bxs in a carton/large box or 30 bxs per carton/large box

Bidders are advised to use the following attached forms and submit together with all required documents for the submission of bids on 17th day of January 2022, 9:00 AM:

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SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 033

PROCUREMENT OF 8 UNITS VAN RENTAL

This Supplemental/Bid Bulletin No. 1 is being issued to revise provisions/specifications in the Bidding Documents for a forecited project:

Revision and clarification to provisions/specifications in the Bidding Documents:
*No changes as stated in technical specifications.

Bidders are advised to use the following attached forms and submit together with all required documents for the submission of bids on 17th day of January 2022, 9:00 AM:

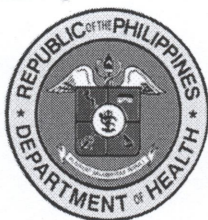
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SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 034

PROCUREMENT OF VARIOUS PRINTING MATERIALS (LOT BIDDING)

This Supplemental/Bid Bulletin No. 1 is being issued to revise provisions/specifications in the Bidding Documents for a forecited project:

Revision and clarification to provisions/specifications in the Bidding Documents:

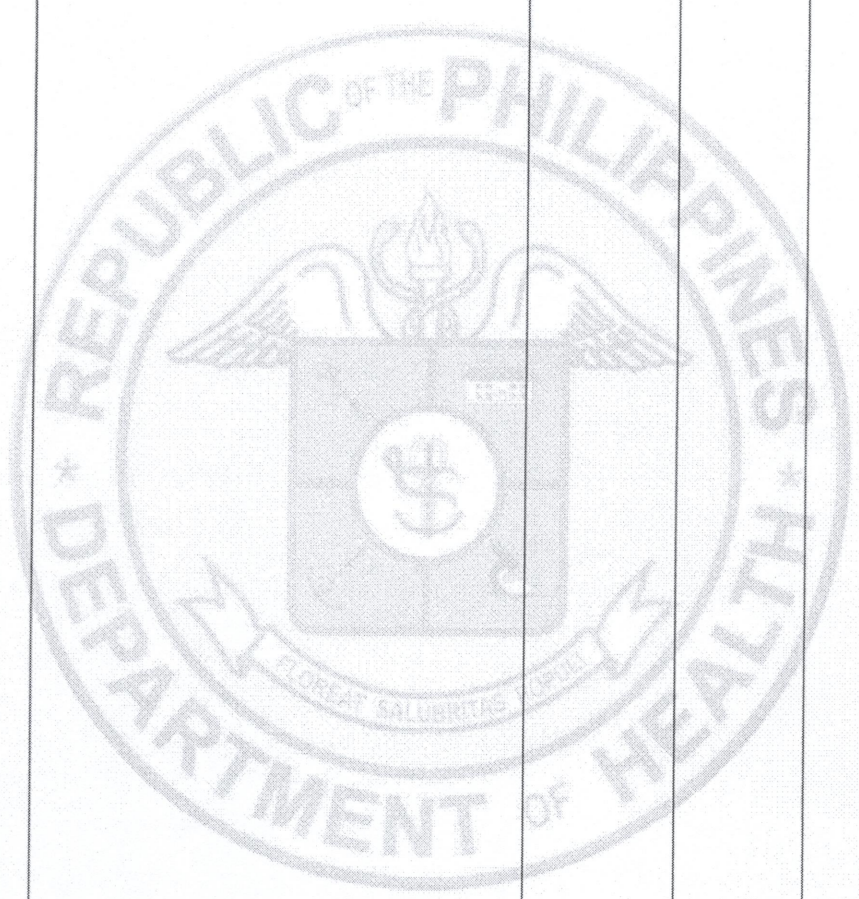
ITEM 1: Procurement of 203,000 pcs Reproduction of Revised FP Form 1

*Delivery Area: DOH-MMCD Tala Warehouse

*Delivery Schedule: 60 – 90 Calendar Days upon receipt of NTP

Prototype Sample:

SIDE A		FAMILY PLANNING (FP) FORM 1		ver. 3.0	
FAMILY PLANNING CLIENT ASSESSMENT RECORD				CLIENT ID: _____	
Instructions for Physicians, Nurses and Midwives: Make sure that the client is not pregnant by using the questions listed in SIDE B. Completely fill out or check the required information. Refer accordingly for any abnormal history/findings for further medical evaluation.				PHILHEALTH NO.: _____	
NAME OF CLIENT: _____				NHTS? <input type="checkbox"/> Yes <input type="checkbox"/> No Pantawid Pamilya Pilipino Program(4Ps) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Last Name Given Name MI Date of Birth Age Educ. Attain. Occupation					
ADDRESS: _____					
No. Street Barangay Municipality/City Province Contact Number Civil Status Religion					
NAME OF SPOUSE: _____					
Last Name Given Name MI Date of Birth Age Occupation					
NO. OF LIVING CHILDREN: _____ PLAN TO HAVE MORE CHILDREN? <input type="checkbox"/> Yes <input type="checkbox"/> No				AVERAGE MONTHLY INCOME: _____	
Type of Client					
<input type="checkbox"/> New Acceptor Reason for FP: <input type="checkbox"/> spacing <input type="checkbox"/> limiting <input type="checkbox"/> others _____				Method currently used (for Changing Method):	
<input type="checkbox"/> Current User				<input type="checkbox"/> COC <input type="checkbox"/> IUD <input type="checkbox"/> BOM/CMM <input type="checkbox"/> LAM	
<input type="checkbox"/> Changing Method Reason: <input type="checkbox"/> medical condition <input type="checkbox"/> side-effects _____				<input type="checkbox"/> POP <input type="checkbox"/> Interval <input type="checkbox"/> BBT <input type="checkbox"/> others _____	
<input type="checkbox"/> Changing Clinic				<input type="checkbox"/> Injectable <input type="checkbox"/> Post-Partum <input type="checkbox"/> STM specify: _____	
<input type="checkbox"/> Dropout/ Restart				<input type="checkbox"/> Implant <input type="checkbox"/> Condom <input type="checkbox"/> SDM	
I. MEDICAL HISTORY				IV. RISKS FOR VIOLENCE AGAINST WOMEN (VAW)	
Does the client have any of the following?				<input type="checkbox"/> unpleasant relationship with partner <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> severe headaches / migraine <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> partner does not approve of the visit to FP clinic <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> history of stroke / heart attack / hypertension <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> history of domestic violence or VAW <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> non-traumatic hematoma / frequent bruising or gum bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No				Referred to: <input type="checkbox"/> DSWD <input type="checkbox"/> WCPU <input type="checkbox"/> NGOs <input type="checkbox"/> Others (Specify: _____)	
<input type="checkbox"/> current or history of breast cancer / breast mass <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> severe chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> cough for more than 14 days <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> unexplained vaginal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No				V. PHYSICAL EXAMINATION	
<input type="checkbox"/> abnormal vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No				Weight: _____ kg Blood pressure: _____ mmHg	
<input type="checkbox"/> intake of phenobarbital (anti-seizure) or rifampicin (anti-TB) <input type="checkbox"/> Yes <input type="checkbox"/> No				Height: _____ m Pulse rate: _____ /min	
<input type="checkbox"/> Is the client a SMOKER? <input type="checkbox"/> Yes <input type="checkbox"/> No				SKIN: <input type="checkbox"/> normal <input type="checkbox"/> normal <input type="checkbox"/> pale <input type="checkbox"/> edema <input type="checkbox"/> yellowish <input type="checkbox"/> varicoseities	
<input type="checkbox"/> With Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No				PELVIC EXAMINATION (For IUD Acceptors)	
(if YES please specify: _____)				<input type="checkbox"/> normal <input type="checkbox"/> normal <input type="checkbox"/> mass <input type="checkbox"/> abnormal discharge <input type="checkbox"/> cervical abnormalities	
II. OBSTETRICAL HISTORY				CONJUNCTIVA: <input type="checkbox"/> normal <input type="checkbox"/> pale <input type="checkbox"/> yellowish	
Number of pregnancies: G _____ P _____				NECK: <input type="checkbox"/> normal <input type="checkbox"/> neck mass <input type="checkbox"/> enlarged lymph nodes	
<input type="checkbox"/> Full term <input type="checkbox"/> Premature				BREAST: <input type="checkbox"/> normal <input type="checkbox"/> mass <input type="checkbox"/> nipple discharge	
<input type="checkbox"/> Abortion <input type="checkbox"/> Living children				ABDOMEN <input type="checkbox"/> normal <input type="checkbox"/> abdominal mass <input type="checkbox"/> varicoseities	
Date of last delivery _____				uterine position: <input type="checkbox"/> mid <input type="checkbox"/> anteфлекed <input type="checkbox"/> retroфлекed	
Type of last delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean Section				uterine depth: _____ cm	
Last menstrual period _____				ACKNOWLEDGEMENT:	
Previous menstrual period _____				This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the _____ method.	
Menstrual flow: <input type="checkbox"/> scanty (1-2 pads per day) <input type="checkbox"/> moderate (3-5 pads per day) <input type="checkbox"/> heavy (>5 pads per day)				Client Signature _____ Date _____	
<input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Hydaiidilom mole (within the last 12 months) <input type="checkbox"/> History of ectopic pregnancy				For WRA below 18 yrs. Old: I hereby consent _____ to accept the Family Planning method.	
III. RISKS FOR SEXUALLY TRANSMITTED INFECTIONS				Parent/Guardian Signature _____ Date _____	
Does the client or the client's partner have any of the following?					
<input type="checkbox"/> abnormal discharge from the genital area <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "YES" please indicate if from: <input type="checkbox"/> Vagina <input type="checkbox"/> Penis					
<input type="checkbox"/> sores or ulcers in the genital area <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> pain or burning sensation in the genital area <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> history of treatment for sexually transmitted infections <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> HIV / AIDS / Pelvic inflammatory disease <input type="checkbox"/> Yes <input type="checkbox"/> No					
Implant = Progestin subdermal implant; IUD = Intrauterine device; BTL = Bilateral tubal ligation; NSV = No-surgical vasectomy; COC = Combined oral contraceptives; POP = Progestin only pills; LAM = Lactational amenorrhea method; SDM = Standard days method; BBT = Basal body temperature; BOM = Billings ovulation method; CMM = Cervical mucus method; STM = Symptothermal method					

FAMILY PLANNING CLIENT ASSESSMENT RECORD				
DATE OF VISIT (MM/DD/YYYY)	MEDICAL FINDINGS (Medical observation, complaints/ complication, service rendered/ procedures, laboratory examination, treatment and referrals)	METHOD ACCEPTED	NAME AND SIGNATURE OF SERVICE PROVIDER	DATE OF FOLLOW-UP VISIT (MM/DD/YYYY)
<div></div>				
<div><p>How to be Reasonably Sure a Client is Not Pregnant</p><div><div><div>1. Did you have a baby less than six (6) months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div><div><div>2. Have you abstained from sexual intercourse since your last menstrual period or delivery?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div><div><div>3. Have you had a baby in the last four (4) weeks?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div><div><div>4. Did your last menstrual period start within the past seven (7) days?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div><div><div>5. Have you had a miscarriage or abortion in the last seven (7) days?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div><div><div>6. Have you been using a reliable contraceptive method consistently and correctly?</div><div><input type="checkbox"/> Yes <input type="checkbox"/> No</div></div></div><div><div>■ If the client answered YES to at least one of the questions and she is free of signs or symptoms of pregnancy, provide client with desired method.</div><div>■ If the client answered NO to all of the questions, pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.</div></div></div>				

ITEM 2: Procurement of 6,587 pads Reproduction of FP Target Client List

- *Delivery Area: DOH-MMCD Tala Warehouse
- *Delivery Schedule: 60 – 90 Calendar Days upon receipt of NTP

From	To
Specification: No. pages 50 leaves per pad excluding cover	Specification: No. pages 75 leaves per pad excluding cover

ITEM 3: Procurement of 300 Pcs of HCPN Handbook

- *Delivery Area: DOH-MMCD Pasig Warehouse
- *Delivery Schedule: 60 – 90 Calendar Days upon receipt of NTP

ITEM 4: Reproduction of 522 pcs BHW ID with Lanyard

- *Delivery Area: DOH-MMCD Office
- *Delivery Schedule: 60 - 90 Calendar Days upon receipt of NTP
- *Specifications:
Size: 2.2” x 3.4”
Material: PVC Card

Green is C-90, M-34, Y-100, K-27
Logos will be provided

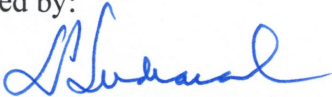
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METRO MANILA CENTER FOR HEALTH DEVELOPMENT

SUPPLEMENTAL/ BID BULLETIN NO. 1

IB 2022 - 035

PROCUREMENT FOR THE PROVISION OF JANITORIAL SERVICES FOR DOH-MMCHD, PASIG & TALA WAREHOUSE

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