INVITATION TO TENDER FOR THE PROVISION OF:

The Fleming Fund – Independent Evaluation Supplier

Deadline: 27th June 2016 – 15:00

ITT Reference: 60236

**PART B** – Tender Schedules

(To be returned by Bidders)

1. Specification

Acronyms

|  |  |
| --- | --- |
| AMR | Antimicrobial Resistance |
| CDC | Centre for Disease Control |
| DFID | Department for International Development |
| DH | Department of Health |
| ECDC | European Centre for Disease Prevention and Control |
| FAO | Food and Agriculture Organisation |
| FCO | Foreign and Commonwealth Office |
| GHS | Global Health Security |
| GHSA | Global Health Security Agenda |
| HMG | Her Majesty’s Government |
| ITT | Invitation to tender |
| MA | Management Agent |
| NGOs | Non-Government Organisation |
| ODA | Official Development Assistance (UK aid budget) |
| OIE | World Organisation for Animal Health |
| PHE | Public Health England |
| PQQ | Pre-qualification questionnaire |
| TAG | Technical Advisory Group (for the Fleming Fund) |
| WHO | World Health Organization |

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Executive Summary

This section provides information on the Fleming Fund, and the Independent Evaluation Supplier role (the latter being the subject of this requirement).

1. **Introduction** 
   1. The Department of Health (DH) has launched the Fleming Fund, a £265 million one health programme to support low and middle income countries (LMICs) in tackling antimicrobial resistance (AMR).
   2. To help deliver the Fleming Fund, DH is intending to contract a supplier to deliver an independent evaluation of the Fleming Fund country and regional level projects.
   3. The Evaluation Supplier will evaluate how far the *outputs* of the portfolio of country and regional grants will contribute to the *outcomes* and *impact* defined within the agreed Fleming Fund Theory of Change (see Annex B). It is understood that this analysis would be indicative, due to the amount of external variables which could affect the desired Fleming Fund impact as stated.
   4. The formative aspect of the evaluation (see section 5.10 for detailed information) will indicatively answer the evaluation questions agreed during the Inception Phase, and produce recommendations to guide the portfolio of country and regional grants in how their *outputs* can best achieve and contribute to the *outcomes* and *impact* of the Fleming Fund. The formative report will be a key opportunity for any course correction suggestions.
   5. The summative aspect of the evaluation (see section 5.10 for detailed information) will answer the evaluation questions agreed during the Inception Phase and evaluate how far the *outputs* of the portfolio of country and regional grants have contributed, or will contribute, to the *outcomes* and *impact* of the overarching Fleming Fund.
   6. This document outlines the shape of the Fleming Fund programme, initial work already underway and the specification for an Evaluation Supplier.
   7. AMR is a global problem that needs concerted action at both a national and global level using a one health approach that spans work across the human, veterinary, environment and development sectors. The UK is at the forefront of action to address the threat of AMR.
   8. Drug-resistant infections could kill an extra 10 million people across the world every year by 2050 if they are not tackled. By this date they could also cost the world around $100 trillion in lost output: more than the size of the current world economy[[1]](#footnote-1). See Annex A for detailed background information on the challenge of AMR in LMICs.
   9. Ongoing systematic collection, analysis, and interpretation of health data is essential to the planning, implementation and evaluation of public health practice, closely integrated with the dissemination of these data to those who need to know and linked to prevention and control.[[2]](#footnote-2)
   10. Both the Prime Minister and Chief Medical Officer are clear that tackling AMR at home and abroad is a key priority and that the UK will help lead a global response.
   11. The Fleming Fund will aim to improve laboratory capacity and diagnosis as well as data and surveillance of AMR in LMICs.
   12. The Fleming Fund itself is funded through Official Development Assistance (ODA).[[3]](#footnote-3) Evaluating the impact and lessons of aid programmes is a crucial part of ODA funded work. A high quality evaluation helps ensure funding is being spent effectively to meet the aim of the Fund.
2. **Programme Description and Features**

**Programme aims, activities and approach**

* 1. The aim of the Fleming Fund is to improve laboratory capacity and diagnosis as well as data and surveillance of AMR in LMICs through a one health approach: building capacity to collect drug resistance data; enabling the sharing of drug resistance data locally, regionally and internationally; collating data on AMR; and encouraging the application of these data to promote the rational use of antimicrobials.

2.2 The Fund will do this by:

* + Building laboratory capacity for diagnosis;
  + Collecting drug resistance data;
  + Enabling the sharing of drug resistance data locally, regionally and internationally;
  + Collating and analysing data on the sale and use of antimicrobial medicines, particularly antibiotics;
  + Advocating the application of these data to promote the rational use of antimicrobials for human health, animal health and agriculture;
  + Shaping a sustainable system for AMR surveillance and data sharing.

2.3 For details of initial scoping activities, technical support and guidance, and Fleming Fund Core Principles, see Annex G.

**Country and regional focus**

* 1. ***Country focus:***The Fund will have a focus principally on countries which are encompassed by a high level set of priority principles set out by DH such as ODA eligibility, countries in Sub-Saharan Africa, Southern and South Eastern Asia, and countries with existing UK diplomatic relations. These high level principles will be the first maker in country selection and are detailed in Annex C. Within this selection the Management Agent - the identification of which is the subject of a separate procurement exercise - will be expected to work with DH to further shortlist countries through a series of country assessments to understand where investments will be most effectively targeted. Fleming Fund country investments will benefit from being implemented alongside other DFID programming where relevant, but projects will not be limited to DFID priority countries.
  2. ***Regional focus*:** The Management Agent will be expected to run a call for regional grants to support the development of networks and data sharing. However, the makeup of a regional network can remain flexible to reflect geographical proximity, a specific collection of countries with similar priorities or regional partnerships.
  3. ***Cross-border thematic focus*:** The Fleming Fund will target country and regional grants which can demonstrate a clear path to impact through a one health approach[[4]](#footnote-4); this may include a one health commitment from governments as part of AMR National Action Plans.

**Technical focus**

* 1. The Fleming Fund will focus on detecting and reporting on pathogenic bacteria-antibacterial drug combinations in line with those that were identified as of international public health concern by WHO in the Antimicrobial Resistance Global Report on Surveillance 2014[[5]](#footnote-5), **subject to adaptation to suit local priorities and infectious disease prevalence (including zoonotic infections).** DH expects that programmes will include some of the following pathogenic bacteria-antibacterial drug combinations:
* Escherichia coli vs. 3rd generation cephalosporins and fluroquinalones;
* Klebsiella pneumoniae vs. 3rd generation cephalosporins and carbapenems;
* Staphylococcus aureus vs. methicillin;
* Streptococcus pneumoniae vs penicillin;
* Salmonella species vs. fluoroquinalones;
* Shigella species vs. fluroquinalones;
* Neisseria gonorrhoeae vs. 3rd generation cephalosporins.
  1. Specific countries and regions may have identified priorities within this list dependent on their country burden of disease and reported resistance, or additional priorities such as tuberculosis. The aim of the Fund, aligned with the GHSA AMR target, is to encourage each country receiving Fleming funding to begin improving laboratory capacity for, and surveillance of, a minimum of three of the above pathogenic bacteria-antibacterial drug combinations as a starting point, with the ambition of improving capacity to test for all. However, in consultation with country governments and national stakeholders, the programme can support additional pathogens alongside those in the WHO list, if this is a national priority.

**What the programme will not fund**

* 1. Research - although it will be informed by research agendas, have close links with researchers and generate useful new knowledge on AMR, the prime objective of the fund is not AMR research.
  2. New product development – other funding mechanisms and relationships will be required to do this.
  3. Support to non-ODA eligible countries.
  4. Financial disbursements directly to governments.

1. **Programme Activities**
   1. With initial projects underway (see Annex G), DH is commissioning a set of Fleming Fund projects which will be sustained through the five year funding cycle. The following represents the shape of the programme as a whole over this five year period with detail on each work stream.
   2. The Fleming Fund programme will be managed by DH and will be made up of **five interdependent work streams** as shown below. DH is separately tendering to procure a Management Agent who will deliver the country and regional projects and the Fleming Fellows (work streams 1 and 2), although alignment is expected between all work streams in the programme. The current tender is to procure an Evaluation Supplier to deliver an independent evaluation of the country and regional projects.
   3. Work stream 1 and 2 and 5 will be structured into two phases:

* **Phase 1:** The eight month **inception phase** to design the programme portfolio of country and regional grants, Fleming Fellows and the independent evaluation alongside DH.
* **Phase 2:** The **implementation phase** to set up and manage the portfolio of country and regional grants, Fleming Fellows and the delivery of the independent evaluation.

**Fig 1. Organogram of Fleming Fund work streams**

The Fleming Fund

£265m up to

2020/21

1. Portfolio of One Health Country and Regional Projects

2. Fleming Fellows

3. Grants to Multilaterals WHO, FAO, OIE

4. Surveillance protocol and platform

5. Independent Evaluation

* 1. Work stream 1 – Portfolio of country and regional projects (Management Agent): This work stream is the focal point of the Fleming Fund and will be delivered by the selected Management Agent supplier.
  2. The focus of country and regional grants will be to improve laboratory capacity for diagnosis as well as surveillance on AMR, as well as surveillance of the use of antimicrobial medicines. It is recognised that any improvements to laboratory infrastructure and capacity will not happen in isolation but will rather need to complement the sustaining ecosystem around the laboratory including: external quality assurance; effective collection of samples; flow of samples to the laboratory; trained staff to undertake sample testing; and efficient mechanisms to share data.
  3. Country one health grants during implementation phase may include but are not limited to:
* Equipping and refurbishing laboratories so that they are able to reliably undertake bacterial diagnosis and antimicrobial sensitivity testing;
* Supporting bio-safety and bio-security improvements within and around the laboratory and sample sharing context.
* Training staff on diagnosis and antimicrobial sensitivity testing, using laboratory equipment and undertaking AMR surveillance;
* Hardware and software to support epidemiological investigation and improved surveillance of resistance trends;
* Developing surveillance systems that are capable of delivering real time AMR surveillance that can be shared nationally, regionally and globally;
* Undertaking point prevalence studies to gain a snapshot of the AMR burden in specific areas;
* Collation and analysis of data on the sale and use of antimicrobial medicines, particularly antibiotics at a country level;
* Policy and advocacy work with national governments, using AMR data and analysis collected to make the case for evidence based public health interventions;
* Improving national capacity to regularly collate and upload data to an international data sharing platform represented by GLASS[[6]](#footnote-6), and other data sharing platforms such as the Institute of Health Metrics Evaluation (IHME) global burden of disease.
  1. National grants must be effectively embedded in national public health systems, acceptable under principles for support set out by the relevant Ministry of Health in the chosen location and integrated as part of a sustainable plan to improve laboratory capacity for bacterial diagnosis, data collection and surveillance on AMR long term. Grants should align with wider national work on achieving the International Health Regulation Core capacities[[7]](#footnote-7) and make a measureable contribution to this progress.
  2. Regional one health grants during implementation may include but are not limited to:
* Enhancing the capability of existing regional surveillance networks;
* Training and development on laboratory testing, AMR surveillance at a regional level and undertaking regional quality assurance of surveillance data;
* Delivering external quality assurance services.
* Improving regional capacity to regularly collate and upload data to an international data sharing platform represented by GLASS[[8]](#footnote-8), and other data sharing platforms such as the Institute of Health Metrics Evaluation (IHME) global burden of disease;
* Collation and analysis of data on the sale and use of antimicrobial medicines, particularly antibiotics at a regional level;
* Convening regional meetings and conferences to share skills and learning on improving laboratory capacity, data collection and surveillance of AMR in low resource settings.
* Developing MOOCs (Massive Open Online Courses) to disseminate information on AMR, infection prevention control, surveillance protocols and other relevant subject areas required to improve national, regional and international understanding.
  1. Country eligibility for receipt of grant funding will be:
* An ODA eligible country with a particular focus on the low or lower-middle income group[[9]](#footnote-9);
* Evidence of a robust National Action Plan or considerable effort towards developing this plan;
* Evidence of recognition and commitment to Fleming Fund projects by the national government. This may be a memorandum of understanding or letter of intent with the relevant Ministry of Health with details of any national engagement or resources that could be used to support the projects.

The Fleming Fund will not expect explicit country financial or in-kind buy-in to receive Fleming Fund investments but evidence of country ownership and commitment to support the Fund’s activities will be a requirement.

* 1. Between £200 and £235 million (excluding VAT) will be utilised through the selected Management Agent, profiled to rise incrementally over the five year period to reach the total budget. There may also be a possibility of absorbing additional budget into the Fund from other donors to further increase the capacity of the programme.
  2. Funding by region

DH will not prescribe the exact split of funding across the two key regions, but will rather look to country and regional capability assessments carried out by the Management Agent during the design of the implementation phase to dictate the number of countries selected between the two regions and the absorptive capacity for funding of each of these countries to make up the total regional budget available. At a minimum, it is expected that a single region would receive 30% of the total budget for country and regional projects.

* 1. Funding by country

DH will not prescribe how many grants can be agreed in each country, but where multiple grants are agreed in a country there is an expectation that they will link together or align, and this may need to be supported through the Management Agent coordination function. During the design of the implementation phase, DH will decide with the Management Agent whether the amount of funding per country will be allocated in advance of a call for funding, and the number of grants will depend on the amount of projects that can be funded under this budget; or rather if the budget allocated per country will depend on the total budget of the accepted grants.

* 1. During implementation, the Management Agent is expected to manage the portfolio of country and regional grants.
  2. The Fleming Fund will initially run for a five year period from 2016/2017. Individual grants under the Fleming Fund would normally be expected to run for between two to three and a half years. The independent evaluation carried out by the Evaluation Supplier, which is the subject of this procurement, will evaluate how far the outputs of the portfolio of country and regional grants will contribute, or have contributed, to the outcomes and impact defined within the agreed Fleming Fund Theory of Change (see Annex B), while suggesting areas for course correction and improvement throughout the programme lifecycle. This will help to inform any decision by the UK government to extend funding beyond the initial five year period. Additional funding from other partners or host governments may be considered.
  3. Work Stream 2 – Fleming Fellows (Management Agent): The Fleming Fellowship scheme will be a network of practitioners from different disciplines and sectors such as laboratory technicians, clinicians, policy makers, community leaders, hospital managers and more. The network will focus on professional development facilitating the cross-pollination of ideas and experience, peer to peer learning, and finding creative solutions as part of a multi-disciplinary network to tackle AMR in LMICs. The scheme would facilitate the kind of cross-pollination of experience and ideas that cannot be delivered on a course or through academic programmes. Our offer to Fellows can include:
* Mentoring - Fleming Fellows will be allocated a regional mentor who is an expert in their field and could offer support and advice for tackling AMR in their specific context;
* Secondments - With agreement from their home institutions, Fellows could be offered the opportunity to spend 3 months on placement being given formal training on their subject matter e.g. for laboratory technicians spending time at a high quality laboratory in their region to gain experience and bringing back learning to their host country of standards and processes used;
* Training - Fellows will be offered written and verbal communication training to present their findings and support them as key influencers in their fields;
* Support for travel - Fellows would be alerted to learning opportunities in their region around infectious disease and drug-resistant infections and given travel and subsistence funding to make the most of these opportunities;
* Networks - Fellows will be linked into a network of other Fellows and Friends of the Fleming Fund working on drug-resistance and brought together annually to share their learning and experiences at a regional conference;
* Collaborative projects - Fellows would commit a set period of time within their one or two year fellowship to join together with other Fellows to undertake scoping work, link with in-country Fleming Fund projects, travel to regional or other country projects, share experiences and bring local challenges to the network to find creative solutions as a group;
* Other initiatives - Small amounts of funding would be available to support Fleming Fellows projects or initiatives/solutions devised as a group.

The Management Agent will be expected to design this Fellowship scheme during inception phase and launch during implementation. Fellows may choose to bid for country funding or may be identified out of developed relationships with country grantees. Conflict of interest must be monitored by the Management Agent closely, but Fellows will be identified for their unique influence on country AMR laboratory and surveillance systems which could be an asset to the portfolio of country and regional grants. Fellowships will be piloted initially in a small number of countries.

* 1. To support the portfolio of country and regional projects, additional activities will be commissioned through the Fleming Fund. These three work streams are detailed below.
  2. **Work Stream 3 – Grants to multilateral organisations (DH):** An essential part of delivering the ambition of the Fleming Fund is to ensure there is support for international AMR surveillance and alignment of activities at the international level. WHO, FAO and OIE have a central role in providing global leadership not only within each of their sectors, but also through their tripartite collaboration in promoting the one health approach. Going forward, the expectation is that the three organisations continue to work together to drive forward the international work on data and surveillance and directly linked to this, for them to be supported in providing additional support to LMICs in developing, agreeing and implementing National Action Plans.
  3. It is intended that grants be agreed for the first three years of the Fleming Fund aimed predominantly at supporting LMIC development. The Management Agent will be provided with the outputs of these activities, planned activities and key contacts to ensure alignment of international and country/regional level activities. The management and disbursement of funds to these organisations will remain with DH.
  4. **Work Stream 4 – Surveillance protocol and platform (DH):** DH is commissioning the writing of a set of tiered protocols for initiating AMR surveillance in low resource settings. This will build on the recently published WHO manual for early implementation of a Global Antimicrobial resistance Surveillance System (GLASS).
  5. The aim of the work stream is to develop of a set of standard protocols for improving laboratory capacity and initiating AMR surveillance that:
* Are suitable for use by low income countries, recognising the context of different health systems;
* Are based on an assessment of available evidence and review of established protocols in comparable resource settings;
* Provide a basis for early collection and analysis of data on AMR that will help countries to rapidly assess the impact of AMR and participate in global and regional surveillance (GLASS);
* Take into account the need for epidemiological and statistical validity and quality assurance, so that the data can be used, shared and combined (multicentre and multinational analysis) to provide evidence of prevalence of AMR and effectiveness of interventions with confidence;
* Is structured as a set of tiered options so that countries can select the types of surveillance, samples and scale of operation to suit their circumstances, with the ability to expand and broaden the scope of surveillance with time;
* Can be used as a basis for supporting the development of National Action Plans, and assessing applications to the Fleming Fund.
* Provide a roadmap for how to improve laboratory capacity, data collection and surveillance for AMR with an effective one health approach.
  1. It is anticipated that the above set of protocols will be completed by the time the Management Agent and Evaluation Supplier have been selected.
  2. The protocols will then be tested with experts and will be available for piloting by the Management Agent supplier during the inception phase. Fleming Fund country and regional projects will need to demonstrate how they contribute to and improve the use of these surveillance protocols.
  3. The Fleming Fund will require all grants to share data on an international platform represented by GLASS and will provide financial support to ensure these platforms are fit for purpose.
  4. In addition to sharing data through GLASS, the Fleming Fund will expect partners to share data on other international platforms such as the Institute of Health Metrics Evaluation (IHME) global burden of disease.
  5. **Work stream 5 – Independent Evaluation (Delivered by the Independent Evaluation Supplier):** A core principle of the Fleming Fund is a robust and independent evaluation, which is being commissioned to run alongside and evaluate the portfolio of country and regional projects. This evaluation will be carried out by an Evaluation Supplier procured by DH and is the subject of this procurement exercise. The selected Evaluation Supplier will be expected to work alongside the Management Agent to design a monitoring strategy that can feed information into the evaluation.
  6. DH aims to award a contract to both the Independent Evaluation Supplier and Fleming Fund Management Agent at around the same time, at which point both organisations will commence their inception phase which is expected to last eight months.
  7. The Fleming Fund has been designed so that, in having the Evaluation Supplier and Management Agent working together closely during the inception phase, evaluation considerations are ‘embedded’ in the programmes across the project cycle. This means clear assessments of the evidence for what does or doesn’t work in the initial stages of programme design, analysis of baseline data and effective evaluation over the life of the programme and beyond. It is key, however, that the Evaluation Supplier retains independence in order to deliver their independent Evaluation of the programme as delivered by the Management Agent to ensure a balanced, accurate and unbiased Evaluation.
  8. The Evaluation Supplier will evaluate how far the *outputs* of the portfolio of country and regional grants will contribute to the *outcomes* and *impact* defined within the agreed Fleming Fund Theory of Change (see Annex B). It is understood that this analysis would be indicative, due to the amount of external variables which could affect the desired Fleming Fund impact as stated.
  9. The formative aspect of the evaluation will indicatively answer the evaluation questions agreed during the Inception Phase, and produce recommendations to guide the portfolio of country and regional grants in how their outputs can best achieve and contribute to the outcomes and impact of the Fleming Fund. The formative report will be a key opportunity for any course correction suggestions.
  10. The summative aspect of the evaluation will answer the evaluation questions agreed during the Inception Phase and evaluate how far the outputs of the portfolio of country and regional grants have contributed, or will contribute, to the outcomes and impact of the overarching Fleming Fund.
  11. The evaluation questions, (see ‘Proposed Evaluation Questions’ at 5.4 below, and ‘Indicative Evaluation Sub-Questions’ at Annex D) will be used to evaluate the overall impact of the Fund at agreed intervals.

1. **Programme Approach and Governance**

**Programme approach**

## For details on Technical Support and Guidance, see Annex G

**Collaboration and partnership with Department of Health**

* 1. The Department of Health is dedicated to ensuring a close and collaborative working relationship is developed with the Evaluation Supplier and Management Agent. A key focus of evaluating Evaluation Supplier and Management Agent bids will be to assess the strength of proposals for working with DH in both the inception and implementation phases.
  2. DH has one dedicated FTE acting as lead for country and regional project delivery for the Fleming Fund, who will work closely with the selected Management Agent, and one dedicated FTE policy and programme adviser who will act as the point person dedicated to delivering the evaluation. This lead will be the main DH focal point for the selected Evaluation Supplier; however additional support is available from an AMR expert consultant working with the department and further policy support within the Global Health Security Team.
  3. Consultation time with the programme SRO and access to the Chief Medical Officer will be coordinated through the Fleming Fund country lead. There will be considerable scope for regular discussions, particularly while shaping and designing the portfolio of country and regional grants.

**Governance**

Red lines indicate accountability chains and blue lines indicate a working relationship.

* 1. **Governance during inception phase- Fig. 2.** - the inception stage of the programme assumes regular collaboration between the DH Fleming Fund Project Team, the Evaluation Supplier and the Management Agent, as well as other key grantees such as the WHO. The following represents the governance of the inception phase.

**DH Ministers**

**C. Cross Whitehall Alignment and Assurance Group for the Ross Fund**

**Fleming Fund Project Team**

**Management Agent**

**Evaluation Supplier**

**A. DH Seniors**

**D. Technical Advisory Group**

**B: Global Health Security Programme Board**

**A:** During inception phase - proposals, decisions and approaches will be discussed and approved by this group of DH seniors including the Senior Reporting Officer for the Global Health Security portfolio.

**B:** The Fleming Fund is part of the DH portfolio of work on Global Health Security. This work is regularly reviewed and governed by a Global Health Security Programme Board chaired by the DH Senior Reporting Officer for the funds. The Project Team will report progress on the Fleming Fund design into this group.

**C:** The Fleming Fund is part of the broader Ross Fund as a joint initiative between DH and DFID as announced in the 2015 government spending review. To ensure all activities across Whitehall are aligned and on track, a cross-Whitehall group will meet to review and discuss interdependencies between projects and give assurance to ministers that planned activities are on track.

**D:** The Technical Advisory Group will be a small group of multidisciplinary experts that DH, the Management Agent or the Evaluation Supplier are able to call on during either the inception or implementation phases to advise, input or quality assure elements of the wider Fleming Fund.

* 1. **Governance during the implementation phase- Fig.3. -** the implementation phase of the programme will devolve much of the day to day management decisions to the Management Agent with approvals being taken and decisions reviewed where necessary by a Steering Committee. The Steering Committee will be a high level group including representatives from the key programme areas.

**E. Fleming Fund Steering Committee**

**Management Agent**

**Evaluation Supplier**

**F. Country and Regional Grantees**

**Department of Health Project Team**

**Technical Advisory Group**

**Cross Whitehall Alignment and Assurance Group for the Ross Fund**

**DH Global Health Security Programme Board**

**E:** When fully operational, the Fleming Fund portfolio of country and regional grants will be governed by a Steering Committee. Representation on this committee will include, but not be limited to, senior members of DH, DFID, the Management Agent and the Evaluation Supplier, and it may also include independent experts. This group will likely meet to review and approve key documents including the funding call specification, proposed grantees, annual reports, results and recommendations from the independent evaluation. This group will have the opportunity to provide strategic challenge and will be charged with using their remit of challenge and approval to keep the programme working towards the desired impact in the most effective and efficient way. The terms of reference for this group will be defined between the Management Agent, the Evaluation Supplier and DH during the inception phase. Although day to day management for the Fund will be devolved to DH, the Management Agent and the Evaluation Supplier respectively, all elements of the Fund will be accountable to this group.

**F:** Country and regional grant holders will be accountable directly to the Management Agent on financial and delivery related matters. Devolved responsibility for decision making, monitoring, risk, and management with these suppliers rests with the Management Agent. If required, an issue can be escalated to either the DH Project Team informally or formally to the Fleming Fund Steering Committee.

**Specific Governance for the Evaluation Supplier**

* 1. The Evaluation Supplier and Management Agent are viewed as equal independencies, both of whom will report through the Governance structures outlined above. To ensure independence of the Evaluation Supplier through the inception phase, the Evaluation Supplier will have an advisory and consultancy role whilst working collaboratively with the Management Agent in designing the monitoring strategy of the Fund, but ultimate accountability for the strategy put in place will rest with the Management Agent. Furthermore, if required, conflict of interest can be declared at any time.
  2. During implementation, the Management Agent will answer to the Steering Committee if they are not collecting the data based on the best advice provided by the Evaluation Supplier.

1. **Scope and Deliverables of the Fleming Fund Evaluation** 
   1. The ultimate desired impact of the Fleming Fund Theory of Change is reduced morbidity and mortality associated with AMR. The Evaluation Supplier will evaluate how far the *outputs* of the portfolio of country and regional grants will contribute to the *outcomes* and *impact* defined within the agreed Fleming Fund Theory of Change (see Annex B). It is understood that this analysis would be indicative, due to the amount of external variables which could affect the desired Fleming Fund impact as stated.
   2. The formative aspect of the evaluation will indicatively answer the evaluation questions agreed during the Inception Phase, and produce recommendations to guide the portfolio of country and regional grants in how their outputs can best achieve and contribute to the outcomes and impact of the Fleming Fund. The formative report will be a key opportunity for any course correction suggestions.
   3. The summative aspect of the evaluation will answer the evaluation questions agreed during the Inception Phase and evaluate how far the outputs of the portfolio of country and regional grants have contributed, or will contribute, to the outcomes and impact of the overarching Fleming Fund.

**Proposed evaluation questions**

* 1. The following are the minimum proposed evaluation questions to be answered by the successful Evaluation Supplier as part of the provision of the Services:

1. How relevant are the Fleming Fund investments to influencing data use within the country context? (OECD DAC Criteria – Relevance)
2. What is the effect of a common protocol(s) to collect AMR data on programme implementation and results? (OECD DAC Criteria – Efficiency)
3. To what extent has the AMR data collected been used to support national level policy and regulation of antimicrobials? (OECD DAC Criteria – Effectiveness)
4. To what extent has the AMR data collected impacted on clinical and social practice surrounding antimicrobials? (OECD DAC Criteria – Effectiveness)
5. To what extent has the AMR data collected been used on an international level to inform relevant agenda? (OECD DAC Criteria – Effectiveness)
6. How successfully has the Fleming Fund aligned with other international work on AMR? (OECD DAC Criteria – Efficiency)
   1. Indicative sub-questions for the evaluation are presented in Annex D. The successful Bidder will be expected to develop and refine these questions during the inception phase.
   2. DH welcomes advice on any other products which may be of value when evaluating the Fleming Fund projects and the programme as a whole. Bidders are encouraged to include any suggestions in their proposals.
   3. DH would welcome any suggestions around how counterfactual or quasi-experimental designs could be built into the evaluation process linked to improvements in AMR data collection processes.

**Evaluation Supplier Deliverables**

* 1. The expected deliverables for the Evaluation Supplier are detailed below.
  2. **Inception Phase**

The selected Evaluation Supplier will be required to achieve, at a minimum, the following deliverables during the inception phase.

|  |  |  |
| --- | --- | --- |
|  | **Inception Phase Milestone/Deliverable** | **Expected activities and deliverables** |
| 1 | An approved joint strategy between the Evaluation Supplier and the Management Agent | The Evaluation Supplier is expected to agree a draft protocol for ways of working with the Management Agent including proposed meetings and workshops inviting the Authority.  The Evaluation Supplier is expected to agree with the Management Agent a draft monitoring and evaluation framework for the portfolio of country and regional grants, containing at a minimum the following:   * Key data collection points; * A detailed description of the focus for analysis and the outputs to be analysed throughout evaluation);and * A monitoring and evaluation framework for the portfolio of country and regional grants. |
| 2 | An approved refined Theory of Change | The independent Evaluation Supplier will collaborate with the Authority and with the appointed Management Agent to refine the theory of change set out in Annex B of the Specification.  The theory of change document will be submitted to DH for approval. |
| 3 | An approved evaluation approach/ methodology | The Evaluation Supplier will be required to work  collaboratively with DH and with the appointed Management Agent during the inception phase in order to create a detailed methodology for the evaluation  This work will include discussions and decisions about what data and information will need to be collected regularly by the Management Agent in order to feed the analysis needed for the evaluation questions. This, in turn, will help to shape and feed into the monitoring strategy.  The Evaluation Supplier will refine, expand and revise the evaluation questions laid out at paragraph 5.4 of the Specification. The Evaluation Supplier will refine, expand and revise the indicative evaluation sub questions laid out at Annex D of the Specification.  It is expected that the evaluation implementation and reporting will comply with the OECD-DAC quality standards for development evaluation  The methodology submitted to DH for approval will include, but is not limited to:   * The final evaluation questions and sub-questions; * Key data collection points * A detailed description of the focus for analysis and the outputs to be analysed throughout evaluation * A detailed evaluation approach (including a framework of collaborative typologies and levels to be used in the mapping and sample selection) |
| 4 | Regular reporting   * Quarterly * Continued collaboration with the Authority Representative / appointed Contract Manager | Regular reporting will be in the form of an activity update to DH submitted on a quarterly basis, either through a document, presentation with PowerPoint summary or a face-to-face meeting. This opportunity will allow the Evaluation Supplier to provide evidence of working against the agreed activities as well as a chance to share lessons learnt.  DH will require interim reporting throughout the life of the contract to ensure progress and the financial status of the evaluation is monitored as being within planned funding / budget, as well as ensuring continued learning from the analysis throughout the programme. |
| 5 | An approved Implementation Plan | The Evaluation Supplier will be expected to conduct workshops with the Management Agent and with grantees from the pilot schemes to gather learning and help to ensure learning from these projects informs the Implementation Plan.  The Independent Evaluation Supplier will be expected to support and work with the Management Agent to design and draft the Implementation Plan for the Fleming Fund. This early involvement of the Evaluation Supplier is intended to ensure that evaluation considerations are embedded within the Implementation Plan. It is expected that the evaluation implementation and reporting will comply with the OECD-DAC quality standards for development evaluation.  The Evaluation Supplier will hold regular meetings with the Authority and Management Agent to discuss requirements and progress of the draft Implementation Plan. The format of the meetings will be agreed between the parties.  The Evaluation Supplier will collaborate with the Authority and Management Agent to identify data collection required to answer the evaluation questions developed and approved in accordance with Milestone/Deliverable 3.  The Evaluation Supplier will work with the Management Agent to provide a draft Implementation Plan, to be submitted by the Management Agent to the Authority by a date to be agreed.  The draft Implementation Plan must contain, but is not limited to:  A detailed methodology for data collection, analysis and regular reporting including proposals for verifying the baseline information for each project granted funding by the Management Agent;  A detailed work plan outlining timeframe, details of the final project time, defined output payments and a detailed financial plan for the implementation phase. The financial plan must draw on the pricing structures provided by the Evaluation Supplier within the tendered rate cards , and be accompanied by narrative explanation and reasoning for any planned costs exceeding the average price given within those rate cards. Any costs exceeding the maximum price given within those rate cards will require the Authority’s prior written approval before the costs can be incurred.  The evaluation methodology, questions and sub questions Approved in accordance with Milestone/Deliverable 3;  Any learning gathered from the workshops conducted in relation to the pilot schemes;  A proposed approach for working with grantees and other key stakeholders throughout the life of the contract  Proposals for detailing the Service Levels in Annex 1 to Part A of Schedule 6 (Service Levels and Performance Monitoring);  Proposals for Delay Payments for Part A of Schedule 4 (Inception Plan) and Annex 1 of Schedule 2 (Implementation Plan)   * 1. Proposals for the capability building activities to be undertaken with grantees in understanding the Monitoring and Evaluation (MandE) and the theory of change laid out in Annex B of the Specification and   Proposals to ensure compliance with the quality standards referred to in paragraph 5.13 of the Specification, or equivalent quality standards;  A detailed business continuity and disaster recovery plan  Proposals for the provision of a mid-point review report which answers the evaluation questions indicatively and supplies formative recommendations for the remainder of the Fleming Fund;  Proposals for the provision of a final summative evaluation report that answers the evaluation questions agreed in accordance with Milestone/Deliverable 3 |

* 1. **Implementation Phase**

Specific objectives and Deliverables for the implementation phase will be developed in consultation between the Evaluation Supplier and DH during the inception stage of the Contract. The Evaluation Supplier will be held financially accountable for the agreed outputs and should show effective progress towards these targets through the lifetime of the programme.

Although specific objectives, Deliverables and Milestones will be defined in consultation with DH during inception phase, the table indicates the minimum expected Deliverables.

|  |  |  |
| --- | --- | --- |
|  | **Implementation Phase Milestone/Deliverable** | **Expected activities and minimum Deliverables** |
| 1 | Regular reporting   * Quarterly * Continued collaboration with the Authority Representative / appointed Contract Manager | Regular reporting will be in the form of an activity update to DH submitted on a quarterly basis, either through a document, presentation with PowerPoint summary or a face-to-face meeting. This opportunity will allow the Evaluation Supplier to provide evidence of working against the agreed activities as well as a chance to share lessons learnt.  DH will require interim reporting throughout the life of the contract to ensure progress and the financial status of the evaluation is monitored as being within planned funding / budget, as well as ensuring continued learning from the analysis throughout the programme. |
| 2 | Continued collaboration, data analysis and provision of recommendations for course correction with the Management Agent | The Evaluation Supplier will gather data from the Management Agent and undertake analysis during the programme’s implementation period.  Country and regional grants under the Fleming Fund may start at different times, will be at different stages of implementation, and will have had different levels of engagement with the linked scientific and clinical institutions (such as local hospitals and universities). The Evaluation Supplier will be required to take account of this in its approach and analysis.  The Evaluation Supplier will be expected to verify the baseline information for each project granted funding, completed by the Management Agent.  Any formative recommendations would be made through the reporting mechanism built into the programme structure which will be finalised during the inception phase. |
| 3 | Strong stakeholder collaboration and support to grantees | DH will encourage strong collaboration between key stakeholders throughout the evaluation period. This will include national and international policy makers. The Management Agent is expected to complete advocacy work with national governments, and so will be able to provide entry points to national government officials where necessary for the purposes of evaluating the programme. DH is managing the relationship with multilaterals such as WHO, FAO and OIE and therefore will be able to provide entry points and contacts within such organisations.  The Evaluation Supplier will be expected to provide workshops with grantees in order to support understanding of Monitoring and Evaluation and the theory of change (see Annex B for Theory of Change). |
| 4 | Formative report | The Independent Evaluation Supplier will be expected to complete and submit for approval a mid-point review of the programme, indicatively answering the evaluation questions agreed during the Inception Phase, and producing recommendations to guide the portfolio of country and regional grants in how their outputs can best achieve and contribute to the outcomes and impact of the Fleming Fund. The formative report will be a key opportunity for any course correction suggestions  It is expected that the evaluation implementation and reporting will comply with the OECD-DAC quality standards for development evaluation.  Generally, the Evaluation Supplier should seek to   * Support grantees at appropriate points during the life of the Fund, supporting an adaptive approach to implementation that is able to continually improve the quality of the programme and help to achieve the stated outcomes of each project; * If possible, analyse how effectively the application of the standard surveillance protocols is working across the portfolio of country and regional projects and contributing to the collection and sharing of global surveillance data through the WHO Global AMR Surveillance System (GLASS). * Evaluate how far the outputs of Fleming Fund portfolio of country and regional grants have contributed/are contributing to the outcomes and impact of the Fleming Fund Theory of Change.   The formative aspect of the evaluation will encourage the grantees to provide honest reflections on their achievements and challenges and be open to recommendations from the Evaluation Supplier that aim towards continual improvement for the portfolio of grants. It will also encourage grantees, as well as the Management Agent and DH, to see how each project fits with the overarching aim of the Fund and ensure the outcomes of each project are aligned and relevant to achieving the outcomes and impact of the Fleming Fund as a whole.  Formative recommendations would be made through the reporting mechanism built into the programme structure which will be finalised during the inception phase.  DH is keen to ensure that the evaluation results in learning for:   * DH; * Country and regional grantees during the life of the Fleming Fund; * Ministries of Health, Agriculture and Finance in Fleming Fund investment countries; * AMR policy community more broadly, including Ministries of Health, Agriculture and Finance in countries broader than the Fleming Fund investment countries; * AMR scientific community; * Multilateral organisations, such as the World Health Organization (WHO), Food and Agriculture Organisation (FAO) and the World Organisation for Animal Health (OIE) and their respective member states. |
| 5 | Summative final report | The Evaluation Supplier is expected to complete and submit for approval an evaluation report at the agreed time within the Implementation Plan, answering the evaluation questions agreed during the Inception Phase and evaluating how far the outputs of the portfolio of country and regional grants have contributed, or will contribute, to the outcomes and impact of the overarching Fleming Fund.  It is expected that the evaluation implementation and reporting will comply with the OECD-DAC quality standards for development evaluation.  The summative aspect of the evaluation will, at a minimum,   * Answer the agreed evaluation questions and sub-questions identified during the inception phase * Discuss how far portfolio outputs contributed to the desired outcomes and impact of the Fleming Fund. It is understood that this analysis would be indicative, due to the amount of external variables which will impact the level of mortality and morbidity due to AMR. * Analyse how effectively the application of the standard surveillance protocols have worked across the projects and contributed to the collection and sharing of global surveillance data through the WHO Global AMR Surveillance System (GLASS). * Identify which funded approaches/projects have been the most effective in delivering the desired outcomes and impact.   DH is keen to ensure that the evaluation results in learning for:   * DH; * Country and regional grantees during the life of the Fleming Fund; * Ministries of Health, Agriculture and Finance in Fleming Fund investment countries; * AMR policy community more broadly, including Ministries of Health, Agriculture and Finance in countries broader than the Fleming Fund investment countries; * AMR scientific community; * Multilateral organisations, such as the World Health Organization (WHO), Food and Agriculture Organisation (FAO) and the World Organisation for Animal Health (OIE) and their respective member states. |
| 6 | Evidence briefs of key thematic lessons. | An evidence brief is designed to provide an overview of the key evidence included in a systematic review/evaluation, to assist policy-makers and researchers in assessing the evidence in the field being researched. It summarises key findings, and provides links and references to the included studies.  DH is keen to ensure that the evaluation results in learning for:   * DH; * Country and regional grantees during the life of the Fleming Fund; * Ministries of Health, Agriculture and Finance in Fleming Fund investment countries; * AMR policy community more broadly, including Ministries of Health, Agriculture and Finance in countries broader than the Fleming Fund investment countries; * AMR scientific community; * Multilateral organisations, such as the World Health Organization (WHO), Food and Agriculture Organisation (FAO) and the World Organisation for Animal Health (OIE) and their respective member states. |

**Available Data**

* 1. It is anticipated that the Evaluation Supplier would join the project during inception phase and would help to shape the data collected by the programme in order to best answer the proposed evaluation questions. Below are the resources available to the selected Bidder:
* Scoping reports commissioned by DH to the Wellcome Trust on: an analysis of approaches to laboratory capacity strengthening; networks and education resources supporting drug resistant infection surveillance; and an analysis of the human/animal interface with a focus on LMICs;
* Individual project start up forms (showing project outcomes and indicators, many of which involve a specific outcome on learning and collaboration);
* Project baseline information;
* The bidding institutions supporting documents, such as operational reports;
* Any existing quantitative and qualitative data already being collected by projects’ own monitoring and evaluation systems (although it is important, as with the general approach taken throughout the evaluation, that this is approached in a manner that is sensitive to grantees’ capacities and avoids overburdening grantees). The quality of the data available is likely to be variable.
  1. Also available to the Evaluation Supplier throughout the programme will be:
* Annual project reports submitted by grantees to Management Agent (including progress against each project outcome indicators);
* Annual reports from the Management Agent to DH.

**Quality Standards**

* 1. It is expected that the evaluation implementation and reporting will comply with the OECD-DAC quality standards for development evaluation.[[10]](#footnote-10)
  2. Bidders are expected to outline an appropriate quality assurance process for the evaluation implementation and outputs, and the ethical guidelines they will follow in carrying out the evaluation in their response.
  3. The evaluation products produced by the Evaluation Supplier will also be submitted to DH and peer reviewed before being published.

1. **Contracting Phases and Management**

**Contracting Phases and Outputs**

* 1. The evaluation will follow three distinct phases, with an *indicative* schedule as follows.

**Figure 4: Indicative evaluation phases and schedule**

| **Period of Activity** | **Timeline** | **Activities and Outputs** |
| --- | --- | --- |
| **Inception phase (8 months)** | Autumn 2016 – Spring 2017 | See table of deliverables and activities above, at 5.9 |
| **Implementation –**  **Data analysis mid-programme** | Spring 2017 – Autumn 2019 | See table of deliverables and activities above, at 5.10 |
| **Implementation –**  **Data analysis and final reporting** | Autumn 2019 – Autumn 2021 | See table of deliverables and activities above, at 5.10 |

**Contract Period**

* 1. DH intend to award one single contract to the successful bidder for the five year funding period to cover both inception and implementation phase. The contract will include a break clause after:
* 8 months, at the end of the inception period;
* 3 years.
  1. Ahead of the break point at the end of the inception phase, DH will review the Evaluation Supplier deliverables and Implementation Plan. At this point a final set of objectives and deliverables will be agreed and payment schedule suggested. Subject to strong performance by the supplier during the inception phase, and on basis that DH has fully accepted all proposals, work-plans and budgets for the implementation period, DH will proceed to the implementation phase.
  2. If there is ongoing need and further funding is available beyond the original five year period DH may seek to extend this contract by any period up to a further five years. This would only be considered if it makes sense from a Value for Money perspective, and further break points would be included.

**Payment by Results**

* 1. DH is committed to ensuring value for money through the commissioning of the Evaluation Supplier contract. DH will look to agree an output or milestone based payment model, recognising the need to release payments for both the evaluation outputs and key activities. Bidders must propose a detailed output/milestone based payment schedule for the Inception phase of the contract within Pricing Schedule Two.

**Resources available to the Evaluation Supplier**

* 1. DH and the Management Agent will provide support to the Evaluation Supplier in contacting and liaising with grantees, particularly at the start of the evaluation.
  2. The Evaluation Supplier is expected to supply and manage its own logistics, including for in-country visits, and to be responsible for the organisation and delivery of all events carried out under the evaluation. Multi-country evaluations can raise significant logistical and coordination challenges, and proposals will need to demonstrate that the Evaluation Supplier has sufficient management and coordination structures and processes to address these challenges.

**Duty of care**

* 1. The Evaluation Supplier will be responsible for the safety and well-being, including appropriate security arrangements for its team. The Evaluation Supplier will also be responsible for the provision of suitable security arrangements for their domestic and business properties. The Evaluation Supplier is responsible for ensuring appropriate safety and security briefings for all of its Personnel working under the Evaluation Supplier contract. Travel advice is available on the FCO website and the Evaluation Supplier must ensure that it is up to date with the latest position. Please also see Annex E and Annex F for DFID Duty of Care Assessments for Sierra Leone and Burma, which are likely to be pilot countries.[[11]](#footnote-11)
  2. Bidders must develop their proposal on the basis of having a duty of care towards, and being fully responsible for, their Personnel in line with the details provided in section 6.8 above. Bidders must confirm in the proposal that they have capability to manage their duty of care responsibilities throughout the life of the Evaluation Supplier contract. Bidders should consider the following questions in this regard:
* Have you completed an initial assessment of potential risks that demonstrates your knowledge and understanding, and are you satisfied that you understand the risk management implications?
* Have you prepared an outline plan that you consider appropriate to manage these risks at this stage and are you confident/comfortable that you can implement this effectively?
* Have you ensured or will you ensure that your Personnel (if any), are appropriately trained (including specialist training where required) before they are deployed and will you ensure that on-going training is provided where necessary?
* Have you an appropriate mechanism in place to monitor risk on a live / on-going basis?
* Have you ensured or will you ensure that your Personnel (if any) are provided with and have access to suitable equipment and will you ensure that this is reviewed and provided on an on-going basis?
* Have you appropriate systems in place to manage an emergency / incident if one arises?

**Authority Responsibilities**

* 1. Alongside the work detailed at paragraphs 4.2-4.4 above, DH and the Management Agent will provide support to the Evaluation Supplier in contacting and liaising with grantees, particularly at the start of the evaluation;
  2. DH will appoint a nominated Contract manager (the Authority Representative) to oversee the Services, in accordance with Clause 15 of the Contract terms and conditions;

**Supplier Responsibilities**

* 1. The Supplier shall
* Appoint a Contract manager (Supplier Representative) in accordance with Clause 15 of the Contract terms and conditions to oversee the work and liaise with / report as DH requires to DH’s Authority Representative;
* The Evaluation Supplier is expected to supply and manage its own logistics, including for in-country visits, and to be responsible for the organisation, logistics and delivery of all events carried out under the evaluation (which should be included in the Charges submitted as part of the bidder’s proposal). Multi-country evaluations can raise significant logistical and coordination challenges, and bidder’s proposals will need to demonstrate that the evaluation team has sufficient management and coordination structures and processes to address these challenges.
* Monitor the quality of the Service provision to ensure customer satisfaction in accordance with the key performance indicators outlined in the Contract (Schedule 6: Service Levels and Performance Monitoring), unless otherwise approved by the Authority Representative;
* Provide regular reporting as and when required by the Authority Representative. This will be in the form of, at a minimum, a quarterly activity and financial update to DH either through a document, presentation or a face-to-face meeting. This opportunity will allow the Evaluation Supplier to provide evidence of working against the agreed activities detailed in the inception report as well as being a continuing opportunity to provide lessons learnt.
* Provide updates on costs to be incurred under the Contract on a quarterly basis
* Attend meetings on site by phone or by video conference to review progress and discuss the Service, as required by the Authority Representative;
* Attend a post Contract review with DH to discuss the Evaluation Supplier’s final evaluation report, and review whether the objectives of the Contract were met, to review the benefits achieved and to identify any lessons learnt for future projects.
* DH has a zero tolerance approach to corruption. Although the appointed Management Agent will have full responsibility for monitoring and mitigating the risk of fraud and corruption in the procurement and delivery of country and regional grants, the Evaluation Supplier will be expected to report any suspected corruption to the Authority Representative.

**Annex A: Background**

*The scale of the problem*

Improvements in global health over recent decades are under threat because pathogens that cause many common human diseases and medical conditions have become resistant to a wide range of antimicrobial medicines. Resistance to all antimicrobials, including antivirals and antifungals, is increasing, but of greatest concern is the rapid development of bacterial resistance to antibiotics. If the number of hard-to-treat infections continues to grow, then it will become increasingly difficult to control infection in a range of routine medical care settings. Furthermore it will be more difficult to maintain animal health and protect animal welfare.

The direct consequences of infection from resistant bacterial can be severe, including longer illnesses, and increased mortality. Doctors must increasingly use “last-resort” medicines that are more costly, may have more side effects and are often unavailable or unaffordable in low- and middle-income countries. The loss of effective antibiotics in particular compromises many other areas of health and medicine; with increased risk of prolonged illness or death from a failure to treat or prevent infection arising from surgery or childbirth for example. AMR affects all areas of health, involves many sectors and has an impact on the whole of society.

AMR also has an additional impact in low resource settings where access to quality assured, safe, effective and affordable medicines is already a challenge. Good quality data on antibiotic use, and prevalence of AMR, are crucial for development of health policies and programmes to preserving the effectiveness of existing antibiotics, and provide the arguments for affordable access to “last resort” and to new antibiotics and other antimicrobial medicines

*The impact of AMR in low and middle income countries*

There is a growing expectation that the increase of antibiotic consumption in LMICs will continue to rise markedly going forward (Grundmann et al, 2011), associated with:

Rising incomes correlated with rising consumption of antimicrobials;

Changing patterns of health-seeking behaviour post HIV/AIDS pandemic with a greater demand for antimicrobials;

Civil unrest, food shortages and natural disasters in some regions forcing people into crowded, unsanitary conditions conducive to the spread of infectious disease;

Expansion of the generics industry in LMICs, leading to greater supply of cheap antimicrobial;

Shortfalls in hospital hygiene procedures increasing the likelihood of contracting an infection.

With increased consumption of antibiotics in LMICs, it is important to understand the potential burden of antibiotic resistance in particular.

While there are often fewer data on the prevalence and burden of AMR in LMICs, and the impact is consequentially difficult to quantify, there are many factors likely to impact the scale of this problem. These include:

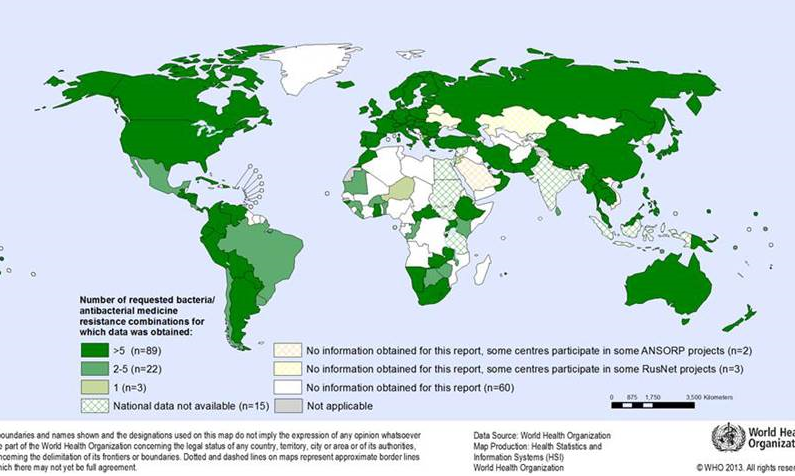
* + - The high prevalence of infectious diseases or conditions including for example tuberculosis, pneumonia, neonatal sepsis, HIV;
    - Poor access to healthcare services including to diagnostic laboratories;
    - Poor access to safe, effective, quality assured medicines including to antibiotics and other antimicrobial medicines;
    - Lack of effective regulation and supervision of the use of antimicrobial medicines in human health, animal health and agriculture.

*Surveillance of AMR*

The WHO global report on surveillance of AMR published in 2014 documented the global prevalence of AMR in humans, with high prevalence of resistance to many of the most important antimicrobial medicines in all parts of the world. Reports of infections resistant to all available antimicrobial medicines are becoming more frequent, rendering diseases such as gonorrhoea and tuberculosis potentially untreatable.

WHO’s 2014 global report on surveillance of AMR also revealed many gaps in information on AMR in pathogens that are of major public health importance. The report identified a lack of agreed and harmonized methodologies for collecting resistance data, particularly across medical, veterinary and agricultural sectors.

The following map (**Figure 5**) illustrates the extent to which each country was able to contribute data to the AMR Global Report on Surveillance in 2014, and provides an indication of countries and regions with insufficient surveillance capacity for AMR.



Good surveillance data are key to national and global public health action to maintain the effectiveness of antimicrobial medicines. Such data are important at many levels of health care:

* At the local level, laboratory microbiology and antimicrobial susceptibility testing (AST) guides patient treatment;
* Good current knowledge of the prevalence of AMR in different pathogens provides a basis for evidence based treatment guidelines, medicine procurement and formulary decisions;
* Knowledge of the prevalence of AMR nationally, regionally and globally, together with data from other sectors (animal health, agriculture, and aquaculture) and on antimicrobial medicine use (consumption, prescription) is necessary for an understanding of the factors driving such resistance. This in turn provides the evidence to support action and intervention;
* Surveillance data collected over time enables international and national actors to monitor the effectiveness of interventions and adjusted as necessary.

With the combination of increased use of antimicrobials and the anticipation that AMR would have a disproportionate effect on LMICs, surveillance of AMR in these countries is more important than ever.

*Moving towards a set of global surveillance standards*

The WHO has issued a Global Action Plan (GAP)[[12]](#footnote-12) on AMR which calls for countries to develop a national AMR surveillance system in animal and human health which at a global level would feed into the Global AMR Surveillance System (GLASS) for comparability and assessment of resistance data. GLASS would act as a forum for the rapid sharing of information on AMR to best inform necessary global and national actions.

To develop strategies for implementing a national AMR surveillance system, monitoring the effectiveness of these strategies, and feeding surveillance data into the Global AMR Surveillance System, WHO member states have been encouraged to develop National Action Plans (NAP) on AMR by 2017. Around 33 member states have NAPs to date.

Resolutions on AMR have also been adopted by the governing Council of the Food and Agriculture Organisation (FAO) and the Assembly of Delegates to the World Organisation for Animal Health (OIE). Both FAO and OIE resolutions call for improvements to surveillance, cross-refer to the GAP delivery and reinforce the one health approach. Together these reflect a growing commitment from world governments to address AMR, and recognition of the need to work across human health, animal health and agriculture.

WHO published a manual for early implementation of a Global Antimicrobial Surveillance System (GLASS, 2015)[[13]](#footnote-13) which sets out the framework for collection and sharing of resistance data, but many countries will need technical and financial support to develop their own diagnosis surveillance capacity.

Many LMICs are unlikely to have the resources or capacity to implement all the components of AMR surveillance as set out in the WHO GLASS manual for early implementation. To ensure all countries are able to work towards the global set of AMR surveillance standards set out in the GLASS manual, we must ensure that these targets can be translated into practical and achievable activities for countries with lower capacities. The UK supports the production of a tiered (step wise) set of protocols to help all countries progress towards improved AMR surveillance targets.

**Annex B: Theory of Change**

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Support at regional level

Capacity building

In-Country Support

Data shared

in-country

Data used domestically to drive regulation, and impact on clinical and social practice

Control on AM use in LMICs, both human and livestock

Rational AM use in developing countries

Data collected

Data shared internationally

Data used internationally to inform the relevant agendas by monitoring trends and develop the evidence base

Global advice and policy; clear international standards agreed by WHO, FAO and OIE

Mortality and morbidity due to AMR minimised

Ongoing surveillance

Global willingness to tackle in-country budgetary health system constraints

Global awareness

**Annex C: Principles of Fleming Fund priority countries**

The following principles should be used as a guideline to the country and regional selection determining where projects can be located, and therefore to which countries a call for funding will be carried out.

Key criteria which all priority countries need to meet:

* Official Development Assistance (ODA) eligible, in order that the country can receive the funds
* Located in Sub-Saharan Africa, Southern or South Eastern Asia
* Fragile states will be considered, however conflict countries[[14]](#footnote-14) will not be considered

A broad number of countries will be considered. Funding will be granted across a three tiered system:

* Less than £1 million
* Up to £5 million
* Over £5 million

DH is looking to work in around 20 countries in the first call to funding.

Countries applying for funding must follow the below principles in order for a bid to be considered. These are:

1. ***Fit with Strategic vision of the Fleming Fund***

The aim of the Fleming Fund is to improve laboratory capacity and diagnosis as well as data and surveillance of AMR in LMICs through a one health approach: building capacity to collect drug resistance data; enabling the sharing of drug resistance data locally, regionally and internationally; collating data on AMR; and encouraging the application of these data to promote the rational use of antimicrobials. Therefore there needs to be evidence that the country is not collecting and sharing quality data on AMR because it does not have adequate facilities and/or the correct technical personnel to complete this work. Furthermore, there also needs to be evidence that there is a will to share quality data once gathered, both domestically and internationally.

***(2) Enabling Factors***

To help enable the success of the programme DH is keen to work in countries where there is an existing HMG and UK presence, such as DFID, FCO and PHE. This does not mean that DH will not work where there is not a significant HMG footprint, but DH would need to consider carefully how a given project would be sustained.

***(3) Ensuring Alignment***

There are already a number of existing stakeholders in the global health space and DH would want to ensure alignment with these activities and avoid the risk of duplication. On this basis, DH would aspire to ensure work in-country will be aligned with other groups. This does not mean that countries where such stakeholders are not working will not be considered, but it would be expected that all grants will be made in the knowledge of activity in the country. Stakeholders to be aware of include:

* + US Government and CDC;
  + Institute Pasteur;
  + ECDC;
  + Bill and Melinda Gates Foundation;
  + Major NGOs including Medicins San Frontieres;
  + International and multilateral organisations;
  + GHSA Action Package on AMR;
  + G7;
  + WHO staff and centres supporting the Global Action Plan.

**Annex D: Indicative Evaluation Sub-Questions**

These sub-questions are indicative to help guide bidders on the specific areas that the evaluation is expected to cover. The evaluation questions and sub-questions will be finalised with the successful Evaluation Supplier during the inception phase.

|  |  |
| --- | --- |
| Main evaluation question | Indicative monitoring question |
| 1. How relevant are the Fleming Fund investments to influencing data use within the country context? | What proportion of community-level healthcare facilities were able to access data collected? |
|  |
|  |
| 1. What is the effect of a common protocol to collect AMR data on programme implementation and results? | What proportion of healthcare facilities are using standard case definitions? |
| What proportion of samples are using a common protocol when testing for AMR? |
| What proportion of samples testing positive for AMR are reported? |
| Is there routine validation/quality assurance against the data? |
| Is the common protocol detecting healthcare associated infections? |
| 1. To what extent have the AMR data collected been used to support national level policy and regulation of antimicrobials? | What national policies or regulations have been introduced to control, regulate antibiotic use or address AMR following the start of surveillance? |
| What new data have been used to inform or support these policy changes? |
| 1. To what extent have the AMR data collected impacted on clinical and social practise surrounding antimicrobials? | What proportion of diagnoses of infection have been supported with laboratory confirmation and anti-susceptibility testing? |
| What was the time taken for a test result to be reported back to a clinician/prescriber? |
| What proportion of healthcare facilities used guidelines for antibiotic prescribing? |
| What proportion of surveillance reporting was delivered on time? |
| 1. To what extent have the AMR data collected been used on an international level to inform relevant agenda? | To what extent have collected data been quality assured against the GLASS protocol? |
| To what extent have the data to GLASS standards been shared internationally? |
| Is there evidence of functional laboratory networks? |
| Is there evidence of regular intercountry meetings on AMR? |
| Is information sharing between neighbouring countries, regional and international networks routine? |
| 1. How successfully has the Fleming Fund aligned with other international work on AMR? | What proportion of Fleming Fund projects were co-funded with others? |
| What proportion of Fleming Fund supported institutions subsequently received support/funding from other agencies or foundations? |
| What proportion of Fleming Fund supported institutions are participating in international networks? |
| What evidence is there of the Fleming Fund support to multilaterals promoting the One Health approach to collaborative working? |
| How many supported and subsequent projects have been designed with other parties? |

**Annex E – Duty of Care assessment for Sierra Leone**

**Summary Risk Assessment Matrix: Sierra Leone**

**Date of assessment:** 29 January 2016

|  |  |
| --- | --- |
| **Theme** | **Risk Rating** |
| **OVERALL RATING[[15]](#footnote-15)** | **3** |
| FCO travel advice | 3 |
| Host nation travel advice | N/A |
| Transportation | 4 |
| Security | 2 |
| Civil unrest | 2 |
| Violence/crime | 3 |
| Terrorism | 2 |
| War | 1 |
| Hurricane | 1 |
| Earthquake | 1 |
| Flood | 2 |
| Medical Services | 3[[16]](#footnote-16) |

The contracted supplier will accept full liability for their employees and any sub-contractors. The supplier will arrange and include in the quote for this contract all logistical and substance costs for the duration of the work.

The supplier is responsible for their own medical clearance/checks and anti-malarial provisions and also for ensuring appropriate insurance cover, including for any evacuation required.

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.

DH 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 and ensuring that their personnel register and receive briefing as outlined above. 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.

The Supplier is responsible for ensuring that appropriate arrangements, processes and procedures are in place for their personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the contract (such as working in dangerous, fragile and hostile environments etc.).

Bidders must develop their response and tender on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix prepared by DFID. They must confirm in their response that:

* They fully accept responsibility for security and Duty of Care.
* They have made a full assessment of security requirements.
* They have the capability to provide security and Duty of Care for the duration of the contract.

If you are unwilling or unable to accept responsibility for security and Duty of Care as detailed above, your tender will be viewed as non-compliant and excluded from further evaluation.

Acceptance of responsibility must be supported with evidence of Duty of Care capability and DH reserves the right to clarify any aspect of this evidence. In providing evidence, interested suppliers should respond in line with the Duty of Care section.

The contract will include a duty of care clause. The contract will make clear that responsibility for the safety and security of supplier personnel (including sub‐contractors) rests with the supplier.

Further detailed discussion will take place during the inception phase of the contract to establish a clear process for managing risk, including duty of care throughout the programme.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Very Low risk | 2  Low risk | 3  Med risk | **4**  **High risk** | 5  Very High risk |
| **Low** | | **Medium** | **High Risk** | |

**Annex F – Duty of Care assessment for Burma**

**Summary Risk Assessment Matrix: Burma**

**Date of assessment:** December 2015

The contracted supplier will accept full liability for their employees and any sub-contractors. The supplier will arrange and include in the quote for this contract all logistical and substance costs for the duration of the work.

The supplier is responsible for their own medical clearance/checks and anti-malarial provisions and also for ensuring appropriate insurance cover, including for any evacuation required.

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.

DH 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 and ensuring that their personnel register and receive briefing as outlined above. 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.

The Supplier is responsible for ensuring that appropriate arrangements, processes and procedures are in place for their personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the contract (such as working in dangerous, fragile and hostile environments etc.).

Bidders must develop their response and tender on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix prepared by DFID. They must confirm in their response that:

* They fully accept responsibility for security and Duty of Care.
* They have made a full assessment of security requirements.
* They have the capability to provide security and Duty of Care for the duration of the contract.

If you are unwilling or unable to accept responsibility for security and Duty of Care as detailed above, your tender will be viewed as non-compliant and excluded from further evaluation.

Acceptance of responsibility must be supported with evidence of Duty of Care capability and DH reserves the right to clarify any aspect of this evidence. In providing evidence, interested suppliers should respond in line with the Duty of Care section.

The contract will include a duty of care clause. The contract will make clear that responsibility for the safety and security of supplier personnel (including sub‐contractors) rests with the supplier.

Further detailed discussion will take place during the inception phase of the contract to establish a clear process for managing risk, including duty of care throughout the programme.

|  |  |  |
| --- | --- | --- |
| **Theme** | **DFID Risk score** | **DFID Risk score** |
| OVERALL RATING[[17]](#footnote-17) | 2 | 3 |
| FCO travel advice | 1 | 3 (4 for Kachin and Northern Shan state) |
| Host nation travel advice | 1 | 3 |
| Transportation | 2 | 3 |
| Security | 1 | 2 |
| Civil unrest | 2 | 3 |
| Violence/crime | 2 | 3 |
| Terrorism | 2 | 3 |
| War | 1 (2 in parts of Shan State and South East Burma) | 3 (4 for Kachin and Northern Shan state) |
| Hurricane | 1 | 1 |
| Earthquake | 2 | 2 |
| Flood[[18]](#footnote-18) | 2 | 3 |
| Medical Services | 2 | 3 |
| **Nature of Project/**  **Intervention** | 2 | 3 |

Details of restricted areas to travel by the host country government can be found [here](http://www.mip.gov.mm/restricted-areas-for-foreigners-tourist-travelling-in-the-country/). <https://www.gov.uk/foreign-travel-advice/burma>

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1  Very Low risk | 2  Low risk | 3  Med risk | **4**  **High risk** | 5  Very High risk |
| **Low** | | **Medium** | **High Risk** | |

**Annex G**

**Initial Scoping Activities, Technical Support and Guidance, Fleming Fund Core Principles**

**Initial Scoping Activities**

* Ahead of commissioning the Fleming Fund portfolio of country and regional grants, DH has progressed a number of key areas of work to build laboratory capacity and capability on diagnosis, one health and international AMR surveillance to lay the ground work for the country and regional projects. Information and data from these initial projects will provide vital feedback while developing the portfolio of country and regional grants.
* **Initial grants to multilateral groups: Grants have been made to** WHO and FAO to build capacity for developing National Action Plans in LMICs and aligning international standards on AMR surveillance around a one health approach.
* The grant to the World Health Organization is supporting implementation of the Global Action Plan on antimicrobial resistance with a focus on low and middle income countries (LMICs). The aim is to achieve increased national and global capacities to prevent and control AMR and identify investment needs particularly in LMICs. This is being delivered via a number of activities including:
  + Increasing the number of countries, especially LMICs, with comprehensive National Action Plans;
  + Fostering global AMR surveillance and assessing investment needs;
  + Developing national policies and strengthening leadership in preventing multidrug resistant infections.
* Over the coming months, there will be continued support for countries in developing their National Action Plans with the aim of meeting the target of all countries having plans in place for the World Health Assembly in May 2017. Workshops with national focal points for AMR will take place in all WHO regions and additional support will be provided to Indonesia, Bangladesh, Timor Leste, Samoa, Mongolia, and other countries upon request.
* WHO will work at the global level to better understand antimicrobial consumption; developing a tool and training materials for monitoring consumption; and will conduct workshops focusing on improving the utilisation of antibiotics. At country level, antimicrobial stewardship activities will take place in the India, Indonesia, Bangladesh, Vietnam and the Cook Islands, among others.
* Further work will be done on reviewing and selecting effective and safe antimicrobial medicines for inclusion in the WHO Model List of Essential Medicines, with the development of a Smart phone application for rapid alert for substandard/ spurious/ falsely-labelled/ falsified/ counterfeit (SSFFC) medical products from 113 countries. Further work is also being done in relation to Infection, Prevention and Control (IPC) programmes with IPC capacity being strengthened in countries such as Vietnam and the Cook Islands.
* The grant to the Food and Agriculture Organization is supporting the FAO with the overarching aim of proving targeted assistance to, initially, four countries to develop national strategies on AMR with a focus on agriculture, fisheries, food and livestock production as part of the overall implementation of the Global Action Plan. The support will particularly concentrate on ensuring a one health approach and harmonising national capacities for AMR across animal and human health.
* The initial focus on the funding will be to support four target countries - Zimbawe, Kenya, Ghana, and Cambodia. These have been selected based on need, capability, regional mix, and countries where FAO have a relatively stronger presence or interest.
* **Scoping and mapping of existing laboratory capacity and AMR surveillance capacity in LMICs** through Wellcome Trust commissioned studies, to better understand country and regional needs and potential for targeted investment. These studies cover:
  + Laboratory capacity strengthening – to complement the work that is ongoing in WHO on mapping laboratories with the capacity to undertake a quality assurance function. This work will include a mapping of the major laboratories, and relevant agencies providing support in LMICs, particularly focussed on Africa and Asia, which have capacity, or potential, to undertake AMR surveillance and identification of pathogens to internationally quality assured levels; a review of which of these countries have national laboratory policies and how these are being implemented; consider options for fragile states; and for at surveillance and laboratory system strengthening for the diagnosis of key diseases and AMR.
  + Regional networks and education resources available in low and middle income contexts: the work will map what networks including academic networks exist in LMICs dealing with resistance/ surveillance/ quality assurance and support and factors impacting on success; map what educational resources, for example toolboxes, training resources/programmes are available and provide guidance to low resource countries to support surveillance capacity and identify gaps; and identify options for standard setting and sharing.
  + The animal/human interface with a focus on LMICs, which will include mapping known antibiotic use in agriculture in LMICs; evidence of the hotspots for zoonotic disease transmission linked to AMR from animals to humans; use of antimicrobials used as growth promoters; and evidence in effect of antibiotic manufacturing waste disposal on antibiotic resistance in the environment.
* Outputs will be available in the first half of 2016 and will be shared.
* **The UK is piloting the Fleming Fund country approach to improving laboratory capacity** through funding of a national AMR Reference Laboratory and Surveillance Programme in Vietnam working with the Oxford University Clinical Research Unit (OUCRU). The objective is to support the Vietnamese government to develop a sustainable national AMR reference laboratory and surveillance scheme to be housed in the new National Hospital for Tropical Diseases (NHTD) in Hanoi. Specific deliverables include:
  + Developing a national AMR reference laboratory with a focus on AMR in medically important bacteria other than mycobacteria. This will include setting up the required infrastructure and recruitment and training of a dedicated laboratory and surveillance team
  + Developing a national antibiotic resistance surveillance programme to develop a surveillance network of around 30 participating hospitals throughout Vietnam. In the first instance the surveillance programme will focus on the hospitals. Later in the project, they will consider to expand the surveillance system to the community setting, including the human-animal interface
  + Ensuring sustainability once the development phase is completed. The Vietnamese government are committed to the on-going support and development of the laboratory and surveillance programme, and they will continue to receive technical support from OUCRU.

**Technical support and guidance**

* **Technical Advisory Group (TAG)** - To help ensure effective delivery on the aims and anticipated objectives of the Fleming Fund, the programme will draw on a high calibre group of independent experts with experience including but not limited to: laboratory diagnosis; one health; external quality assurance of data; disease surveillance within low and middle income countries; international development; health system strengthening in low and middle income countries; public health; antimicrobial resistance and data sharing.
* Friends of the Fleming Fund will be the brand used to identify all such experts providing technical input or guidance to the Fleming Fund.
* In mid-2016 DH will contact a number of experts and register the support of a small multi-disciplinary group to form a TAG that will help with inputs to the broad Fleming Fund programme. This might include peer review of multilateral grant agreements, technical input for the team as a surveillance protocol is being commissioned and quality assurance or peer review of inception phase deliverables from the Management Agent and Evaluation Supplier.
* The TAG will be established to support the DH policy team during commissioning, review and approval of key deliverables and aspects of the full Fleming Fund programme. The group can also provide independent technical guidance to the Steering Committee if needed to inform a specific decision. They may also be called on to peer review progress and annual reports from the fund’s suppliers before they are sent to the Steering Committee.
* The TAG will not form part of the programme’s decision making governance but will rather help to technically advise where requested, to inform direction and decisions made by DH, the Management Agent, the Evaluation Supplier or the Steering Committee
* Any expert approached to become part of the TAG will be asked to declare if they are part of the Management Agent or Evaluation Supplier bid. In this case they then could not be called on as part of this group’s remit would include peer review of deliverables from these suppliers.

**Core principles for the Fund**

* The following table details for the four core principles of the entire Fleming Fund which the Management Agent would be expected to uphold, and the Evaluation Supplier would be expected to remain mindful of, while designing the portfolio of country and regional projects.

|  |
| --- |
| 1. **One health** |
| **What does this mean in practice:** The one health concept recognises that the health of humans is connected to the health of animals and the environment. AMR is, in part, driven by practices in all three; hence collaborative efforts across multiple disciplines are required to reduce AMR and to mitigate its impact.  Fleming Fund projects will strengthen the surveillance of AMR in human and animal populations and collect data from agriculture where possible. Although surveillance is only one aspect of the one health approach to AMR, all projects should demonstrate understanding of the one health concept, and how multidisciplinary data collection can lead to evidence based policies relating to public health, veterinary medicine and agricultural practices. |
| 1. **2. Country ownership:** |
| **What does this mean in practice:** Genuine engagement with country governments and stakeholders to meet nationally identified needs when undertaking country selection, decisions on funding envelopes for each country, and specific activities to target Fleming investments.  Grants must be effectively embedded in national public health systems and existing national infrastructure, acceptable under principles for support set out by the Ministry of Health and integrated as part of a sustainable plan to improve laboratory capacity for diagnosis, data collection and surveillance on AMR long term.  The portfolio of country and regional grants will remain flexible in focus within the parameters of the fund, both with regards to investment activities within each country and to the priority pathogens for laboratory testing; ensuring projects truly meet local needs.  Evidence will be required that the country government and relevant stakeholders have been identified and consulted in developing the aforementioned portfolio of support for each country. A stakeholder communication and engagement plan should set out how the project will ensure country engagement throughout the programme lifetime, which may at inception include letters of intent from Ministries of Health. The role of relevant partners and documentation of their involvement and consultation should be detailed for DH. |
| 1. **3. Sustainability** |
| **What does this mean in practice:** Projects should build capacity of government and relevant partners to sustain and further expand laboratory capacity and capability as well as AMR surveillance beyond the lifetime of the programme. This includes strengthening human resource capacity, ensuring the analysis and use of AMR data to inform National Action Plans, and strengthening oversight/quality assurance mechanisms.  The selected Management Agent will be charged with developing a sustainability and exit strategy for the Fleming Fund from the inception of the programme. Actioning this strategy will ensure the impact of the programme outlasts specific country funding, but also that downscaling programme activities is undertaken in a responsible manner without leaving an unsustainable cost on the host country.  Transition plans will be discussed with each Fleming Fund country and local stakeholders to ensure timescales for potential exit or scale back are understood. Transition plans will need to detail costs and strategies to maintain national laboratory capacity and surveillance networks through an increase in government contributions or support from other donors. |
| 1. **Alignment of activities from national to regional and international levels** |
| **What does this mean in practice:** Individual country and regional grants should demonstrate cognisance of the wider laboratory capacity within the national public health system, as well as AMR surveillance networks both globally and locally, and describe how the project will align within this.  Country and regional grants will target gaps in local capacity to deliver aspects of improved AMR surveillance rather than creating a parallel process to existing national delivery, overlapping with AMR surveillance work from other donors or diverting resources from existing regional surveillance networks. The Management Agent will need to ensure coordination is carried out effectively at country and regional levels with governments and other partners, and alignment and complementarity is sustained. |

1. Bidder Response

See accompanying template questions for completion and return **(Schedule One (a)).**

1. Pricing Schedule

See accompanying **Pricing Schedule Two** for completion and return

1. General Instructions
   1. The rates contained within the Pricing Schedule are, unless otherwise expressly agreed between the parties, firm.
   2. The rates entered shall be deemed to include complete provision for full compliance with the requirements of the Contract.
   3. The rates exclude VAT.
   4. The rates entered in the Pricing Schedule shall include all travel and subsistence costs. Original receipts will need to be provided for all such expenditure.
   5. The Authority will only make payment for overnight stays that have been authorised in line with the agreed Inception Plan and Implementation Plan.
   6. The Department will only pay for expenses claimed that are included in this Pricing Schedule or as agreed within the Inception Plan and Implementation Plan and are deemed to be reasonable for delivery of the requirement.
   7. Bidders must include in the Pricing Schedules any discounts or any reduced pricing they are proposing to offer to the Authority in delivery of this requirement.
   8. See accompanying Pricing Schedule Two template for completion of pricing proposals, (which includes the Inception Plan pricing response, rate card South East Asia, rate card sub-Saharan Africa, scenario 1 and scenario 2 (scenarios for evaluation purposes only)); and return to the Authority.
2. Schedule of Payments
   1. The Authority requires Bidders to competitively tender against the requirements of the Specification. Payments to the Supplier for Service delivery will be in accordance with the Contract terms and conditions.
   2. DH is committed to ensuring value for money through the commissioning of the evaluation contract. DH will look to agree an output or milestone based payment model, recognising the need to release payments for both the evaluation outputs and key activities. DH will ask Bidders to suggest a Payment Schedule for the Inception Phase of the Contract in their responses to the tender, and Bidders will be asked to produce a detailed financial plan during the Inception Phase for the remainder of the Contract.
3. Contract Monitoring

Please read this Schedule alongside the Contract.

The Supplier will:

(a) Appoint a Contract Manager to oversee the work and liaise with / report as DH requires to DH’s Contract Manager;

### Monitor the quality of the service provision to ensure customer satisfaction in accordance with the key performance indicators outlined in the Contract, unless otherwise approved by the Project Manager;

* + 1. Provide regular reporting as and when required by the Department Project Manager. This will be in the form of, at a minimum, a quarterly activity and financial update to DH either through a document, presentation or a face-to-face meeting. This opportunity will allow the Evaluation Supplier to provide evidence of working against the agreed activities detailed in the inception report as well as be a continuing opportunity to provide lessons learning.
    2. Perform quality assurance on all aspects of the programme; and provide the Department with timely and on-going evaluation and quality assurance information relating to the programme;
    3. Provide on a monthly basis updates on costs

### Attend meetings on site by phone or by video conference to review progress and discuss the service, as required by the Project Manager; and

### Attend a post contract review with the Department to review whether the objectives of the contract were met, to review the benefits achieved and to identify any lessons learnt for future projects.

1. General Instructions

Bidders will be required to complete all the information requested in the following section once the contract is awarded. Any supporting documents (e.g. Inception Plan, Implementation Plan etc.) will need to be clearly referenced back to the appropriate section.

1. Representatives

Name of Authority's Representative(s): To be confirmed at Contract award

Name of Supplier's Representative(s): [Bidder to complete]

1. Deliverables

List of deliverables, outputs and reports Supplier is to supply is set out at section 5 of Schedule One.

Period(s) over which each deliverable, output and report is to be supplied are set out at section 6 of Schedule One.

Information requirements: [Authority to complete]

Milestones: [Authority to complete]

1. Meetings

Frequency of contract management meetings: Quarterly or on request

* 1. Location of contract management meetings: on site (London) by phone or by video conference

Checking performance against anticipated plan: [Authority to complete]

1. Remedies

Remedies for below par performance: [Authority to complete]

1. Confidential & Commercially Sensitive Information

See accompanying template (Schedule One (A)) for completion and return to the Authority.

1. Administrative Instructions

See accompanying template for (Administrative Instructions) completion and return to the Authority.

1. Form of Tender

See accompanying template for (Form of Tender) completion and return to the Authority.

1. Sub-Contractors

See accompanying template for (Sub-Contractor information) completion and return to the Authority.

1. Parent Company Guarantee

See accompanying template for (Parent Company Guarantee information) completion and return to the Authority.

1. Review on Antimicrobial Resistance (2014) Antimicrobial Resistance: Tackling a crisis for the health and wealth of nations. <http://amr-review.org/sites/default/files/AMR%20Review%20Paper%20-%20Tackling%20a%20crisis%20for%20the%20health%20and%20wealth%20of%20nations_1.pdf> [↑](#footnote-ref-1)
2. Center for Disease Control. "CDC’s vision for public health surveillance in the 21st century." MMWR Morb Mortal Wkly Rep 61 (2012): 1-44. [*http://www.cdc.gov/mmwr/pdf/other/su6103.pdf*](http://www.cdc.gov/mmwr/pdf/other/su6103.pdf) [↑](#footnote-ref-2)
3. https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/478834/ODA\_strategy\_final\_web\_0905.pdf [↑](#footnote-ref-3)
4. The one health concept recognises that the health of humans is connected to the health of animals and the environment. AMR is, in part, driven by practices in all three; hence collaborative efforts across multiple disciplines are required to reduce AMR and to mitigate its impact. [↑](#footnote-ref-4)
5. Available at <http://apps.who.int/iris/bitstream/10665/112642/1/9789241564748_eng.pdf> [↑](#footnote-ref-5)
6. Global AMR Surveillance System <http://www.who.int/drugresistance/surveillance/en/> [↑](#footnote-ref-6)
7. IHR Core Capacities: **Core capacity 1:** National legislation, policy and financing, **Core capacity 2:** Coordination and National Focal Point (NFP) communications, **Core capacity 3:** Surveillance, **Core capacity 4:** Response, **Core capacity 5:** Preparedness, **Core capacity 6:** Risk communication, **Core capacity 7:** Human resources, **Core capacity 8:** Laboratory. [↑](#footnote-ref-7)
8. Global AMR Surveillance System <http://www.who.int/drugresistance/surveillance/en/> [↑](#footnote-ref-8)
9. Middle income countries may be considered for regional hubs if a strong rationale was given for this. [↑](#footnote-ref-9)
10. See <http://www.oecd.org/dac/evaluation/qualitystandards.pdf> [↑](#footnote-ref-10)
11. Rationale for selecting Burma and Sierra Leone as pilot countries: DH would like to pilot the surveillance protocol and Fleming Fund approach in both Sub-Saharan Africa and Southern/South-Eastern Asia to identify any key differences between regions, as well as building in learning on how best to approach and implement the Fleming Fund country investments. Both Burma and Sierra Leone have an identified need on AMR collection data to varying degrees, providing an opportunity for nuanced learning from each pilot to feed into the ultimate implementation strategy. For pilot countries, DH is also keen to ensure these are also host to DFID and FCO offices, FAO offices where possible, and where the UK has good diplomatic relations and the ability to engage quickly and effectively with national stakeholders. [↑](#footnote-ref-11)
12. Global Action Plan for AMR <http://apps.who.int/iris/bitstream/10665/193736/1/9789241509763_eng.pdf?ua=1> [↑](#footnote-ref-12)
13. Global AMR Surveillance System <http://www.who.int/drugresistance/surveillance/en/> [↑](#footnote-ref-13)
14. For the purposes of the Fund please consider conflict countries to be countries where an active conflict is nationwide; however the Fund may work in countries with pockets of conflict or fragility but where there is potential to develop a sustainable surveillance system. [↑](#footnote-ref-14)
15. The Overall Risk rating is usually calculated using the MODE function which determines the most frequently occurring value. [↑](#footnote-ref-15)
16. This risk rating applies only for Freetown. Outside of Freetown the risk rating is a 4 [↑](#footnote-ref-16)
17. The Overall Risk rating is calculated using the MODE function which determines the most frequently occurring value. [↑](#footnote-ref-17)
18. Medium to high risk could be rated in the monsoon season especially in the areas which are closer to delta region, river and ocean. [↑](#footnote-ref-18)