Department for International Development

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Section 4 Appendix A

CALLDOWN CONTRACT

Framework Agreement with: Oxford Policy Management (OPM)

Framework Agreement for: Global Evaluation Framework Agreement

Framework Agreement Purchase Order Number: PO 7448

Call-down Contract For: Tackling Deadly Diseases Africa Programme – Third Party Monitoring.

Contract Purchase Order Number: 8279

I refer to the following:

1. The above-mentioned Framework Agreement dated **12 September 2016**;

2. Your proposal of June 2018

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

1. Commencement and Duration of the Services

1.1 The Supplier shall start the Services no later than **2 January 2019** ("the Start Date") and the Services shall be completed by **30 December 2022** ("the End Date") unless the Call-down Contract is terminated earlier in accordance with the Terms and Conditions of the Framework Agreement.

2. Recipient

2.1 DFID requires the Supplier to provide the Services to the DFID Africa Regional Department ("the Recipient").

3. Financial Limit

3.1 Payments under this Call-down Contract shall not, exceed £**1,250,000** ("the Financial Limit") and is exclusive of any government tax, if applicable as detailed in Annex B**.**

When Payments shall be made on a 'Milestone Payment Basis' the following Clause shall be enforced.

Milestone Payment Basis

Where the applicable payment mechanism is "Milestone Payment", invoice(s) shall be submitted for the amount(s) indicated in Annex B and payments will be made on satisfactory performance of the services, at the payment points defined as per schedule of payments. At

each payment point set criteria will be defined as part of the payments. Payment will be made if the criteria are met to the satisfaction of DFID.
When the relevant milestone is achieved in its final form by the Supplier or following completion of the Services, as the case may be, indicating both the amount or amounts due at the time and cumulatively. Payments pursuant this clause are subject to the satisfaction of the Project Officer in relation to the performance by the Supplier of its obligations under the Call-down Contract and to verification by the Project Officer that all prior payments made to the Supplier under this Call-down Contract were properly due.

4. DFID Officials

4.1 The Project Officer is:

REDACTED
Africa Regional Department
Department for International Development

REDACTED
Africa Regional Department
Department for International Development
REDACTED

4.2 The Contract Officer is:

REDACTED
Procurement and Commercial Department
Department for International Development
REDACTED

5. Key Personnel

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

All international personnel identified within the Technical and Commercial Proposals cannot be substituted by the Supplier without DFID's prior consent. The substitute's qualifications and expertise should match that of the key personnel being replaced and DFID will require copies of CV's for each proposed substitute.

6. Sub – contractors

6.1 The following of the Supplier's sub-contractors cannot be substituted by the Supplier without DFID's prior written consent:

University of Oxford
London School of Hygiene and Tropical Medicine
BMJ
AEDES

6.2 For the avoidance of doubt clause 8.1 to 8.3 (inclusive) of the Framework Agreement shall not apply to the Supplier's sub-contractors named above and DFID hereby confirms that such sub-contracting opportunities will not be required to be advertised on Contracts Finder. Additional sub – contractor opportunities, that cannot be fulfilled using the Supplier's approved Framework Agreement consortium will be required to be advertised in line with clause 8 of the Framework Agreement.

7. Reports

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

8. Duty of Care

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

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

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

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

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

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

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

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

9. Schedule 3: Insurance Requirements

9.1. OBLIGATION TO MAINTAIN INSURANCES

9.1.1 Without prejudice to its obligations to DFID under this Agreement and/or any Call Down Contract, including its indemnity obligations, the Supplier shall for the periods specified in this Schedule 2 take out and maintain, or procure the taking out and maintenance of the insurances as set out in Annex 1 (Required Insurances) and any other insurances as may be required by applicable Law (together the "**Insurances**"). The Supplier shall ensure that each of the Insurances is effective no later than the Commencement Date.

9.1.2 The Insurances shall be maintained in accordance with Good Industry Practice and (so far as is reasonably practicable) on terms no less favourable than those generally available to a prudent Agreement and/or any Call Down Contractor in respect of risks insured in the international insurance market from time to time.

9.1.3 The Insurances shall be taken out and maintained with insurers who are of good financial standing and of good repute in the international insurance market.

9.1.4 The Supplier shall ensure that the public and products liability policy shall contain an indemnity to principals' clause under which DFID shall be indemnified in respect of claims made against DFID in respect of death or bodily injury or third party property damage arising out of or in connection with the Services and for which the Supplier is legally liable.

9.2. GENERAL OBLIGATIONS

9.2.1 Without limiting the other provisions of this Agreement and/or any Call Down Contract, the Supplier shall:

9.2.2 take or procure the taking of all reasonable risk management and risk control measures in relation to the Services as it would be reasonable to expect of a prudent Agreement and/or any Call Down Contractor acting in accordance with Good Industry Practice, including the investigation and reports of relevant claims to insurers;

9.2.3 promptly notify the insurers in writing of any relevant material fact under any Insurances of which the Supplier is or becomes aware; and

9.2.4 hold all policies in respect of the Insurances and cause any insurance broker effecting the Insurances to hold any insurance slips and other evidence of placing cover representing any of the Insurances to which it is a party.

9.3. FAILURE TO INSURE

9.3.1 The Supplier shall not take any action or fail to take any action or (insofar as is reasonably within its power) permit anything to occur in relation to it which would entitle any insurer to refuse to pay any claim under any of the Insurances.

9.3.2 Where the Supplier has failed to purchase any of the Insurances or maintain any of the Insurances in full force and effect, DFID may elect (but shall not be obliged) following written notice to the Supplier to purchase the relevant Insurances, and DFID shall be entitled to recover the reasonable premium and other reasonable costs incurred in connection therewith as a debt due from the Supplier.

9.4. EVIDENCE OF POLICIES

9.4.1 The Supplier shall upon the Commencement Date and within 15 Working Days after the renewal of each of the Insurances, provide evidence, in a form satisfactory to DFID, that the

Insurances are in force and effect and meet in full the requirements of this Framework Schedule 2. Receipt of such evidence by DFID shall not in itself constitute acceptance by DFID or relieve the Supplier of any of its liabilities and obligations under this Agreement.

9.5. AGGREGATE LIMIT OF INDEMNITY

9.5.1 Where the minimum limit of indemnity required in relation to any of the Insurances is specified as being "in the aggregate":

9.5.2 if a claim or claims which do not relate to this Agreement and/or any Call Down Contract are notified to the insurers which, given the nature of the allegations and/or the quantum claimed by the third party(ies), is likely to result in a claim or claims being paid by the insurers which could reduce the level of cover available below that minimum, the Supplier shall immediately submit to DFID:

(a) details of the policy concerned; and

(b) its proposed solution for maintaining the minimum limit of indemnity specified; and

9.5.3 if and to the extent that the level of insurance cover available falls below that minimum because a claim or claims which do not relate to this Agreement and/or any Call Down Contract are paid by insurers, the Supplier shall:

(a) ensure that the insurance cover is reinstated to maintain at all times the minimum limit of indemnity
specified for claims relating to this Agreement and/or any Call Down Contract; or

(b) if the Supplier is or has reason to believe that it will be unable to ensure that insurance cover is reinstated to maintain at all times the minimum limit of indemnity specified, immediately submit to DFID full details of the policy concerned and its proposed solution for maintaining the minimum limit of indemnity specified.

9.6. CANCELLATION

9. 6.1 The Supplier shall notify DFID in writing at least five (5) Working Days prior to the cancellation, suspension, termination or nonrenewal of any of the Insurances.

9.7. INSURANCE CLAIMS

9.7.1 The Supplier shall promptly notify to insurers any matter arising from, or in relation to, the Services and/or this Agreement and/or any Call Down Contract for which it may be entitled to claim under any of the Insurances. In the event that DFID receives a claim relating to or arising out of the Services or this Agreement and/or any Call Down Contract, the Supplier shall co-operate with DFID and assist it in dealing with such claims including without limitation providing information and documentation in a timely manner.

9.7.2 Except where DFID is the claimant party, the Supplier shall give DFID notice within twenty (20) Working Days after any insurance claim in excess of **£12,500** relating to or arising out of the provision of the Services or this Agreement and/or any Call Down Contract on any of the Insurances or which, but for the application of the applicable policy excess, would be made on any of the Insurances and (if required by DFID) full details of the incident giving rise to the claim.

9.7.3 Where any Insurance requires payment of a premium, the Supplier shall be liable for and shall promptly pay such premium.

9.7.4 Where any Insurance is subject to an excess or deductible below which the indemnity from insurers is excluded, the Supplier shall be liable for such excess or deductible. The Supplier shall not be entitled to recover from DFID any sum paid by way of excess or deductible under the Insurances whether under the terms of this Agreement and/or any Call Down Contract or otherwise.

10. Break Clause

10.1 The Contract Period is subject to the following formal review points

- At the end of the inception period, 3 months after signing of the contract.

Movement from Inception to Implementation and continuation of the contract beyond the Inception review point will be subject to the satisfactory performance and achievement of the standards required by the Inception phase key performance indicators (KPIs) detailed in Section 4, Appendix A, Annex B, Schedule of Prices.

11. Call-down Contract Signature

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

For and on behalf of The Secretary of State for International Development	Name: Position: Signature: Date:
For and on behalf of Oxford Policy Management	Name: Position: Signature: Date:

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ANNEX 1: REQUIRED INSURANCES

PART A: THIRD PARTY PUBLIC & PRODUCTS LIABILITY INSURANCE

1.INSURED

1.1 The Supplier

2.INTEREST

2.1 To indemnify the Insured in respect of all sums which the Insured shall become legally liable to pay as damages, including claimant's costs and expenses, in respect of accidental:

2.1.1 death or bodily injury to or sickness, illness or disease Agreement and/or any Call Down Contracted by any person;

2.1.2 loss of or damage to property; happening during the period of insurance (as specified in Paragraph 5 of this Annex 1 to this Schedule 2) and arising out of or in connection with the provision of the Services and in connection with this Agreement and/or any Call Down Contract.

3.LIMIT OF INDEMNITY

3.1 Not less than 'the financial limit' in respect of any one occurrence, the number of occurrences being unlimited, but 'the financial limit' in any one occurrence and in the aggregate per annum in respect of products and pollution liability.

4.TERRITORIAL LIMITS

N/A

5.PERIOD OF INSURANCE

5.1 From the Commencement Date for the Term and renewable on an annual basis unless agreed otherwise by DFID in writing.

6.COVER FEATURES AND EXTENSIONS

6.1 Indemnity to principals clause.

7.PRINCIPAL EXCLUSIONS

7.1 War and related perils.

7.2 Nuclear and radioactive risks.

7.3 Liability for death, illness, disease or bodily injury sustained by employees of the Insured during the course of their employment.

7.4 Liability arising out of the use of mechanically propelled vehicles whilst required to be compulsorily insured by applicable Law in respect of such vehicles.

7.5 Liability in respect of predetermined penalties or liquidated damages imposed under any Agreement and/or any Call Down Contract entered into by the Insured.
7.6 Liability arising out of technical or professional advice other than in respect of death or bodily injury to persons or damage to third party property.

7.7 Liability arising from the ownership, possession or use of any aircraft or marine vessel.

7.8 Liability arising from seepage and pollution unless caused by a sudden, unintended and unexpected occurrence.

8.MAXIMUM DEDUCTIBLE THRESHOLD

8.1 Not used

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PART B: PROFESSIONAL INDEMNITY INSURANCE

1.INSURED

1.1 The Supplier

2.INTEREST

2.1 To indemnify the Insured for all sums which the Insured shall become legally liable to pay (including claimants' costs and expenses) as a result of claims first made against the Insured during the Period of Insurance by reason of any negligent act, error and/or omission arising from or in connection with the provision of the Services.

3.LIMIT OF INDEMNITY

3.1 Not less than 'the financial limit' of the Call down contract in respect of any one claim and in the aggregate per annum.

4.TERRITORIAL LIMITS

N/A

5.PERIOD OF INSURANCE

5.1 From the date of this Agreement and/or any Call Down Contract and renewable on an annual basis unless agreed otherwise by DFID in writing (a) throughout the Term or until earlier termination of this Agreement and/or any Call Down Contract and (b) for a period of 6 years thereafter.

6.COVER FEATURES AND EXTENSIONS

6.1 Retroactive cover to apply to any claims made policy wording in respect of this Agreement and/or any Call Down Contract or retroactive date to be no later than the Commencement Date.

7.PRINCIPAL EXCLUSIONS

7.1 War and related perils

7.2 Nuclear and radioactive risks

8.MAXIMUM DEDUCTIBLE THRESHOLD

8.1 Not used

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PART C: UNITED KINGDOM COMPULSORY INSURANCES

1.GENERAL

1.1 The Supplier shall meet its insurance obligations under applicable Law in full, including, UK employers' liability insurance and motor third party liability insurance.

Section 4, Appendix A, Annex A

Terms of Reference

Tackling Deadly Diseases in Africa Programme (TDDAP)
Independent monitoring and verification – third party monitoring

Contents

1. Introduction

The Ebola crisis, and subsequent Zika and Yellow Fever epidemics, showed clearly how better preparedness could enable disease outbreaks to be picked up earlier; saving lives, saving resources and protecting countries around the world. The Tackling Deadly Diseases in Africa Programme (TDDAP) aims to save lives and reduce the impact of disease outbreaks and epidemics on African populations. The UK will provide up to £60m over 4 years (July 2017 to March 2022 working across Africa through World Health Organisation (WHO)'s regional programme with more focused support in six most at risk countries. It will be the UK's main instrument, alongside a £16m Public Health England (PHE) programme, to prevent and respond to future disease outbreaks.

The core programme will be £40m but DFID will retain some flexibility if public health emergencies arise through triggering a draw down on a contingency mechanism of up to £20m (included in the total budget of £60m). No funds are currently allocated to this, but we are seeking approval to facilitate a rapid response if needed in future. The outcome of this investment will result in the strengthening of African health systems and institutions to prevent outbreaks and epidemics of deadly communicable diseases (see Theory of Change below and annexed).

TDDAP will be competitively tendered and implemented by an External Technical Supplier (ETA) and will deliver targeted support in countries with high vulnerability to disease outbreaks but lacking the investment to meet the needs. It will strengthen African health systems and institutions by supporting the following outputs:

(i) World Health Organisation Africa Office (WHO AFRO) reform,
(ii) countries' ability to achieve the International Health Regulations (IHRs),
(iii) better governance and accountability of public health systems,
(iv) improved data and evidence for preparedness, response and decision-making, and
(v) Improved capacity to respond to outbreaks through enhanced surveillance systems.

This Terms of Reference document (TOR) sets out DFID's requirement for an independent third-party monitoring (TPM) supplier, (hereinafter referred to as the 'TPM Supplier') to undertake an ongoing independent monitoring and quality assurance of programme delivery, finances, documentation of lessons and robust verification and tracking of results. The ToR should be read in conjunction with the TDDAP Business Case (Annex A), the Log frame (Annex B), the Theory of Change (Annex C) and the Duty of Care matrix (Annex D).

The TPM Supplier will form one of three organisations involved in the delivery of TDDAP, the other two being the ETA and WHO AFRO. Distinction of responsibilities between the three agencies is outlined further in this TOR.

2. Objective

DFID requires a TPM supplier to provide a continuous critical and constructive review of TDDAP implementing supplier, recommend improvements, and verify reported results at all levels of the results framework; specifically, the following:

a) Independent verification of activities and results as outlined in the log frame.
b) Generating additional evidence.
c) Independent verification of financial and programme management data.
d) Inform and facilitate learning.

The **purpose** is to ensure that TDDAP is having the intended impact by focusing on **assurance and accountability** and the **facilitation of learning and adaptive management** in order to improve the overall

performance. Third Party monitoring will ensure independent monitoring and quality assurance of programme delivery, documentation of lessons and robust tracking of results

The TPM Supplier will construct systems and strong relationships to ensure sharing of data and information across the implementing suppliers, and where appropriate, more broadly as part of global best practice and learning. The supplier will build relationships with WHO and implementing suppliers based on mutual respect and information flow. WHO AFRO's existing monitoring and evaluation system will be utilised. The log frame is clear on what sources of data will be used, and both WHO and the ETA fully utilise these and ensure they are strengthened. The third-party monitoring supplier will verify these.

The ETA supplier will set-up its monitoring and evaluation system, aligning as closely as possible with WHO AFRO, using existing data sources, and ensuring that programme data is captured, managed and analysed. This will be clearly articulated by the ETA in the proposal to DFID during the tender process.

Many of the existing data sources, including country-level district health information systems and WHO AFRO outbreaks analyses are available. However, the TPM may need to analyse raw data as part of the verification process and collect new primary data where applicable.

The data sources are stated in the log frame and include (list not exhaustive):

- African Health Observatory.
- Analysis by WHO AFRO
- AFRO outbreaks data
- National budget analyses collated by WHO AFRO/civil society
- Beneficiary/stakeholder feedback
- WHO reports
- Qualitative spider gram assessment on aspects of coordination and leadership led by TPM
- Relevant policy documents
- Implementation reports
- WHO AFRO Key Performance Indicator dashboards for the Transformation Agenda
- Financial reporting from partner organisations
- After Action Review Reports
- Collation of raw data on transformative effects of the programme
- District Health Information Systems and Surveillance data (which are currently weak).
- Real-time strategic information website

It will be critical to have a close understanding of the political economy of each country and the risks and opportunities on the ground. **The ETA will be required to have a country engagement strategy** within the overall programme that the monitor can use to track progress.

The TPM supplier will engage and seek advice from specialists based in those countries where DFID has a presence before and during implementation and may commission separate analysis for any target countries (e.g. in the Sahel) where DFID does not have an office. This will help ensure the programme remains grounded in the realities of the operating environment.

3. Recipient

The recipient of all the outputs from the TPM supplier is DFID, the implementers of TDDAP and WHO.

4. Scope of Work

It is not expected to replace the monitoring we require our ETA supplier to undertake, nor does it replace DFID's internal monitoring system but will complement and support it.

Distinction of responsibilities between ETA, WHO AFRO and TPM Supplier:

ETA: are responsible for managing the TDDAP Programme and monitoring progress against the agreed outputs for focus countries on the log frame Outputs 2-4. This will include all relevant disaggregation of data where applicable and process indicators which help to track implementation of the programme. The ETA will assume full responsibility for delivering areas of work under their contract; they will sub-contract other partners with the appropriate specialist skills and geographic presence as needed and will set out the responsibilities and required standards.

WHO AFRO: Are responsible for managing and reporting on progress against the agreed outputs on the log frame for Output Indicator no.1. and countries where they support in outputs 2-4 as well as regional progress.

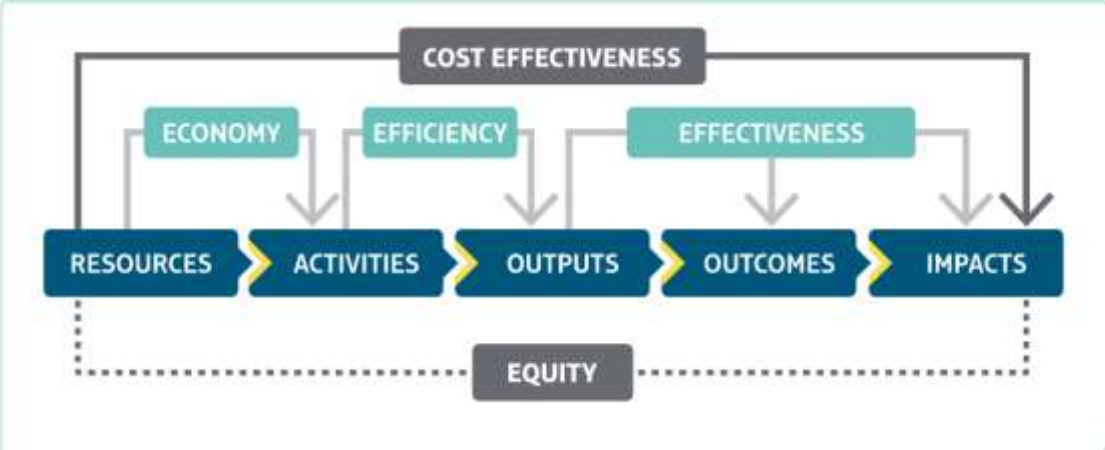
TPM Supplier: is responsible for defining and collecting additional primary data required for independent monitoring, and verification purposes. This includes verification of results (all aspects of the TDDAP log frame), activities, outputs, finances and programme management data. The TPM supplier will be responsible for ensuring lessons from this verification processes are tracked and lessons are disseminated and taken up (objective i). The TPM supplier is also responsible for generating new evidence related to the programme (objective ii). Ultimately, the independent TPM is to ensure quality assurance of programme delivery, documentation of lessons and robust tracking of results activities, outputs, finances and programme management for TDDAP.

The TPM Supplier will provide the following:

a) *Independent verification of activities and results as outlined in the log frame:*
   - Verify activities, outputs, and results reported for the entire TDDAP log frame of particular importance to DFID are the milestones and key performance indicators, including those reported by WHO AFRO.
   - Verify results, this will include primary data collection.
   - Data disaggregated by gender, poverty and monitor compliance with the Gender and Disability Acts. Other areas of disaggregation may be needed and will be finalised in the design phase.
   - The TPM supplier will complete sampling and spot checks of programme and financial records and stakeholder interviews.
   - Activities and results verification exercises will be analysed in the context of emerging issues, contextual issues and any relevant data trends.
   - Identify key issues and learnings through the verification exercises and provide DFID and implementing partners with recommendations. (see also objective e)
   - Proposals will be clear on how much primary data collection the bid makes provisions for and proposed sampling strategy for results and activities verification.

b) *Generating additional evidence*
   - This will include aspects of operational research and economic and value for money analysis. However, during the design phase this may also be refined or expanded to other types of research or analysis upon mutual agreement between DFID and the TPM supplier. While we do not require a full-scale evaluation, relevant questions from the OECD DAC criteria will be addressed pending discussions and agreement between WHO, the ETA and DFID.

- Conduct operational research. With the ETA and WHO AFRO, the TPM will be expected to identify areas for operational research. The final list of research questions should: add to the global evidence base; respond to programme issues as they become apparent; or test and add evidence to linkages within the TDDAP Theory of Change to adjust the programme and share the learning. This will include (list not exhaustive and would need to be refined):
    - Evidence of how to prioritise investment in International Health Regulations (IHR) in resource-limited settings;
    - Elaborating on preparedness and best practices in strengthening public health systems;
    - How to ensure implementation of IHR coverage at scale;
    - How to best measure impact of disease preparedness interventions;
    - Understanding better how country Governments can deliver to meet the needs of vulnerable groups included in the leave no one behind agenda.
- Proposals will be clear on how many operational research questions they have made provisions for, including detail on proposed methodology for questions**.**
- Conduct economic and value for money analyses of the TDDAP programme. This should include proposals using the '4E' approach, analysis shaped by economy, efficiency, effectiveness and equity. Cost effectiveness should also be addressed.
- Proposals should be clear on the extent to which each aspect will be addressed and the methodology for doing so.



c) Independent verification of financial and programme management data

- Thorough oversight and assurances on fraud and fiduciary risk through regular inspections, data verification and interviews with staff and clients.
- Perform an independent risk assessment to identify risks and vulnerabilities impacting the programme.
- Fiduciary and fraud risks are communicated early to DFID, WHO and the ETA and assurances received on how these are being addressed.
- Document accounting and reporting procedures during implementation assess compliance with financial procedures and seek evidence of control systems.

d) Inform and facilitate learning

- Using the findings from verification of results, activities, financial and programme management data, facilitate programme learning between implementers, WHO, DFID and relevant external stakeholders.
- Disseminating the research outputs appropriately and facilitating learning and uptake of findings. This will include to external audiences as a global good and will include theory of change workshops if the research was shaped to strengthen or test linkages within the TDDAP theory of change.

- Using the totality of the TPM supplier activities, provide insights into the implementation and progress of programme delivery. Of importance to DFID is the inclusion of beneficiary[1] feedback and evidence to inform the programme and communications (e.g. voices) (this should be collected under the verification of results and activities).
- Sharing learning from the evidence generated from the programme with DFID and key partners (convening meetings, sharing reports), promoting evidence uptake in Global Health Security Programmes. The TPM Supplier should clearly set out its lesson learning and dissemination approach in its communication plan to be agreed in consultation with DFID.
- Coordinate with the Public Health England TPM on their global health programme, particularly around research (once in place).

Geographic focus:
The TPM Supplier will provide assurances that it can cover the entire TDDAP programme area through effective sampling and spot checks. This includes at least the 26 countries being covered by WHO AFRO and the six countries where the ETA will be working which could include but not be limited to Benin, Burkina Faso, Cameroon, Central Africa Republic, Cote D'Ivoire, Guinea-Bissau, Ethiopia, Gambia, Ghana, Mali, Mauritania, Niger, Senegal, Togo, Chad, DRC, Malawi, Tanzania and Uganda.

The suppliers will be responsible for their own duty of care and will be able to operate independently in the countries above (refer to DoC section 11).

5. Methodology

All three parties will agree on methodologies; however, it is suggested that the TPM Supplier will employ a range of methods to meet the objectives, including (but not limited to):

- A diverse interaction of qualitative and quantitative methods to ensure correct triangulation of information and avoid data gaps during analysis and reporting.
- Adaptive monitoring, evaluation and learning processes.
- Innovative ways to collect data including open and digital data collection methods, innovative sampling and other techniques.
- Ensuring that national and southern based organisations or those representing the stakeholders and beneficiaries are involved in providing feedback on the programme.
- An analysis of the operating environment and opportunities and challenges this presents.
- Involving implementing partners, donor agencies and beneficiaries through a process of consultation and constructive feedback.

The programme covers different interventions in different country contexts. A sampling approach will be found which allows for conclusions to be drawn. We expect the TPM Supplier to proactively reach out to all key stakeholders for interviews, to check information and to fill in any knowledge gaps.

These methodologies will be refined and agreed upon during the three-month start-up phase.

6. Outputs

Proposed outputs under the scope of the programme will include:

a) Independent verification of activities and results as outlined in the log frame:

- Third-party monitoring of programmes, providing robust and independent oversight of the programme's delivery [quarterly review of KPI reports]
- Provision of evidence and monitoring to support DFID reviews [at least annually]

[1] Beneficiaries could include (but are not limited to): Government stakeholders; partners, community members, other stakeholders working in those countries on health security or health systems (indirect)

- Assessment of monitoring systems currently used by the implementing partner to build an evidence base of which interventions are working well

User: DFID, Programme Steering Committee - WHO, ETA, PHE, DFID and FCO post holders, cross Whitehall global health security working group

b) Generating additional evidence of results

- Testing and generation of evidence from the programme to enable adaptive programming, with a variety of prioritised studies that test innovation or gaps in evidence to either adjust the programme or strengthen global knowledge.

User: DFID, Programme Steering Committee, WHO, ETA, PHE, country governments, other relevant stakeholders with interest in Global Health Security.

c) Independent verification of financial and programme management data

- Critical review (operational, financial, and advisory) of the data provided by the Implementing Partners to make recommendations to improve reporting and compliance.
- Verification of results and financial reporting and reported KPI's upon which payments are being made. The findings will be discussed at quarterly review meetings.
- Constructive feedback to DFID and implementers to enable programme delivery, ensure VFM and adaptation for outputs and results.

***User:** DFID, Programme Steering Committee*

d) Inform and facilitate learning

- Organise a start-up meeting with the TDDAP implementing partners to share tools and methods and agree monitoring and communication plan. Then to arrange annual meetings thereafter of all partners to share findings and learnings to inform programme delivery.
- Provide a key learning function for TDDAP across all implementers to ensure as effective programming as possible.
- An annual and final summary of findings, evidence and lessons learned to inform other Global Health Security initiatives.

User: DFID, Programme Steering Committee, WHO, ETA, PHE, country governments, other relevant stakeholders at national, regional and international levels with interest in Global Health Security.

This is not an exhaustive list and we welcome suggestions by suppliers on other interventions that would be useful to ensure the TDDAP programme is effectively implemented.

7. Deliverables

The final design work is expected to begin with a draft overarching Design Report due within six weeks of the contract being signed. The report should set out the following deliverables with indicative timelines:

- A **work plan** detailing how to meet the requirements of this ToR, including how it will work independently of WHO and ETA to provide reassurances for financials and data. The work plan should provide a breakdown of activities and outputs (with associated budget) and will include methodologies for sampling including confidence levels. It should be submitted to DFID within ten weeks of contract being signed.
- Data quality assessment reports. **Six-monthly** based on sampling from different countries.
- **Quarterly** report on financial verification assessment
- **Quarterly** reports on results verification assessment accompanied with financial report.

- A risk matrix identifying the main risks and challenges for the monitoring and how these will be mitigated: to be reviewed on a **quarterly** basis.
- A delivery chain risk map which should, where possible, identify all partners involved in the delivery of a programme (see annex E for example) – updated quarterly
- Convening of meetings including WHO, ETA and DFID, commencing with a start-up meeting to agree monitoring and communication plan; thereafter on the findings of assessments (6 monthly in year one, annual thereafter, aligned to the reporting cycles including annual reviews)
- annual reports to feed in the annual reporting cycle of the TDDAP programme including a section on results verification, generating additional evidence and learning what works
- Succinct summary papers and recommendations for programme governance and reviews according to a schedule and ad hoc requirements in line with the meetings convened above.
- Develop a costed and time-bound communication, evidence and dissemination strategy. By the end of the three-month start-up phase.

A consultation will be held with DFID to finalise the draft design report. The TPM Supplier will conduct workshops with DFID and the implementing partners to refine the plan during the start-up phase and hold six-monthly workshop sessions throughout the programme lifetime.

8. Performance Management

An output based model will be used for the effective implementation of the main TDDAP programme. TDDAP is intended to be flexible and adaptive, using data generated through the life of the programme to feed into decision-making and corrective action; data collected by the TPM supplier will be used to help DFID verify key components of the implementation of TDDAP.

This contract will be results based and an output based deliverables schedule will be agreed between DFID and the TPM Supplier, based on the delivery of high quality products and strategies outlined in the TOR. Payment will be made upon satisfactory delivery of outputs/ Key Performance Indicators.

Personnel fee rates for each output will be linked to the delivery of time-bound, quality outputs and key performance indicators (KPIs). The payment for KPIs will be reduced if the quality is not satisfactory. KPIs will not be allowed to be deferred unless under exceptional circumstances which will be approved by DFID. The contract will use a hybrid approach of payment and suppliers should include a proposed hybrid payment mechanism in their bids clearly linked to the outcomes / deliverables of the programme. The supplier will include, in their commercial proposal a scoring matrix and score card for milestone deliverables and propose KPIs that DFID will approve and finalise when the preferred bidder has been identified. Suppliers should detail their proposed hybrid approach in pro forma 5 and provide supporting narrative.

The TPM Supplier will be responsible for managing their and all their sub-contractor's performance and tackling poor performances. They will be required to demonstrate strong commitment towards transparency, financial accountability, due diligence of partners and zero tolerance to corruption and fraud.

9. Constraints and dependencies

- WHO started implementation in December 2017 and it is recognised that there will be a disconnect between the TPM, Supplier and WHO's timelines. The TPM Supplier will undertake retrospective analysis for the interim period of transition.
- The ETA will start in June 2019 if not sooner (subject to tender), however the TPM Supplier will review the proposed M&E plan and fiscal controls and provide recommendations once appointed.
- Work on WHO's component can start immediately.
- At the earliest time feasible, the WHO, ETA and TPM will be convened by the TPM to ensure that all parties agree on the frameworks, structures and methodologies to ensure that the TPM requirements are met.

- The TPM should have audit-type capacities as well as a good contextual understanding of the geographies and programme components with a strong practical capability of assessing data and programme quality.
- The TPM will have good relationships with country partners and ability to operate.

10. Contract Management

DFID will monitor programme performance through key progress update meetings quarterly, during which results will be reported by the TPM Supplier, in addition to formal annual performance reviews. The contract will allow for formal review points after the three-month start-up phase and at the programme mid-point (18-20 months), based on overall performance. Performance will be assessed according to delivery and quality of reports and progress against the work plans, with timely recommendations to feed into adaptive programming.

DFID Co-ordination

The DFID Deputy Programme Manager will be the key point of contact with the TPM Supplier, supported by a wider programme team. The ARD DFID Health Adviser will be the Senior Responsible Officer (SRO); DFID Social Development and Evaluation Advisers will be consulted and included in discussions with the TPM Supplier and ETA.

Data Ownership
All data and metadata are owned by DFID and bidders should ensure that all data is rigorously documented.

11. Risks and Challenges
The TPM Supplier will be required to provide a **risk register** as part of the design report which will be monitored and updated on a quarterly basis. Guidance will be shared with the TPM Supplier on DFID's risk management but should cover External Context, Delivery, Safeguards, Operational, Fiduciary and Reputational risks.

Fraud: the TPM Supplier will be required to set out their fraud mitigation strategies including internal risk management and reporting systems. An annual audit will be required.

TPM Suppliers will be required to produce a **delivery chain risk map (example supplied at Annex E)** which should identify all downstream partners involved in the delivery of this TOR. As a minimum it should include details of: the name of all downstream partners and their functions; payment flows (amount, type) to each delivery partner; high level risks involved in programme delivery, mitigating measures and associated controls. The delivery chain map will be required in advance of payment and reviewed quarterly with DFID.

Finance
DFID have conducted a due diligence checks on the suppliers as part of the framework agreement. The TPM Supplier will be responsible for conducting due diligence on all downstream suppliers.

TPM Supplier will be required to submit a quarterly financial report to accompany the quarterly performance reports. These should provide a clear and detailed breakdown of activities against the work plan, fees and expense at HQ and country level.

Assets
If the supplier procures assets, we will require a comprehensive asset register. A decision on the assets from DFID, through an asset disposal plan, will be required at the end of the programme.

12. Expertise

It is essential that the TPM suppliers combine evidenced expertise relevant to all outputs in the following areas:

a) Independent verification of activities and results as outlined in the log frame:

- Strong experience of various quantitative and qualitative third-party monitoring (including results verification) methodologies.
- Experience in undertaking monitoring and verification of large programmes with multiple components and partners leading to programme adaption.
- In particular experience of drawing together findings from verification exercises, interpreting and analysing these alongside contextual factors to produce recommendations and learnings for the programme.
- Experience and operational mobility in the countries/regions of operation including fragile states.
- Experience of working with national governments/ international and regional bodies and independent contractors in African contexts.

b) Generating additional evidence

- Ability to integrate creative approaches to traditional qualitative and quantitative research methods.
- Experience of operational research, inclusive of identifying and prioritising operational research needs with other parties and disseminating findings appropriately, ensuring evidence uptake by a range of partners.
- Economic and VFM analytical skills. In particular experience of using applying the 4Es in complex developmental programmes, adapting traditional methodologies where needed. Ability to call on a range of experts as needed to address specific requirements.
- Ability to present complex issues in a clear and accessible way.
- Ability to incorporate flexibility and innovation into M&E design and approach.
- Close understanding of political economy of each country and risks and opportunities.
- Good understanding and application of global health security and disease preparedness work as well as the ability to apply the remit of International Health Regulations (IHR) and 'One Health' to different country contexts as required.

c) Independent verification of financial and programme management data

- Familiarity with DFID systems and processes would be helpful and experience in risk assessment and management.
- Audit-type skills will be essential for robust analysis of the financial and programme management data. Including evidence-based, robust analysis of fiduciary risks and of fraud.
- Familiarity with issues of fraud in developmental contexts.

d) Inform and facilitate learning

- Ability to bring together a wide range of partners for lesson learning and evidence uptake by a range of partners.
- Expertise in data disaggregation and analysis for illustrative and learning purposes.
- Facilitation skills to share learning and communicate course correction between stakeholders, ensuring where possible evidence uptake and utilisation.
- Experience in running Theory of Change workshops to map new evidence and research to the TDDAP Theory of Change.
- The TPM Suppliers will propose learning/sharing opportunities (based on other convened events where possible) with costings.

13. Logistics and procedures

The TPM Supplier will be responsible for all logistical arrangements for themselves and members of the team. During the start-up phase, the TPM will detail how it will meet the requirements in collaboration with WHO AFRO and the ETA.

In terms of delivery of the overall TORs, suppliers should lay out how they propose to hire both core and contract staff to deliver the overall contract and for how many days a year. We would expect however at least [two] staff working full time to ensure coordination, consistency, timely reporting and to provide regular point of contact with DFID (including travel to London or East Kilbride at short notice). Other staff should be based where it makes sense to fulfil this contract effectively, including countries where TDDAP operates.

14. Reporting

The person to whom reports should be sent is the DFID Senior Responsible Officer for TDDAP, currently the Regional Health Adviser within Africa Regional Department. All reports should be copied to the Programme Manager within Africa Regional Department. For day-to-day matters, the Programme Manager should be contacted copying the Senior Responsible Officer.

The TPM Supplier will provide quarterly narrative reports on results verification accompanied by a financial report, risk matrix and delivery chain mapping updates. The TPM Supplier will meet DFID on a quarterly basis to discuss the reports and completion of deliverables prior to payment. These reports will be shared with the implementing partners of TDDAP and meetings will be convened regularly [at least 6 months] to discuss the results and findings.

The TPM Supplier will provide annual reports to feed in the annual reporting cycle of the TDDAP programme including a section on results verification, generating additional evidence and learning what works. The annual report should be specific on timely recommendations for improved programme delivery. The timing of the Annual Reports will be clearly articulated prior to TDDAP implementation.

The TPM Supplier will provide a high quality final report summarising the learning, evidence and clear recommendations resulting from the programme to inform disease preparedness programmes going forward. The timing will be set to coincide with the end of the TDDAP programme. Final payment will be made upon satisfactory agreement of the report, including any independent assessment required (e.g. EQUALS).

Financial reporting: As set out above, TPM Suppliers will submit quarterly detailed financial reports. Monthly forecasts against the work plan will also be provided to assist with accurate forecasting. Where possible, the supplier (ETA, WHO and TPM) will aim to spend 90% of the financial year spend between April- December.

15. Communication:

In agreement with DFID, documents and findings may be published and shared more widely in order to be made available to a broader public audience. The TPM Supplier should clearly set out its lesson learning and dissemination approach in its communication plan to be agreed in consultation with DFID. The TPM Supplier expected to agree this plan with partners at the start-up meeting; this should then be developed into a costed and time-bound communication, evidence and dissemination strategy.

16. Timeframe and Scale up/Extension options

The TPM Supplier will be mobilised during the three-month start-up phase. The WHO component of the programme started in December 2017 and the ETA will be in place by August/September 2018 or sooner (subject to tender). The intention is for the Third-Party Monitoring supplier to be in place prior to the ETA contract, and to have concluded the final results verification and lesson learning by the end of the TDDAP programme. The end of the programme is scheduled for March 2022 including at least three months for the ETA to complete close-out.

17. Budget

A maximum budget of up to £1,500,000 including any taxes, for the monitoring has been set aside. Bidders are invited to demonstrate what they could deliver within the allocated budget while maintaining excellent value for money and delivering high quality work.

In the event that DFID takes the decision to increase the scale and ambit of the programme during its entire term the increase will be up to an additional £750,000 over and above the £1,500,000 budget.

18. Duty of care

The TPM 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**. Please see Annex D for full details of DFID's Duty of Care Policy and Country Risk Assessment.**

19. Branding

UK Aid Branding suppliers that receive funding from DFID must use the UK aid logo on their development and humanitarian programmes to be transparent and acknowledge that they are funded by UK taxpayers. Suppliers should also acknowledge funding from the UK government in broader communications, but no publicity is to be given without the prior written consent of DFID. A branding discussion will be held with the TPM Supplier and the Implementing Partners. Given the nature of the study and work, the TPM supplier should seek prior consent from DFID before using the logo or acknowledging funding. This will also be captured on the visibility statement and agreed prior to contract signature.

20. Transparency

DFID requires suppliers receiving and managing funds, to release open data on how this money is spent, in a common, standard, re-usable format and to require this level of information from immediate subcontractors, sub-agencies and partners. It is a contractual requirement for all suppliers to comply with this, and to ensure they have the appropriate tools to enable routine financial reporting, publishing of accurate data and providing evidence of this DFID. Further information is available from: http://www.aidtransparency.net/

21. Ethical Principles

It is a requirement that all DFID evaluations comply with DFID's Ethics Principles. Proposals and tenders to conduct research or evaluations should include consideration of ethical issues and a statement that the researchers will comply with the ethics principles. This assurance will then be contractually binding. Treatment of ethics will be included in the assessment of bids. In practice this will involve:

- Considering whether external ethics approval is needed
- Ensuring that the research will not cause harm to participants
- Ensuring participation is voluntary
- Ensuring confidentiality is protected
- Taking account of international and local legislation
- Checking research and evaluation designs respect gender and cultural sensitivities
- Ensuring data is stored securely and safely
- Publication of research findings
- Protecting the independence of research and evaluation
- Seeking to ensure participation of marginalised groups.

22. Safeguarding

DFID maintains a zero-tolerance approach to sexual exploitation and abuse within supplier organisations, which includes their downstream supply chains. We expect DFID partners to follow our lead and robustly consider environmental and social safeguards through their own processes. The capacity of our partners to

do this and their effective performance should be a key risk assessment factor in programme design, delivery and monitoring and evaluation.

DFID have identified the following social safeguarding risks that supplier's will address in their tender proposals. The assessment detailed below is not exhaustive, and suppliers are encouraged to consider and mitigate their own safeguarding risks as part of their tender proposal.

Safe Guard	Mitigation
Implementing partner's staff violate safeguarding rules bullying, harassment and sexual exploitation causing harm to beneficiaries and reputation.	Selected partners for the Third-Party Monitoring contract and for the External Technical Agency will be required to demonstrate at tender evaluation stage that they have robust approaches in place to i) reduce this risk-taking place, and ii) manage instances of violations. Due diligence on WHO AFRO should demonstrate that WHO has robust safe guarding rules in place
Mistrust of communities around disease preparedness activities reduces ability to deliver programme	Programme is designed and delivered ensuring community engagement and contextually relevant with local expertise.
Accountability efforts by CSOs threaten to demotivate and demoralise providers who, with inadequate supervision and resources, will resent feeling under greater scrutiny.	TDDAP aims to avoid blame and shame approaches and use of positive deviance to highlight good practice and learning to counterbalance examples of poor performance and outcomes. Work with Africa CDC and national public health agencies. Use learning from African Leaders Malaria Alliance (ALMA)

DFID does not envisage the necessity to conduct any environmental impact assessment for the implementation of the issue-based programme. However, it is important to adhere to principles of "Do No Harm" to the environment.

DFID requires assurances regarding protection from violence, exploitation and abuse through involvement, directly or indirectly, with DFID suppliers and programmes. This includes sexual exploitation and abuse but should also be understood as all forms of physical or emotional violence or abuse and financial exploitation.

DFID expects suppliers as part of their tender response the address the following;

- suppliers are required to demonstrate at tender evaluation stage that they have robust approaches in place to i) reduce this risk taking place, and ii) manage instances of violations.
- all suppliers to demonstrate evidence of strong work place policies against Bullying Discrimination and Harassment (BDH) and exploitation (all types).
- suppliers to have robust whistleblowing policies and systems in place.

22. General Data Protection Regulations (GDPR)

Please refer to the details of the GDPR relationship status and personal data (where applicable) for this project as detailed in Appendix A and the standard clause 33 in section 2 of the contract.

Appendix A: of Contract Section 3 (Terms of Reference)
Schedule of Processing, Personal Data and Data Subjects

Description	Details
Identity of the Controller and Processor for each Category of Data Subject	The Parties acknowledge that for the purposes of the Data Protection Legislation, the following status will apply to personal data under this contract**:** 1) The Parties acknowledge that Clause 33.2 and 33.4 (Section 2 of the contract) shall not apply for the purposes of the Data Protection Legislation as the **Parties are independent Controllers** in accordance with Clause 33.3 in respect of Personal Data necessary for the administration and / or fulfilment of this contract. 2) For the avoidance of doubt the Supplier shall provide **anonymised data** sets for the purposes of reporting on this project and so DFID shall not be a Processor in respect of Personal Data necessary for the administration and / or fulfilment of this contract.

Annex A: Redacted Business Case

Business Case

Summary Sheet

Title: Tackling Deadly Diseases in Africa Programme (TDDAP)		
Programme Summary: The Tackling Deadly Diseases in Africa Programme (TDDAP) aims to save lives and reduce the impact of disease outbreaks and epidemics on African populations. TDDAP will strengthen African health systems and institutions by supporting: (i) World Health Organisation Africa Office (WHO AFRO) reform, (ii) countries' ability to achieve the International Health Regulations (IHR), (iii) better governance and accountability of public health systems, (iv) improved data and evidence, and (v) emergency response.		
Programme Value: £40m plus up to £20m contingency mechanism		**Region:** Africa
Programme Code: 205242	**Start Date:** **July 2017**	**End Date:** **March 2022**
Overall programme risk rating:	**Moderate**	
EDRM Number:	**5759498**	

Acronyms

Africa CDC - Africa Centres for Disease Control and Prevention
ARD - Africa Regional Department
CDC - Centres for Disease Control and Prevention (United States)
CERs – Commercial Expertise Reviews
CHASE – Conflict, Humanitarian and Security Department
CSO - Civil Society Organization
DFID – Department for International Development
DH - Department of Health
DHIS - District Health Information Software
DRC - Democratic Republic of the Congo
EME - Early Market Engagement
EOC -Emergency Operations Centres
EpiThreats Group – Epidemiological Threats Group (cross-DFID group for assessing disease threats and response)
EQUALS - Evaluation Quality Assurance and Learning Service
ETA - External Technical Agency
FCO - Foreign and Commonwealth Office
GDP - Gross Domestic Product
GFATM – Global Fund for AIDS, TB and Malaria
GFD - Global Funds Department
GHSA – Global Health Security Agenda
HEART – Health and Education Advice and Resource Team
HIV/AIDS - Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMG - Her Majesty's Government
IDSR - Integrated Disease Surveillance and Response
IHR- International Health Regulations
INFORM – Index for Risk Management
JEE - Joint External Evaluation
KPIs - Key Performance Indicators
LSHTM - London School of Hygiene and Tropical Medicine
MCDA - Multi-Criteria Decision Analysis
MOU - Memorandum of Understanding
NGO -Non-Governmental Organization
PHE - Public Health England
PHEIC - Public Health Emergencies of International Concern
QAU – Quality Assurance Unit
RECs – Regional Economic Communities
RSIS - Real-time Strategic Information System
SRO - Senior Responsible Officer
TA -Technical Assistance
TB - Tuberculosis
TDDAP – Tackling Deadly Diseases in Africa Programme
ToR -Terms of Reference
UNICEF - United Nations Children's Fund
UNMEER - UN Mission for Ebola Emergency Response
VFM - Value for Money
WAHO – West African Health Organisation
WaSH - Water, Sanitation and Hygiene
WFP - World Food Programme
WHO AFRO – World Health Organisation (Africa Regional Office)
WHO HQ - World Health Organisation (Head Quarters)
X-WH - Cross Whitehall Group

Intervention Summary

Narrative summary of why UK support needed, what the funds will be spent on, where, over what period of time, via whom and what they will deliver. The UK's response to Ebola represented a great success in preventing the spread of a killer disease that threatened to reach 1.4 million cases. However, it came at significant cost to the UK taxpayer and African economies which lost at least $1.6 billion. The Ebola crisis, and subsequent Zika and Yellow Fever epidemics, showed clearly how better preparedness could enable disease outbreaks to be picked up earlier - saving lives, saving money and protecting countries around the world (including the UK). Through TDDAP, the UK will provide up to £60m over 3 years (July 2017 to March 2020) to support (i) WHO AFRO reform and support their Health Emergencies programme; and (ii) a contracted external technical agency (ETA) to support country governments and complement WHO AFRO's work in building national and regional capacity to comply with the IHR; strengthen governance and accountability and strengthen development and use of integrated disease surveillance and response mechanisms. The programme will be the UK's main instrument (alongside a complementary £16m Public Health England (PHE) programme) to prevent and respond to future disease outbreaks. It will work across Africa through WHO's regional programme with more focused support in four to six most at risk countries. TDDAP includes a £20 million contingency mechanism through which additional funds (from the DFID contingency reserve) could be routed in the event of a Public Health emergency. No funds are currently allocated to this, but we are seeking approval to facilitate a rapid response if needed in future.

Does the programme fit with DFID's strategic architecture: the UK Aid Strategy, Single Departmental Plan, International Development Act and the department's Business Plan? Yes. UK Aid Strategy: TDDAP contributes to Strategic Objective 4 (Extreme Poverty) by working in some of Africa's poorest countries to tackle small outbreaks to prevent catastrophic public health disasters. It contributes to Strategic Objective 2 (Resilience) by strengthening systems to deliver on the anti-microbial resistance agenda and guard against future resistance or emerging epidemics. Strategic Defence and Security Review: TDDAP will ensure that countries are better equipped to tackle outbreaks, stopping them from crossing borders and becoming global epidemics. Manifesto Commitments: TDDAP supports progress towards reducing the impact of the 'world's deadliest infectious diseases'; Cross-Whitehall Global Health Security Strategy 2015: TDDAP will support countries and the international system to prevent, predict, detect and respond to health threats.

What percentage of DFID's Single Departmental Plan results target does this programme represent? Could the programme be adjusted in scope or scale to deliver SDP results? The programme is DFID's most significant contribution to tackling 'the world's deadliest diseases' (a non-quantified target). The programme will also help deliver DFID's commitments on Malaria by strengthening surveillance systems and improving data and evidence. Our assessment is that 30% of spend should be counted towards malaria and 70% towards Health Systems Strengthening spend.

Is the programme coherent with the wider international community and partner government response? Has the programme set out a sustainable exit strategy? The global health community has developed strategic recommendations for change particularly since the Ebola outbreak. WHO's mandate for leading global health emergencies has been reaffirmed; and the international community is playing its part to support WHO's Health Emergencies Programme and holding them to account. TDDAP supports reform priorities of WHO and the wider UK drive to reform WHO, led in DFID by the Global Funds Department (GFD), and incentivises effective coordination between WHO headquarters (HQ) and the AFRO regional departments by aligning work with UK priority asks under the UK-WHO Performance Agreement. Public health systems strengthening is the best value for money approach to health security because it ensures that prevention of outbreaks is enhanced rather than just reacting to crises. The support will be multi-sectoral and be integrated into national planning processes. Over the course of the programme, a transition to domestic financing and an appreciation of the importance of preventative health will be a key milestone.

Has the programme considered working with HMG Departments and accessing cross-HMG funds? It will work closely with PHE/Department of Health (DH) £16m IHR programme to ensure complementarity and avoid duplication. DH/PHE/DFID have defined the collaboration with WHO AFRO through an action framework setting out how we will work together on key technical areas and provide

mutual learning and support. It also aligns with the surveillance and laboratory strengthening work of the Fleming Fund. The regional disease preparedness programme has also engaged with the Foreign and Commonwealth Office (FCO) in countries where there are no DFID bilateral programmes such as in Mali. As FCO/DFID capacity increases in the Sahel, TDDAP will utilise FCO country presence to support engagement and monitoring with Governments and implementers. TDDAP reinforces and sits under the UK-WHO Performance Agreement which sets out the UK's priorities for WHO reform and includes TDDAP performance indicators.

How does the programme relate to other UK aid within the specific sector, including multilateral, bilateral and centrally managed programmes? TDDAP is a flagship programme for DFID on Global Health Security, particularly in the African context which features strongly in the UK's dialogue on WHO reform. The programme operationalises **international commitments** including the G7+ through the Global Health Security Initiative and complements the World Bank's Pandemic Financing Facility. It will coordinate with **bilateral** programmes, including Sierra Leone, Zimbabwe and Kenya, where there are plans for funding on IHR and health systems. Nigeria, Ghana and Ethiopia have health systems strengthening programmes although there are still gaps. TDDAP will build on the existing regional disease preparedness programme, which has been an example of how to operationalise global health security by strengthening country level health systems. It will have strong synergies with the programme on "strengthening the use of data for malaria decision making in Africa", as well as work on the National and Regional Health Observatories. The programme **coordinates with other UK funding to WHO** including the core voluntary contribution, the 'one UN' humanitarian business case which will fund the WHO Health Emergencies Programme and the support to WHO's health systems strengthening portfolio (still in design). GFD and Africa Regional Department (ARD) will work closely on coordination between WHO AFRO and WHO HQ. Governance and monitoring mechanisms to support this are detailed in Annex E. GFD has been closely involved in the design of this business case and has approved it as a vital part of the UK's support for WHO's reform and global health security agendas.

Is there sufficient flexibility to learn and adjust to changes in the context? What level of flexibility is there to shift this and future commitments? Yes, through adaptive programme management using evidence from the partners and the third-party monitoring.

Does the proposed level of risk to be taken fit with DFID's risk appetite for this portfolio? Yes, the programme is classified as moderate risk, but the returns are high as catastrophic consequences of outbreaks will be prevented. Previous preparedness programmes show that risks can be mitigated.

Is there a clear communications strategy to reinforce our objectives? Will the programme be branded with the UK aid logo and recognise UK Government funding – and, if not, why not? Yes. Engagement of UK and International media will be sought throughout the life of the programme. UK aid branding will feature predominantly on international activities and in country wherever possible and appropriate. This will be developed further as part of the tender process.

Has the programme been quality assured? How confident are we that the skills, capability, resources and political will exist to deliver the programme? The business case has been reviewed by other health advisers and DFID WHO relationship holders (GFD) in addition to a robust Quality Assurance Unit (QAU) process. The momentum (following the Ebola and Zika response) for the regional preparedness programme and strengthening data for malaria decision making is at its peak, and political will to tackle health security is high. WHO AFRO is technically strong and currently in the process of comprehensive reform to address weaknesses exposed during the Ebola crisis. This programme will in itself help drive forward the reform process. AFRO's performance will be closely monitored by both DFID and a third-party monitoring agent. Payments will be disbursed subject to satisfactory delivery against technical and administrative performance criteria. The ETA will be competitively procured from what is expected to be a strong field of potential delivery partners.

Does the SRO and team have the capability and resources to deliver this programme? It will be one of the most important programmes in the ARD portfolio. Resources have been prioritised for robust programme management and oversight of programme partners, working closely with other relevant departments across DFID (GFD, Country Office network) and Other Government Departments...

A. Strategic Case

Why is UK support required?

Background and Problem Statement

1. Africa's disease burden and health outcomes have notably improved over the past decade, including impressive reductions to nearly halve under-five mortality between 1990 and 2013. The maternal death rate has also declined by 48% during the same period.[2] However, health systems in most countries remain weak, characterised by gaps in financing, skills and the health workforce, low availability of medical products, vaccines and equipment and unequal distribution and access to health services. Disease burdens also remain high: more than 90% of the estimated 300-500 million annual malaria cases are in Africa, mainly in children under five years of age. HIV/AIDS continues to affect the continent, which has 11% of the world's population but 60% of the people with HIV/AIDS.[3] An infectious disease outbreak is reported every 3 to 4 days in Africa, these are often animal in origin defining the need for a 'One Health' approach, which recognises the connection between human, animal and plant health.

During 2016 there was an outbreak of Rift Valley Fever between Mali and Niger. The disease mainly infects animals but can also kill humans. There was a real risk that mass herd movement for the annual 'Salt Festival' could have spread the disease across the Sahel. This demonstrates the need for a joint approach between human and animal health – the **"One Health" approach**.

2. The weaknesses in national public health systems were exposed by the Ebola Virus Disease epidemic in West Africa; the worst in history in terms of magnitude, geographical scope and duration. The outbreak began in Guinea in late 2013, after which the disease spread rapidly to Sierra Leone and Liberia. The WHO designated the outbreak a public health emergency of international concern in August 2014. By the end of 2014, in addition to Guinea, Sierra Leone and Liberia, cases had also been reported in Nigeria, Senegal, Mali, Spain and the United States. Without interventions or changes in community behaviours, the US Centres for Disease Control and Prevention (CDC) predicted that Sierra Leone and Liberia would face up to 1.4 million cases of Ebola by January 2015.[4]

3. The response effort was a success in controlling the spread of infections. As a result of concerted action by international partners (including the UK) and African governments, these cataclysmic predictions did not become a reality: 24,802 cases were reported in Sierra Leone and Liberia, with a further 3,814 cases in Guinea.[5] In addition, a potential fourth country outbreak was averted. However, despite these successes, immense suffering and fear were experienced by communities, national health systems were brought to a halt, and hard-won social and economic gains were reversed. The World Bank estimates that the Ebola outbreak cost the economies of Sierra Leone, Liberia and Guinea $1.6 billion in 2014 and 2015.[6] The cost of dealing with the outbreak was nearly three times the annual cost of investing in building a universal health service in all three affected countries[7].

4. DFID's interventions during the Ebola crises and in other public health emergencies have contributed to a common understanding of the weaknesses in African health systems and the international health architecture. The programme proposed here will address the challenges that have undermined efforts to prevent and respond to disease outbreaks:

[2] WHO AFRO, Atlas of African Health Statistics, http://www.aho.afro.who.int/sites/default/files/publications/5266/Atlas-2016-en.pdf
[3] Ibid.
[4] CDC, Estimating the Future Number of Cases in the Ebola Epidemic: Liberia and Sierra Leone, 2014–2015, http://www.cdc.gov/mmwr/preview/mmwrhtml/su6303a1.htm
[5] The death tolls too were lower than predicted, with the countries at the heart of the outbreak – Guinea, Sierra Leone and Liberia – reporting 11,310 Ebola deaths by April 2016. Figures for April 2016 from CDC: http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html
[6] These losses were as a result of the impact on the mining sector, increased Ebola related expenditures, reduced exports, loss of employment, and decreased services. See World Bank, The Economic Impact of Ebola on Sub-Saharan Africa: Updated Estimates for 2015, http://documents.worldbank.org/curated/en/2015/01/23831803/economic-impact-ebola-sub-saharan-africa-updated-estimates-2015
[7] Wright, S; Hanna, L (2015) A wake-up call: lessons from Ebola for the world's health systems. Save the Children

a. **African national public health systems do not have the minimum level of core capacity to detect report and respond effectively to serious disease outbreaks.** Across Africa, investment in the health sector is below that required to establish and maintain effective services. In 2015, only eight countries had met the Abuja Declaration target of allocating at least 15% of their annual budget to improve the health sector.[8] Even before Ebola killed hundreds of health staff, the three countries at the centre of the outbreak had acute shortages: among every thousand people Guinea could count only 0.1 doctors, Liberia 0.014 and Sierra Leone 0.022.[9] Despite recent progress in the prevention and treatment of diseases like malaria, the continued prevalence of preventable disease is indicative of poor health services. For instance, a child still dies every minute from malaria in Africa.[10] All governments must take responsibility for investing in health capacity, personnel and infrastructure to meet their commitments to international frameworks such as the IHR. Investments in 'everyday' health systems must also be increased to provide the solid foundations which emergency responses can build upon. Before the West African Ebola outbreak, Uganda had the largest Ebola outbreak in history. However, because of excellent technical expertise and a comparatively operational health policy and strategic plan, delivering the essential health service package at a decentralised level, it was better able to contain future outbreaks of Ebola and other diseases through strengthening disease surveillance and control capabilities[11].

International Health Regulations (IHR)
This represents the framework designed to prevent national public health emergencies from becoming international crises, adopted by WHO in 1969. These regulations were updated in 2005 and adopted by the World Health Assembly. All member states signed up to the IHR which legally binds them to notify WHO of public health emergencies of international concern and to develop core public health capacities. They have the aim to prevent, protect against, control and respond to the international spread of disease while avoiding unnecessary interference with international traffic and trade. It embodies a full public health approach and this year; concerted efforts have been made to ensure that there is consistent assessment and costed plans of action for countries.

b. **Governance failures have led to resources being diverted from health services, eroding the trust between state and citizens and making the control of disease outbreaks more difficult[12].** The long-term failure of the governments of Guinea, Sierra Leone and Liberia to provide good quality basic services for their citizens compounded the effect of the Ebola virus. Not only was health care infrastructure under-resourced and unable to deliver life-saving care, but communities displayed suspicion of healthcare workers who represented, at best, a system with which they were unfamiliar and, at worst, a system that they perceived to be illegitimate and untrustworthy[13]. Ensuring health systems are resilient to shocks from outbreaks is essential in reducing morbidity and mortality from non-communicable diseases. In this context, we can see the importance of ensuring African governments and their international partners adequately resource health systems, with a particular focus on embedding public health services in local and community-driven approaches[14]. We also need to think and work politically in our disease interventions; long before the emergency hits we must use our influence and programming to identify and remove the political and institutional barriers to investments in public health and preparedness - not just health services for the elite in urban areas. Alongside this, we must support civil society to hold their governments and international organisations to account.

c. **The incentives for timely reporting and international declaration of a serious disease outbreak have been weak[15].** During the Ebola crisis the threat of trade and travel restrictions, combined with endemic weaknesses in capacity, led to national authorities in some cases seeking to downplay the severity of outbreaks. The WHO must also mobilise the required international attention and global response at the critical early stages of the epidemic.

d. **The international organisations responsible for managing effective responses to health threats require more robust capacity.** Clarity about roles, responsibilities, priority setting and

[8] WHO, The Abuja Declaration, http://www.who.int/healthsystems/publications/abuja_declaration/en/
[9] In comparison, South Africa can 0.776 doctors per 1,000 population. The UK has 2.809 doctors per 1,000 people. See WHO, Global Health Observatory Data Repository (density per 1,000, by country), http://apps.who.int/gho/data/view.main.92100
[10] WHO Africa, http://www.afro.who.int/en/malaria/
[11] Commission on a Global Health Risk Framework for the Future, National Academy of Medicine: The neglected dimension of global security: A framework to counter infectious disease crises. National Academies Press
[12] Edelstein, M. 2014. Ebola thrives in brittle West African Health Systems. Chatham House. Centre on Global Health Security.
[13] Dhillon, RS; Kelly, JD. 2015. *Community Trust and the Ebola endgame.* New England Journal of Medicine 37(9):787-789
[14] APPG Inquiry: Community-Led Systems and the Ebola Outbreak. *Institute for Development Studies.2015*
[15] WHO. Report of the Ebola Interim Assessment Panel. 2015

accountabilities within and between international actors were delayed or absent during the Ebola epidemic. The WHO's reputation has suffered and capacity, management and governance reforms at the country, regional and global level of the organisation are needed. The WHO accepts this: its own *Report of the Ebola Interim Assessment Panel* (known as the Stocking Report) identifies a number of key reform areas for the WHO.[16] The Regional Director for WHO AFRO, Dr Moeti, has also articulated her vision for AFRO's reform.[17]

e. **Existing systems for data production and dissemination do not adequately support outbreak prevention and response.** Prevention is critical and actions early in a response to a health emergency can be truly game changing for averting the most devastating of outbreak scenarios. For example, despite being densely populated, Nigeria was able to contain the virus and early declaration of risks in Mali by WHO also contained the outbreak. Extra capacity needs to be deployed quickly and early to gather further information, address the uncertainty factor and ensure that subsequent decisions about a response can be backed up by stronger data and on-the-ground knowledge. The Ebola crisis has shown the need for further investment in risk-mapping and the development of a predictive, horizon scanning model for epidemic prone countries and regions. The Index for Risk Management (INFORM) Ebola tool, is a way to measure the risk of an outbreak of widespread and intense transmission of Ebola, identifying the relative hazard, vulnerability and coping capacity of individual countries. This tool can also be adapted and utilised for other diseases to prioritise investments and interventions. Detailed risk maps developed through DFID's strengthening malaria for decision-making programme (Figure 1), have been used to stratify risks and interventions, and can be used for other diseases. WHO have used such risk mapping for other communicable diseases and are planning to work with other organisations to overlay these with climate change, environmental, infrastructure and Water, Sanitation and Hygiene (WASH) data (note, there is a business case on WHO-led WASH infrastructure mapping which has also just been submitted for approval). Ebola also underscored inadequate arrangements between governments and the WHO for collecting, sharing and validating information on outbreaks, and opportunities now exist to share reliable and timely data through the District Health Information Software (DHIS-2) and real-time data sharing linked with an effective and prompt public health response.

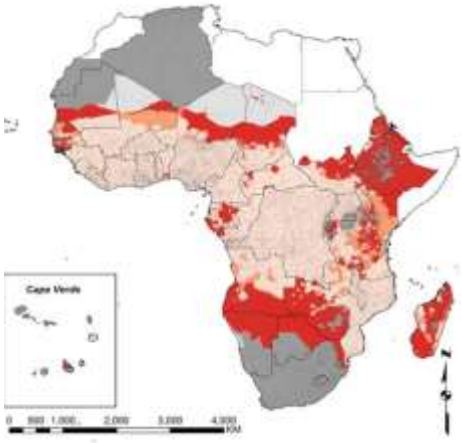


Figure 1: Example of malaria transmission risk map

Global Health Security and the UK National Interest

5. The events in West Africa drew global health security sharply into focus, reinforcing Her Majesty's Government's (HMG's) understanding of its international health interventions as being both an international public good and being in our national interest. Diseases and other health threats can transcend national boundaries and – as Ebola and now Zika demonstrate – have potential national, regional and international impacts. Countries with weaker health systems are less well-equipped to detect and respond to disease outbreaks, less resilient to the social and economic impacts of health emergencies and may be unable to stop the spread of disease outside of their borders[18]. Under these shared realities, the need for a collective and coordinated response to emerging public health threats is clear.

6. However, it is important that political attention and financial resources are not drawn away from the 'everyday' health emergencies posed by diseases like malaria, tuberculosis and respiratory tract infections to focus only on the most recent, attention-grabbing disaster. DFID, international organisations and African governments also need to take into consideration the demands placed on African health systems by multiple lower level outbreaks each year, such as 2016's yellow fever

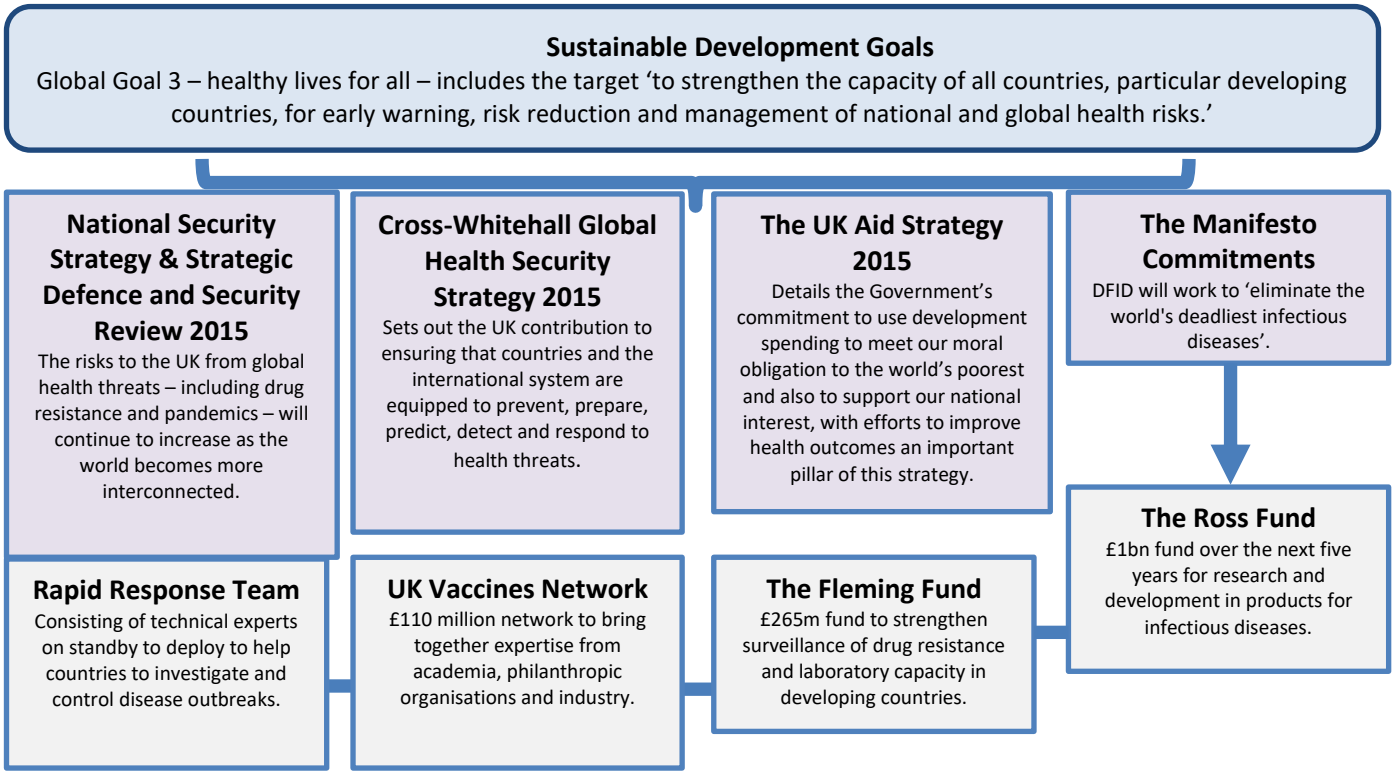
[16] WHO, *Report of the Ebola Interim Assessment Panel,* 2016 http://www.who.int/csr/resources/publications/ebola/report-by-panel.pdf
[17] WHO Africa, *The Africa Health Transformation Programme 2015-2020: A Vision for Universal Health Coverage,* http://apps.who.int/iris/bitstream/10665/206535/1/9789290233022.pdf
[18] Wright, S; Hanna, L (2015) A wake-up call: lessons from Ebola for the world's health systems. Save the Children

outbreak in Angola and Democratic Republic of the Congo (DRC). These lower level outbreaks showed the importance of political and technical commitment with adequate systems. This programme acknowledges this by mainstreaming across its interventions an approach that integrates prevention, preparedness and response capacities for both the extreme emergency outbreaks like the 2013 Ebola epidemic and the more routine and long-term challenges presented by diseases like malaria and HIV/AIDS.

7. Figure 2 summarises the UK initiatives which contribute to global and national health security. Strengthening global health security by building capacity in national health systems, reducing the transmission of preventable endemic diseases like malaria and taking the lead in humanitarian emergencies are HMG priorities, led by the DH and DFID. A Cross-Whitehall Global Health Security strategy was agreed in August 2015, setting out the UK contribution to ensuring that countries and the international system are equipped to prevent, prepare, predict, detect and respond to international health threats. The initiatives below outline the contribution to the Government's Manifesto. TDDAP is well positioned to deliver against these key DFID, HMG and global commitments, taking into account lessons from Ebola and the Department's disease preparedness programme. TDDAP is being designed closely with DH and PHE to ensure that there is complementarity and learning between initiatives.

Figure 2: Links to HMG strategic priorities and global commitments

This figure is not all encompassing, and TDDAP also fits with the UK's commitments to support the global health architecture and reform priorities.



DFID's Leadership in Africa Health Programming

8. The UK is a leader in the global fight against deadly infectious diseases, which disproportionately affect the poorest people. Historically, the UK has been at the forefront of research and development for infectious diseases and the UK is now one of the largest funders of work on neglected tropical diseases and global efforts to tackle disease resistance. Working in partnership with others, the UK has demonstrated a leading role in epidemics, particularly by tackling Ebola in West Africa. The UK is also the third largest contributor to the Global Fund to Fight AIDS, TB and Malaria.

9. DFID's ARD has implemented a significant portfolio of health programmes to address the health challenges in Africa that occur both during emergencies like Ebola and Zika and also in the longer-term. See Table 1 for a summary of recent interventions. At country level, the majority of DFID's

offices also implement health programmes focusing on, *inter alia*, health systems strengthening. These programmes and lessons learnt from them directly inform the design of the TDDAP.

Table 1: Relevant existing DFID programmes and their approved budgets.

Programme	*Outline*
UK Support for Regional Preparedness to Prevent the Spread of Ebola £23.2m January 2015-March 2017 (Implementation)	Part of the UK's total contribution of £427m to stop the spread of and respond to cases of Ebola. Two components: (i) a consortium of Non-Governmental Organisations (NGOs), the Start Network, which worked to prevent the spread of Ebola as well as water, sanitation and hygiene related diseases in four of the most at-risk countries (Guinea Bissau, Mali, Senegal and Ivory Coast); and (ii) support to the WHO to strengthen national capacities to improve country readiness for epidemics in 19 African countries.
Strengthening the use of data for malaria decision making in Africa £26m Start July 2013 London School of Hygiene and Tropical Medicine (LSHTM) component – June 18; WHO September 18 (Implementation)	Designed to help decision-makers use evidence to improve the efficiency and quality of malaria control in Africa, this programme has four streams of work to support context-specific, evidence-based strategic planning, budgeting and implementation: (i) producing and collating malaria data and relevant indices; (ii) building skills and culture for malaria (and other) programmes to draw upon evidence to define technical strategies; (iii) developing implementation and investment plans based on malaria strategies and performance; and (iv) disseminating information nationally and across the region. This programme extends beyond malaria and is building National and Regional Observatories to compile, interrogate and analyse data.
Evidence for Action to Reduce Maternal and Newborn Mortality in Africa (E4A) £20.5m August 2011-April 2016 (Completed)	The programme aims to improve maternal and newborn survival through a combined focus on evidence, advocacy and accountability in six countries (Ethiopia, Ghana, Malawi, Nigeria, Sierra Leone, and Tanzania). The programme will achieve this by promoting more effective use of evidence to generate political commitment, strengthen accountability, and improve planning and decision-making through use of scorecards which are discussed at the highest level on a regular basis – working both at country level and to support strengthening of regional and international accountability frameworks.

Evidence for the Intervention

10. There is no shortage of analysis on national and international responses to the Ebola crises pulled together by United Nations (UN) panels, independent expert panels, NGOs, donors agencies, the WHO and DFID itself. Lessons are summarised in the needs section above. Together these present a large body of evidence for why effective disease preparedness and early epidemic response are essential for public health outcomes in Africa, and also how these can be improved based on the lessons of the Ebola response. Although motivated by the recent Ebola outbreak, many of these reports acknowledge that lessons from this particular epidemic must be applied to the management of longer term health crises like malaria and HIV and the control of new outbreaks in the future. TDDAP has reflected this lesson learning exercise in its design. See Annex A for a summary of the key processes and publications and events related to lesson learning from the Ebola outbreak. There is a strong case for disease preparedness as a good investment based on analysis post-Ebola. If such preparedness investments are strategic, benefit-cost ratios can be as high as 7:1. Costs and mitigation measures should be seen as variable and part of a spectrum along the scale of outbreaks, epidemics and pandemics. Responding to the Ebola crisis cost three times what is estimated to be required annually for health systems strengthening in the three countries affected.

Leave no one behind

11. TDDAP will make concerted efforts to ensure that the poorest, people with disabilities, elderly and children, most excluded and hardest to reach are prioritised to ensure that they can access and benefit from public health systems and prevention activities. The programme start-up phase will identify opportunities to meet the needs of the most disadvantaged. One of the criteria for country selection is vulnerability, and while this focuses on risks of outbreaks and epidemics, decisions will also be made according to poverty levels. TDDAP will hold governments and institutions to account, and the emphasis on increasing health budgets and involving civil society will ensure that there is equitable allocation and use of resources.

12. Rather than focusing on direct service delivery, the programme will aim to build inclusive institutions (WHO-AFRO) and capacity for the identification, location and targeting of services to those most vulnerable to disease outbreaks and/or those likely to left behind in an emergency response. This is where community-based systems are important. Capacity to respond to the needs of the most marginalised and vulnerable includes:

- Data disaggregation and capacity of the management information systems to disaggregate by gender, poverty, age, geography, environmental risks, disability and other ethnic groups who may face socio cultural barriers to access.
- Data analysis to ensure effective targeting to reduce risk and save lives.
- Capacity building of health staff and community members to ensure the needs of certain groups are identified and met.
- Ensuring medicines for vulnerable groups are available e.g. if paediatric formulations are required, or there are other pre-existing diseases where treatments need to be continued during an emergency or there may be interactions between treatments.
- Referral mechanisms to ensure there is good aftercare following an illness.
- Supporting country public health systems to identify, track, locate and target disadvantaged/marginalised/most susceptible populations in a given disease outbreak.

13. Ensuring beneficiary feedback and participation will be an essential part of this programme to ensure that it is meeting the needs of a diverse range of people who should benefit from the public health system. This will be factored both into TOR development and monitoring requirements.

Gender Equality

14. Gender inequalities affect the ability of women and girls to access health care and determine social positioning and familial care roles that expose women to more risk, ultimately affecting patterns of disease among women and girls. The Ebola outbreak pulled into focus the gendered nature of many epidemic and non-epidemic prone diseases in Africa. For example, women make up 57% of all adults living with HIV in sub-Saharan Africa, and in the high prevalence countries of Southern Africa, HIV infection rates among 15-19-year-old females are sometimes five times higher compared to their male peer groups. In Africa, an estimated 10,000 women and 200,000 of their infants die annually as a result of malaria infection during pregnancy.[19] Epidemiological statistics on the Ebola outbreak indicate that the disease slowly became a female epidemic. By September 2014, authorities in Liberia were estimating that as many as 75% of their Ebola fatalities were women, and UN sources in Sierra Leone reported that women represented around 59 per cent of the deceased.[20] While there seems to be no biological sex difference regarding vulnerability to Ebola, many sociocultural and health-care-related factors increased the risks for women in the Ebola outbreak in West Africa.[21]

15. TDDAP is fully compliant with the Gender Equality Act. The programme will start from the premise that adolescent girls and young women are among the most marginalised and at-risk populations in many public health emergencies. Acknowledging this, we will incorporate the following elements to maximise the gender equality impact:

a. **We will analyse the gender context in each of our focus countries and in relation to our target diseases.** This will take into consideration the ways in which the different genders are differently affected by diseases and health emergencies within the prevailing social, economic and cultural norms of each focus country.

b. **Elements of each of the programme's interventions will ensure adequate consideration is given to gender equity.** For instance, in our work to support WHO AFRO's reform processes we will ensure that men and women are given equal opportunities in newly reformed structures and policies. Work with civil society to improve disease prevention will include specific activities to raise awareness and counter the harmful traditional practices that most often negatively

[19] GFATM, Why Does Gender Equality Matter in Public Health?, 7 March 2014, http://www.theglobalfund.org/en/blog/2014-03-07_Why_Does_Gender_Equality_Matter_in_Public_Health/#!

[20] UNWomen, Ebola Outbreak Takes its Toll on Women, 2 September 2014, http://www.unwomen.org/en/news/stories/2014/9/ebola-outbreak-takes-its-toll-on-women#sthash.GRHuChT9.dpuf

[21] Clara Menendez, Anna Lucas, Khatia Munguambe & Ana Langer, 'Ebola crisis: the unequal impact on women and girls' health', *The Lancet,* Vol 3 No 3, e130, March 2015, http://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2815%2970009-4/fulltext?rss=yes

impact women and girls and enhance caregiving practices of women and girls to promote effective hygiene. Data collected as part of the programme will be gender disaggregated wherever possible.

c. **Gender equity will be actively monitored throughout the programme life cycle.** During the tendering process, bids will be assessed against their responsiveness to gender considerations and the track record of implementers in designing and delivering programmes that promote gender equity. The programme's implementing partners will be required to establish benchmarks and subsequently to report on progress toward gender markers and equity. Evaluation work and lessons learnt exercises will ensure that programme activities are analysed with a gendered lens to confirm that the programme responses are adequately differentiated to the needs of men and women.

Counter Terrorist Financing

16. The risks of UK aid being diverted to support terrorist groups or activities are low as funds will be used to support WHO AFRO and an external technical agency (ETA) who will undertake the necessary due diligence and monitoring of downstream partners including NGOs and CSOs. Delivery chain mapping will ensure that partners and DFID keep track of this risk.

Risk

17. This regional programme provides an opportunity on "preparedness investment" – to address the challenges that have undermined efforts to prevent and respond to disease outbreaks before they become catastrophic. It also provides a coordinated opportunity on achieving risk mitigation strategies and economies of scale. Taking into account the current risks identified and applying mitigation strategies (Table 6, on page 38) the programme is classified as moderate risk.

18. The external context risks on political/country governments, conflict and drug resistance are beyond the remit of this programme. However, mitigation strategies to address these have reduced the residual risk to major. The monitoring of these and other risks on delivery, operational, safeguards, fiduciary and reputational will be a continual process and managed in line with DFID's current risk management framework including in conjunction with all programme stakeholders.

19. Risks to effective delivery through the proposed partners and mechanisms will be mitigated through clear governance arrangements including clarity in roles and responsibilities between WHO / WHO AFRO and the ETA. These will be set out fully in Terms of Reference (ToR) and detailed in the performance frameworks to be put in place. Clear key performance indicators (KPI's) will be set in the tender and WHO AFRO performance framework. Payments and project delivery will only proceed subject to satisfactory performance against technical and administrative performance criteria.

Working with Partners

20. DFID has worked closely with DH and PHE in the design of this programme to ensure coherence between initiatives, and PHE will provide actual technical assistance for some of the components which will be identified during the inception phase. Throughout the lifetime of the programme, TDDAP will coordinate closely with the PHE technical committee.

21. TDDAP will be implemented through three main partners:

- **WHO AFRO** will be responsible for directly supporting countries and the region to build IHR capacity, strengthening governance and accountability through direct engagement with governments and building data and evidence at the Africa Regional level. It has been chosen because of its remit to support country Governments and strengthen national health systems, whilst also working regionally and internationally. It has been delivering on our existing regional preparedness programme post-Ebola and has made promising strides in increasing its capacity to prevent, detect and respond to outbreaks. However, we are also mindful that AFRO is in the process of reform following weaknesses exposed during the Ebola crisis. For this reason, TDDAP will in itself help to drive forward AFRO's reform efforts as a separate output and our support will be carefully calibrated against delivery. Progress and further payments will be contingent upon delivery of agreed outputs.

- **WHO HQ** will be responsible for providing technical assistance, backstopping functions and quality assurance to ensure coherence across regions and share learning to strengthen the programme. It will complement the regional team to bridge any gaps in competencies.
- An **ETA** will be commercially procured to deliver targeted support in four to six focal countries at high disease risk. It will complement the work of WHO AFRO by delivering supplementary technical support on IHR where needed, demand-side governance reform and build data, evidence and accountability at national and sub-national levels. It may also be responsible for delivery of aspects of response under the contingency mechanism.

Programme Impact and Outcomes

22. The impact statement for the programme is 'reduced impact of communicable disease outbreaks and epidemics on African populations'. This not only includes the impact in terms of lives saved, and transmission to other countries, but also economic impacts. The outcome is 'African health systems and institutions strengthened to prevent outbreaks and epidemics of deadly communicable diseases', which includes WHO AFRO reform, increased country commitments for **preparedness** and enhanced IHR and surveillance capacity.

23. To achieve these, the programme will be structured around the following areas of work:

- Working with regional and international health institutions to help them clarify their mandates and roles, develop and implement a robust set of international health policies and programmes, and establish adequate systems for preventing and responding to health emergencies.
- Supporting our partner countries to make sure that their national health systems are resilient, responsive, accountable and on-track to meet the standards set out in the IHR.
- Ensuring that governments and regional health institutions are held to account for investing in and tracking public health.
- Gathering accurate data, surveillance and evidence to inform responses to infectious diseases by African governments and international partners.

An **ETA** will be commercially procured to deliver targeted support in four to six focal countries at high disease risk. It will complement the work of WHO AFRO by delivering supplementary technical support on IHR where needed, demand-side governance reform and build data, evidence and accountability at national and sub-national levels. It may also be responsible

24. Detailed TOR and performance indicators for each component will be determined, clearly defining the roles of the respective partners. This is further detailed in the Management Case.

What do we mean by 'preparedness'?

This has not been well-defined despite dialogue which has failed to provide practical, output based country level expectations. DFID's regional preparedness programme has identified the following:

i. **Systems are ready** to prevent, detect and respond to outbreaks. This includes rapid procurement mechanisms pre-vetted, communication strategies agreed, laboratory capacity enhanced, and protocols approved.
ii. **Table-top simulations** have ensured that triggers and response mechanisms are well-coordinated, and governments and institutions can respond rapidly in real-time.
iii. **Routine and surveillance data are analysed and used** to predict risks and plan to mitigate these risks effectively.
iv. Assessments of **compliance against the IHR** are translated into costed and funded action plans which are implemented to increase capacities.
v. **Effective multi-sectoral working** to support holistic public health practice, One Health approach and national security

Appraisal Case

A. Options to respond to the issues established in the Strategic Case

Option 1: Core Contributions to WHO only

25. This option entails providing core funding to WHO only in the expectation that this enhances WHO's work to strengthen the regional and countries health systems to prepare for and respond to disease outbreaks, supporting WHO's Health Emergencies Programme. It should also support reform of WHO AFRO. Africa accounts for 30% of WHO total spend[1]. In scoping this support we have liaised closely with GFD who concur that at this time, this option will not provide the best Value for Money (VFM) for the targeted results we want to achieve, as there needs to be timely funds flow to WHO AFRO. GFD's view is that WHO continues to progress on its reform journey. The greater the progress on reform, the greater our confidence in the WHO to prioritise policies and programmes and ensure adequate funding follows, and therefore the greater the likelihood that UK funds will be provided with less ear-marking and more flexibility for WHO's senior team to deploy. GFD's longer-term aim to consolidate to one funding stream will provide greater flexibility and empower the WHO senior team to advance reform and break down the silos in which these teams are currently prone to work. However, reform has some way to progress before DFID would feel able to offer fully flexible funding support (namely an enlarged core voluntary contribution alone). We do not have the confidence that this money, supplied through the core voluntary contribution, would reach in full, its intended target (potentially being diverted to other "priorities" identified by other Member States). DFID's work with WHO HQ and WHO AFRO is aligned to the UK's reform objectives (as laid out in the UK-WHO Performance Agreement) and is spearheading progress.

Option 2: Support WHO AFRO Reform and IHR capacities of selected countries

26. (a) Support to **WHO AFRO** reform to ensure that they can effectively assist countries and the region on disease preparedness, and;

(b) Focused support in up to six country governments to strengthen their capacities on the International Health Regulations through an ETA.

The Ebola crisis showed that strong partnerships between international organisations and country Governments is essential for success. IHR can be achieved through ensuring national health systems strengthening for universal health coverage and ensuring inter-sectoral collaboration and action. This option includes strengthening of cross-border responses between countries and supporting a One Health approach. It allows for more targeted assured multi-year funding than Option 1.

(c) Independent monitoring and verification – contract with third party monitoring agent.

Option 3: Support to strengthening governance and accountability, data and evidence and work on developing a rapid response

27. This option would provide parallel support to WHO AFRO and a contract to an ETA to focus on governance and accountability with the evidence base.

(a) Accurate data and evidence will be captured by **WHO AFRO**, country governments and non-state actors and disseminated for planning, action and accountability.

(b) The **ETA will support civil society** to strengthen governance and accountability within the region and in countries to hold governments and international agencies to account to deliver on achieving the international health regulation capacities, preventing epidemics, and delivering quality public health services through effective allocation and management of scarce resources.

(c) A **rapid response** component is included as a back-up to ensure that a pre-qualified mechanism is in place to provide a timely contextually-relevant response to outbreaks at community level working with WHO AFRO. WHO AFRO will continue to build the capacity of Emergency Operations Centres (EOC's) in the region.

(d) Independent monitoring and verification – contract with third party monitoring agent.

Option 4: Support to WHO AFRO, national health systems PLUS governance and accountability, data and evidence and rapid response.

28. This is a hybrid of options 2 and 3. Learning from the Ebola crisis and our existing programmes in regional preparedness and data for malaria has demonstrated that initiatives to strengthen

[1] http://extranet.who.int/programmebudget/Biennium2016/Flow

governance and accountability are required which are supported by strong data, surveillance and evidence. This option will support non-state actors to strengthen governance and accountability at national and regional levels as well as strengthen data, surveillance and evidence. The rapid response component is also included. This option would require a Memorandum of Understanding (MOU) with WHO and a contract with an ETA. The programme will incentivise collaboration between WHO AFRO and the ETA consortium as they will need to jointly work on the components of the programme. This option ensures that:

(a) WHO will deliver on its mandates and build on its work on strengthening IHR capacities and enhancing data and surveillance.
(b) The ETA will provide technical assistance and support WHO to strengthen country and regional IHR capacities and improve use of data. They will support operationalisation of systems strengthening efforts and community and district levels.
(c) The ETA will work with civil society and country governments to enhance accountability and governance.
(d) There is rapid response capacity at community, national and regional levels.
(e) There is a third-party monitoring and verification mechanism.

Option 5: Do nothing.

29. The counterfactual to the above is to do nothing and allow the existing programmes on regional disease preparedness and strengthening data for malaria control to come to their planned completion. This would mean that the existing support to WHO AFRO on disease preparedness would end in June 2017 and June 2018 on malaria, and the work with the LSHTM-led consortium on data for malaria control would end in September 2018. Yet there is still work to be done. This option is immediately being discounted as it does not align with the UK manifesto commitments and does not address the needs outlined in the strategic case.

Option 6: Set up a vertical disease response mechanism

30. This option is being immediately discounted as wider public health system strengthening is a more sustainable approach. There are already vertical initiatives through rapid response mechanisms with LSHTM and PHE, and our support to WHO AFRO will provide some support to establish the Emergency Operations Centres in the region, which builds on the existing work through the regional preparedness programme. Only having these does not prevent outbreaks and public health emergencies and this programme is focused on preparedness and prevention through sustainable approaches.

Multi-Criteria Decision Analysis of decision options

31. In order to select the preferred option of funding a Multi-Criteria Decision Analysis (MCDA) was undertaken (Annex B). MCDA is typically adopted when it is not possible to quantify the benefits of particular interventions in a way that is comparable across the alternative options. As an open and explicit process with chosen objectives and criteria open to analysis and review, supplemented by scoring and weighting that generates an audit trail for decision making, MCDA is a more effective analytical tool than informal judgement however we recognise that no tool would be perfect in this scenario, but that we are moving towards a transparent basis for these decisions.

32. The MCDA adopts 6 equally weighted criteria which reflect the key objectives of the programme. Each criterion is scored from 1 to 5, with 1 representing poor performance and 5 strong. These scores are averaged to provide a weighted total to identify the preferred option. Below is a summary of assessment of options using relevant programme evidence:

a. Maximising the public health impact and minimising global health security risk

This programme is seeking to tackle a number of complex and inter-related issues in order to tackle deadly diseases in Africa. Through the provision of broad-ranging support to a number of critical areas Option 4 scores the highest on maximising public health impact and minimising global health security risk. Option 4 entails strengthening the supply of health services (WHO AFRO and health systems strengthening) and the demand for health services (improving governance and accountability and the provision of data and evidence). The other options receive lower scores against this criterion as they are insufficiently broad-ranging to sufficiently maximise the public health impact and minimise the global health security risk.

b. Support health systems strengthening across Africa
Options 1 and 3 do not entail the provision of any direct work on health systems strengthening in Africa and correspondingly receive a low score against this criterion. Conversely options 2 and 4 have a strong focus on this criterion and accordingly receive a high score.

c. Strengthen accountability for service delivery
Just working on systems strengthening alone will not fully address the issues raised in the strategic case and only investing in governance and accountability, would mean that governments and institutions are being asked to increase performance within challenging parameters. The first and fourth options have a strong direct focus on strengthening accountability for service delivery through the provision of support to civil society and the gathering and dissemination of data. The absence of specific work on these topics leads to the second and third options receiving a low score against this criterion. The Evidence for Action programme focusing on Maternal, Newborn and Child Health showed that civil society engagement and accountability mechanisms through scorecards galvanised political will and ensuring that implementers including governments were held to account and public funding was increased to support evidence-based interventions which were incorporated into the national health plans. Increasing investments in Universal Health Coverage supports health security.

d. Provide data and evidence to inform decisions
Good surveillance and routine data is essential evidence to support governance and accountability to ensure that Governments invest in the health system and address the broader determinants of disease outbreaks including water, sanitation and hygiene. Through working to provide data and evidence to inform responses to infectious diseases by both African governments and international partners the first and fourth options receive a high score against this criterion. The limited direct focus of options two and three on the provision and dissemination of data leads to their receiving a low score. Our current work on strengthening data for malaria decision-making has shown promising results in supporting stratified malaria control strategies to ensure that limited resources including from the Global Fund can be allocated effectively. Mapping of actual data has also enabled tracking of changes in transmission risks and enables prediction of whether outbreaks will reach epidemic levels, including taking into account immunity and susceptibility. A key learning from the existing Regional Preparedness programme post-Ebola, showed that there is limited capacity for information management and translation into better policies and programming.

Evidence for decision-making is essential to prepare for, predict, detect and respond to outbreaks. This takes into account relevant population-based, migration, conflict, environmental, climate change and infrastructure data, including water and sanitation. **WHO AFRO's Real-time Strategic Information System (RSIS)** and **Integrated Disease Surveillance (IDSR) system** can be supported to develop to meet the emerging needs. In addition, the **Global and African health observatories** supported by DFID create a common, open platform for quality assured data to be accessible, scrutinised and used. **WHO's Data Collaborative** is working towards this.

e. Strengthen capacity of WHO AFRO
Providing core contributions to WHO (option 1) would indirectly provide some support to strengthening the capacity of WHO AFRO. However, such efforts would likely be insufficient compared to options 2 and 4 which have a direct focus. As stated in the strategic case, without the strengthened role of WHO AFRO in the region to fulfil its mandate to lead and coordinate disease preparedness, and support countries to meet the IHR requirements, health security would be difficult to achieve.

f. Maximising UK's influence and leverage Cross Whitehall working to strengthen disease preparedness
With its cross-cutting focus and ability to bring in Whitehall colleagues, Option 4 scores the highest against this criterion. DFID has worked with PHE and DH on the design of this programme to ensure that efforts are coordinated, and that expertise is utilised effectively. There are possibilities for PHE to provide technical assistance to WHO AFRO through secondments and provide regional assistance especially in underserved areas where PHE do not already have a bilateral presence. This fits with PHE's remit to be a technical agency for the region and utilised according to demand.

The business case being developed by PHE for DH approval is for £16m of ODA for five years and is insufficient to meet the requirements as shown by the scoping mission.

Preferred Option

33. The outcome of the MCDA demonstrates that **Option 4: Support to WHO AFRO (aligned with HMG support to WHO as a whole), national health systems, governance and accountability, data and evidence and rapid response is the preferred option** scoring significantly higher than the other three options across the six criteria. Option 4 is preferred to the counterfactual of do nothing given its strong ability to deliver against the issues and objectives set out in the strategic case and is deemed to represent the strongest Value for Money of the four options. Strategic investments in preparedness could achieve benefit cost ratios as high as 7:1. Costs and mitigation measures should be seen as variable and part of a spectrum along the scale of outbreaks, epidemics and pandemics. Responding to the Ebola crisis cost three times what is estimated to be required annually for health systems strengthening in the three countries affected, and Option 4 would help to achieve the results through the multi-pronged approach to public health systems strengthening. This Option has been agreed by DFID Health Advisers in Africa, DH, PHE and WHO AFRO, as well a number of suppliers at the pre-design early market engagement, as being the most feasible with high impact.

Evidence for the theory of change

34. Based on the lessons from Ebola and other outbreaks, there is strong evidence for the investments. However, there is an assumption that delivering on the IHR would produce the desired results. There is little evidence to suggest which part of the IHR package should be prioritised where a country may be assessed with weaknesses in multiple areas, and the programme will conduct operational research to add to the evidence base to support prioritisation. There is good evidence that climate change, natural disasters and civil unrest can result in catastrophic consequences where outbreaks are difficult to control. This is where the leadership of WHO AFRO to support such contexts is essential to the programme. We have good evidence that WHO AFRO reform, aligned and mutually beneficial to global WHO reform led by WHO HQ, could transform the landscape of disease preparedness and very strong evidence that political will from country Governments can strengthen health systems. See Figure 3.

Country Selection

35. The process of country selection will build on the experience and approach as used through previous programmes (Ebola and Regional Disease Preparedness) where we funded a programme in 21 countries (Benin, Burkina Faso, Cameroon, Central Africa Republic, Cote D'Ivoire, Guinea-Bissau, Ethiopia, Gambia, Ghana, Mali, Mauritania, Niger, Senegal, Togo, Chad, DRC, Malawi, Tanzania, Uganda, Cape Verde and Angola). It selected six countries considered most in need of support for in-depth monitoring of impact – Gambia, Guinea Bissau, Mauritania, Togo, Niger and Tanzania. The selection was joint with WHO and also used the INFORM Ebola tool (designed with WHO, Centres for Disease Control (CDC), LSHTM and DFID to rank countries at high risk on an outbreak and "weakest" in terms of preparedness systems and donor funding). This was then overlaid with WHO tracking of donor commitments to disease preparedness to ensure we were matching resources to risk. WHO AFRO has advanced their work on risk mapping to determine gaps in resources against risk.

36. With TDDAP, we will build on this prioritisation method with WHO. We are also working closely with PHE to understand the country support they are designing as part of their programme. TDDAP will therefore focus on at least four to six high risk countries based on a number of criteria as stated below. The selection will be further defined during the inception phase balanced with the capacity to support Francophone countries and the Sahel. Approaches will be tailored to each country context, including evolving needs.

The programme will work in four to six focus countries (decided in collaboration with WHO, DH, PHE and other stakeholders), selected using criteria such as:

- Country risk assessments using INFORM[22]
- Health status (using indicators such as maternal and U5 mortality rates)

[22] INFORM is a global, open-source risk assessment for humanitarian crises and disasters supported by DFID (among other international partners) http://www.inform-index.org/.

- Country performance against IHR and Global Health Security Agenda (GHSA) joint external evaluation assessments
- Political and institutional context (using proxy indicators such as per capita governmental expenditure on health)
- Profile of external support/DFID ability to fill funding gaps – using WHO's Strategic Partnership Portal (database of support on IHR).
- Supports and strengthens DFID's country-level health programming
- Total country population

A Regional Approach

37. There are major advantages to taking a regional approach to achieving TDDAP's goals. Most obviously, diseases often cross borders and many serious public health emergencies have an international dimension. By working through a network of most at risk countries, the programme can take a pragmatic epidemiological approach to disease prevention and response. Linked to this, many of the key institutions, policies and decisions involved in a public health emergency lie at the regional level. For instance, given its position of responsibility in any African public health emergency, WHO AFRO is an important part of any disease preparedness programme in Africa.

38. A regional approach allows pooling of expertise, and provides opportunities for economies of scale, risk mitigation across a portfolio of countries, quality assurance, monitoring and cross border lesson learning.

39. Both regional and national civil society actors are required to hold governments and regional bodies accountable for delivering quality health services. Advocacy work by civil society in a single country context is limited by the reality that the disease prevention and preparedness efforts of each country will be affected both positively and negatively by those of its neighbours. Finally, from a practical perspective, cost and learning efficiencies can be achieved by working within and across multiple countries. The programme will be able to test and transfer best practice approaches between countries while also taking advantage of economies of scale through sharing and not duplicating resources.

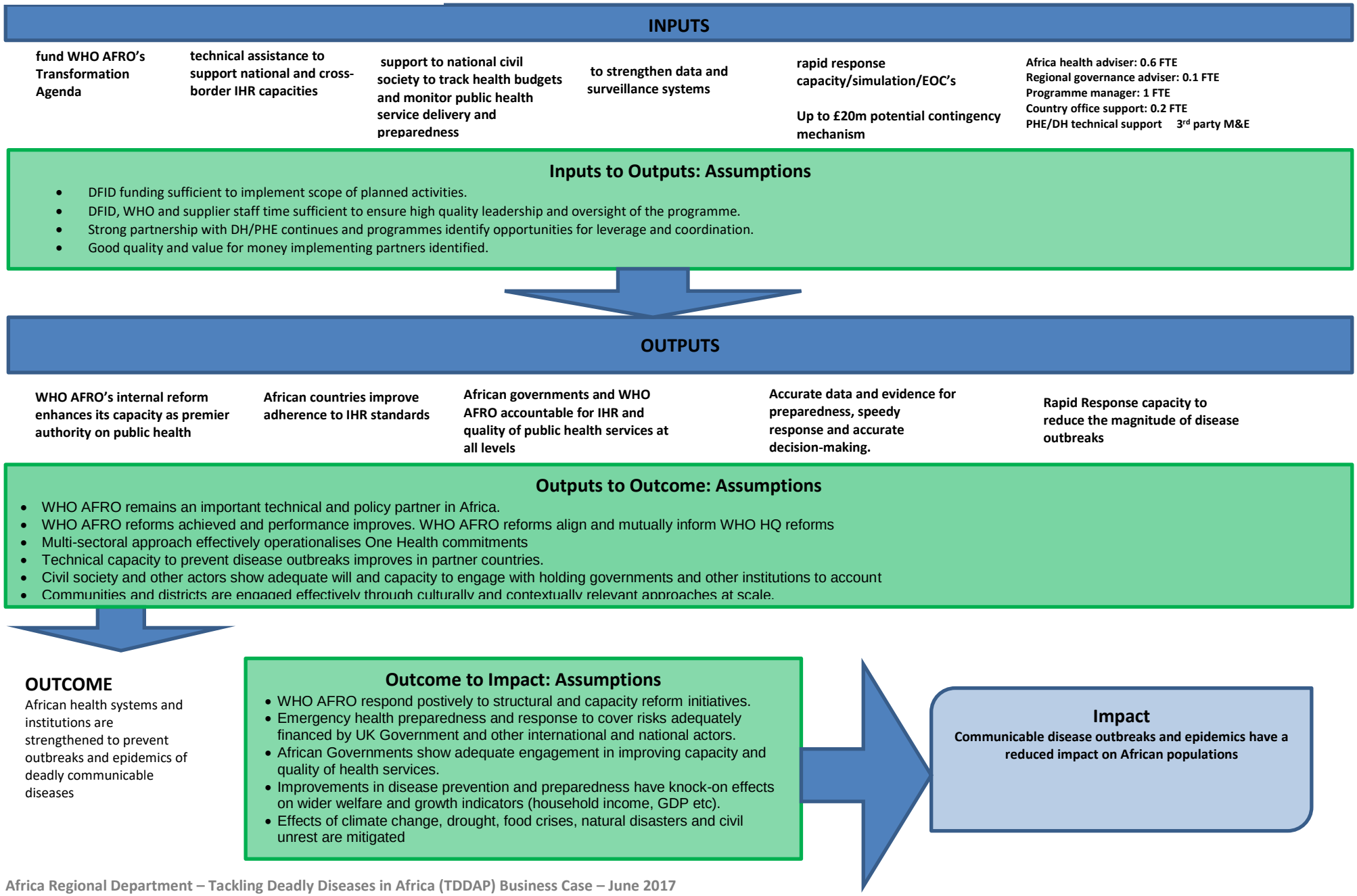
40. The programme's design will retain the flexibility to identify and work in a wider group of core countries if specific needs and/or public health emergencies arise during the programme's lifespan. The countries selected for specific support will be clustered so that a regional and cross-border approach can be demonstrated. These countries will be identified and agreed with DFID, DH, PHE and WHO AFRO in the inception phase, and the WHO's strategic partnership portal will be used to support decision making. Care will be taken to avoid duplication of bilateral efforts and efforts will be made to choose countries which have limited support but high risk.

Disease focus

41. The TDDAP will focus on building the ability of our partner countries and institutions to prevent and respond to the health emergencies presented by diseases which can lead to public health emergencies of international concern (PHEIC) like Ebola, Zika and yellow fever. However, the programme also recognises that health systems – and populations themselves – are weakened by 'everyday' diseases that remain rife in Africa. Although significant progress has been made in combatting a number of diseases – for example, an estimated 60% reduction in malaria deaths since 2000 – malaria, HIV/AIDS and other infectious diseases continue to extract a high human and financial cost from Africa. Some estimates put the economic cost of malaria to the African continent at a minimum of $12 billion a year in lost productivity, accounting in some high burden countries for 40% of public health expenditure.[23]

[23] UK Government, 'The UK's role in cutting malaria deaths since 2000', https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/461358/Facsheet-The-UK-role-in-cutting-malaria-deaths-by-60-percent-since-2000.pdf

Figure 3: Theory of change for the preferred option



42. Consequently, the programme will take an approach that both strengthens health systems in a long-term and non-disease specific way, alongside building surge capacity to respond to particular high-risk epidemic diseases. The work on strengthening IHR capacities will need to fit within the national planning processes and strategies, and support public health systems strengthening, multi-sectoral engagement and coordination. The focus of interventions will vary according to epidemiological patterns, country and institutional need with the programme retaining the ability to adapt to respond to emerging public health crises. To meet our Manifesto Commitments the programme will place a particular emphasis on activities that contribute to reduction of malaria.

43. The programme will strengthen international institutions and our partner countries' health systems. DFID is increasingly working through multilateral organisations given their greater reach and scale on AIDS such as the Global Fund for AIDS, TB and Malaria (GFATM). The UK remains the second largest international donor on HIV prevention, treatment and care. Under this model, it is outside of the scope of this programme to focus direct efforts on HIV/AIDS programming although the work across a number of other areas of disease prevention and preparedness will have an impact on HIV, malaria and TB-relevant capacities.

Sustainability

44. The approaches set-out in the business case are designed to ensure sustainability through increasing capacities and strengthening health systems. The programme will work with existing organisations, specifically WHO AFRO, National Governments and civil society to build their capacity to map risk, create cultures of preparedness, track progress on IHR/preparedness and ultimately ensure we have less outbreaks or epidemics in Africa. Sustainability will be built specifically through support to AFRO's transformation agenda to ensure AFRO is fit for purpose. Through strengthening IHR capacities, a multi-sectoral approach is implicit, which also supports long-term change and enabling governments to transition supporting public health systems alongside increasing domestic financing. There will be indicators relating to sustainability in the log frame. It should be recognised that building and strengthening systems and governance is a long-term process. NGOs will likely be funded (through the ETA) to both offer rapid response if needed and hold governments to account to be prepared.

45. It should be noted that many of the outputs in the log frame are drawn from indicators of compliance with IHR – such as good surveillance systems, stronger public health systems, good multi-sectoral working taking a One Health approach, good incident management systems and disease reporting processes. Indicators will be drawn from the Joint External Evaluation (JEE) tool and we have been pressing WHO to detail prioritised outputs that indicate how IHR fits into Health Systems Strengthening frameworks. This is part of broader WHO reform. The support to AFRO and the TA mechanism will enhance the long-term ability of countries to comply with IHR and tackle outbreaks. The country plans that AFRO and the ETA will support are drawn up after a JEE mission takes place in that country and prioritises specific actions for each country.

Importance of civil society and community engagement

46. A key lesson from Ebola is the importance of early community engagement. The response was commended for the investments in NGOs to mobilise communities to deliver appropriate messages and support interventions (Health and Education Advice and Resource Team - HEART review). This lesson has been incorporated into the design of both support to community partners/civil society (through the ETA) and

through the contingency fund response (involving local community/NGO actors who can mobilise quickly).

47. Communities can play a role in stopping the spread of disease in a number of ways. Citizens and civil society can play an important role in holding governments and other service delivery agents to account for providing quality health services. Typically, this is done through civil society tracing budgets and other service commitments from point of commitment to final point of delivery. Local community groups can also play an important role in identifying and publicising the loss or diversion of public assets thereby reducing corruption and ensuring that public resources are used to strengthen health systems and people's access to health services.

48. More immediately at the outbreak of disease, it is important for communities to be involved in making the decisions that affect their communities and lives. As noted above, the lack of trust between healthcare providers and communities was a severe barrier to containing the Ebola outbreak. By supporting an ongoing model of engagement through this programme that improves the quality and quantity of health services and making sure that communities are more involved with their health decisions during non-crisis times, it is more likely that resilient systems will be in place when the crisis hits.

Economic Appraisal and Value for Money

49. The estimated cost has been set out above and in the Financial Case below. The financial cost has been estimated using learning from the existing programmes. With the economic losses of $1.6 billion from the Ebola outbreak in the countries it affected, and morbidity in the tens of thousands, preparedness actions increase the value for money of investments made with early responses. The regional impact is expected to rise to USD 4.7 billion in 2017 due to the negative fallout of such crises. If such preparedness investments are strategic, benefit cost ratios can be as high as 7:1[24]. Costs and mitigation measures should be seen as variable and part of a spectrum along the scale of outbreaks, epidemics and pandemics. Responding to the Ebola crisis cost three times what is estimated to be required annually for health systems strengthening in the three countries affected. Through investing in the health systems building blocks, the results of investments are multiplied as the capacities can be transferred to a variety of infectious diseases and benefit non-communicable diseases as well as maternal, newborn and child health services. This was a key recommendation from the Ebola lessons learned report commissioned by Africa Regional Department in response to the Public Accounts Committee.

50. This programme is deemed appropriate and timely to ensure that outbreaks do not reach epidemic levels. Prevention and preparedness are highly cost-effective interventions, however estimating the benefits is challenging given the hypothetical nature of deaths averted from epidemics which are unpredictable. Option 4 provides good value for money as it supports strengthening of health systems and aims to integrate within existing systems and build on already established platforms. Avoiding a vertical approach and building capacity of national governments and civil society increases sustainability. Effectiveness and efficiency is also enhanced through the multi-pronged approach to strengthen systems and governance and accountability. The programme aims to enhance equity by using data to track epidemiology and needs, protecting the most vulnerable and supporting countries with the greatest need which have limited support. Pre-qualifying a rapid response mechanism enables containment of outbreaks when needed, to reduce the risk of them turning into

[24] Ebola Preparedness Guidance Note – analysis from Ebola programme.

epidemics and catastrophic consequences in terms of deaths, morbidity, and economic losses amongst others.

51. Taking early action and staying ahead of the epidemiological curve costs less and saves more lives since the speed of programme implementation has direct implications to lives saved during a time of a crisis[1]. A study in 2015 found that three quarters of the preparedness investment examined demonstrated cost-savings beyond the amount of the initial investment (ROI>1.0)[2]

52. Based on this evidence, investing in preventing an outbreak with a budget of £60m TDDAP could save up to £490m which may be needed to deal with the impact of an epidemic. Evidence from humanitarian preparedness investments undertaken by UNICEF and WFP suggests that for every £1 invested in preparation a £2 return was achieved in terms of savings on future spend/investments. Although applied to a different context this evidence, which considered the impact of emergency preparedness spend in terms of both cost and time savings, provides further evidence regarding the cost effectiveness of pre-emptive investments to avert disasters.

53. The evidence above suggests that the approach represents strong value for money (VFM). VFM indicators have been developed, and due to a **lack of data availability**, benchmarks will be developed during the first Annual Review. We have consulted with experts including WHO, and this would require huge assumptions and modelling which would not provide the evidence required. There are a number of indicators which could be used to assess VFM, with the following prioritised, as they are feasible to measure by analysing data available through the programme:

Effectiveness

- Number of countries reporting IHR capacity improvement/per two years
- Number of country Governments reporting satisfaction with services from WHO AFRO

Economy

- Cost/risk map/country
- Cost of reform processes/country office/year

Efficiency

- Cost/outbreak contained
- Cost/death averted from outbreaks occurring during the programme lifetime (modelled)

Equity

- % of target population reached who are women and girls
- Evidence of gender policies implemented within WHO reform processes
- Evidence of improvement of country health system to identify, track, locate and target disadvantaged populations in a given disease outbreak

54. Value for money will be increased through WHO AFRO reform and performance based payments for delivery partners. VFM will be a critical component of the tender analysis. We will be negotiating the KPIs between WHO AFRO, HQ and the ETA. For WHO, we will use the existing performance metrics, such as those of the Transformation Agenda, WHO Emergencies programme, and the systems strengthening indicators. WHO HQ is developing an organisation-wide VFM plan as required under the UK-WHO Performance Agreement. WHO AFRO will contribute to

[1] UNICEF/WFP Return on Investment for Emergency Preparedness Study, January 2015
[2] A ROI (return on investment) above 1 indicates a higher cost saving than the original investment.

the development of this and pioneer VFM approaches. This will form a key part of the TDDAP log frame.

55. We will also include key supplier management indicators which will be shaped through the negotiation period and will be valuable to ensure collaboration, coordination, communication and increased overall VfM. All partners will be expected to have a VFM strategy embedded into their agreement, providing quarterly updates on progress to DFID.

B. Management Case

Management arrangements

85. The TDDAP programme will comprise five outputs implemented through three funding agreements:

(i) a contract with an ETA to deliver services. (This will include an option to have a call-down emergency response mechanism for community/country level work should the contingency mechanism be triggered – see below).

(ii) an MOU with WHO AFRO through WHO HQ,

(iii) a contract for independent monitoring and verification of results, and fiduciary oversight where reporting will be direct to DFID. This expertise will need to be available at the beginning of the programme.

Contingency Mechanism

86. The purpose of the contingency mechanism is to provide flexibility to respond either to new/emerging needs identified through adaptive programming or to respond to disease outbreaks in Africa where ARD assistance is sought. Recent examples include a request for additional help on Yellow Fever, and during the Ebola crisis where DFID needed to provide support to NGOs to help with the preparedness at community and national levels mainly focused on WASH as well as burial practices. The contingency mechanism will mean that in the event of additional funding requirements, we have business case approval and contracts in place with high quality suppliers ready to provide assistance as needed. This mechanism should not duplicate other mechanisms and it will not provide funding for UK medical experts to mobilise and attend medical emergencies (currently covered by the UK Public Health Rapid Response Team through the Conflict, Humanitarian and Security department (CHASE) Operations Team). The TDDAP contingency mechanism would provide funding for specialist suppliers who could fill essential gaps and help sustainable responses (e.g. working at community levels contracting local staff or building local capacity). It could also provide funding to institutions, such as WHO AFRO for targeted emergency responses.

87. For emergency responses, the proposed response pathway would be:

- Identification of need for additional DFID response by X-WH Global Health Oversight Group and / or DFID EpiThreats group and Director General Level decision to respond at Africa Regional level
- Funding submission to appropriate level of Delegated Authority
- Additional funding to be released from within Africa Division or from DFID Crisis Reserve (depending on scale of need)
- ARD to provide funding to most appropriate delivery partner (either International Institution or consortium partner).

88. For new (non-urgent but high priority) needs identified through adaptive programming the process would be:

- Identification of need by DFID staff / project partners
- Approval by TDDAP Programme Steering Committee
- Submission to appropriate level of Delegated Authority
- Additional funding to be released from within Africa Division
- ARD to provide funding to most appropriate delivery partner (either International Institution or consortium partner).

89. The day to day programme implementation and management will be the responsibility of the ETA and WHO AFRO (both held to the performance measures and TOR set out in the respective contract and MOU arrangements). The ETA will be appointed through a competitive bidding process, in accordance with European Union (EU) procurement mechanisms, to manage the programme. The ETA will meet the requirements of the TOR for the tender through a consortium. This will include the requirement to be able to respond (and have a quick reaction mechanism in place) should the EpiThreat group trigger a call down on the crisis reserve). Prior to the appointment of the ETA, DFID will carry out a due diligence of the ETA to ensure sound finance management and robust governance and accountability systems are in place. Detailed Terms of Reference for the ETA are being developed in consultation with all stakeholders. The ETA will account for monies disbursed under the consortium approach.

90. The WHO AFRO component will be managed separately through an MOU. They will be responsible for their own performance against agreed targets and the reporting of funds. For WHO we will use the existing performance metrics, such as those of the Transformation agenda, WHO Health Emergencies Programme and systems strengthening indicators. Close cooperation and engagement will be needed between WHO and the ETA, facilitated by DFID utilising the third-party monitoring agency.

Roles, Responsibilities and Coordination

91. There is a need for collaborative working between all delivery partners; this will be done through appropriate management of partners. DFID will articulate the clear areas for synergy between WHO AFRO and other partners and be clearer on the areas each agency will be performance managed. We are currently developing the ToR for each component which will ensure this clarity. DFID will ensure that appropriate engagement opportunities are in place: this includes a round table kick – off meeting to set the scene of how we want our partners to work together; this could also include activities such as collective reporting against risks and progress against programme deliverables as a whole.

92. An overview of what each agency is responsible for is detailed in Annex C. WHO will be delivering as One WHO according to their unsolicited concept notes (which are currently being consolidated into one concept to form part of the agreement).

93. In the context of the new WHE, AFRO and HQ are working in the spirit of the One Health Emergencies Programme, with one workforce, one budget, one line of accountability, one set of processes and one set of benchmarks. **AFRO is the first line support to countries for preparedness, detection and response to outbreak and emergencies. HQ provides specific expertise when the capacity does not exist at regional level and ensures that the same benchmarks are applied across regions.** Some activities such as the JEE and capacity building are conducted by mixed teams from AFRO and HQ. Standards setting, and guidelines development are led by HQ with contribution from AFRO and other regions.

94. WHO will document the progress of the TDDAP and evaluate the impact of interventions in beneficiary countries, through reports, reviews and assessments in selected countries using indicators predefined in the performance framework.

Coordination

95. Dedicated WHO staff at Regional Office levels will coordinate the project while WHO staff at country level will play an important role in monitoring the project on a day to day basis and ensuring that targets and results are tracked. Country level activities will use existing coordination structures on health security (usually through Presidents or Prime Ministers offices).

96. At Regional level, WHO is working with regional institutions such African Union including African Centres for Disease Control and Prevention (Africa CDC), West African Health Organisation (WAHO), and other Regional Economic Communities (RECs) to ensure coordination and alignment around one national plan and one M&E system. The focus being on JEE, national action plans, capacity building and surveillance based on the Integrated Surveillance and Response (IDSR) mechanism.

External Technical Agency responsibility

97. The ETA will assume the full responsibility for delivering the areas of work under their contract. They will sub-contract other partners with the correct specialist skills and geographic presence as needed, and they will set out the responsibilities and required standards. Overall the ETA will:

- Manage the relationship with the DFID core management team to report on progress, emerging issues and opportunities
- Ensure strong relationships with local actors including government at central and sub-national levels and beneficiaries
- Effectively co-ordinate activities undertaken by sub-contracted partners/consortium members so there is coherence in countries where the programme operates.
- Manage the emergency call-down supplier if this is triggered.

DFID staff capacity

98. Significant DFID time will be required to manage the programme across all the delivery channels and components in addition to regular meetings and dialogue with all implementing partners. There will be adequate staff resources for ongoing supervision, knowing that flexible, frontier, flagship and adaptive programmes can be intensive on staff time. In particular supporting and advising on implementation, reviewing and monitoring progress, as well as ensuring alignment and coordination with government and related DFID/ODA and other externally-financed programmes.

99. TDDAP will be led by the DFID Health Adviser who will also be Senior Responsible Owner (SRO) based in DFID's Africa Regional Department (ARD). They are the named individual with overall responsibility for ensuring that the programme delivers the agreed outputs and outcome, ensuring compliance with Smart Rules, and providing direction to the core programme team and the implementers.

100. The programme will also be closely followed by the Group Head for Extreme Poverty and Southern Africa who will provide strategic guidance, challenge and quality assurance.

101. Our support to non-bilateral countries needs to be balanced with the capacity to be able to support Francophone countries and the Sahel, but now that the FCO has

two staff based in the region, and the Department's family planning programme is operational, resources could be combined to support engagement and monitoring.

Programme Implementation

102. The programme will commence, on approval, with a start-up phase of six months for the ETA and a maximum of three months for WHO. There will be regular reporting and dialogue between the implementing partners (ETA and WHO AFRO) and DFID. The ETA will carry out individual scoping activities in TDDAP countries and will determine the various roles and responsibilities in the governance and management structure with DFID, as well as the reporting structure between national, regional and global levels. In addition, the programme log frame will be finalised.

103. The start-up phase will present the opportunity to build links between technical agencies, governments and national and regional civil society actors. During the inception TDDAP country programmes will commence work on some priority activities, identified in collaboration with DFID and national government colleagues. The ability to move quickly to start work on selected initiatives will demonstrate to governments and partner countries a proactive approach to prevent and respond to the health emergencies presented by exceptional outbreaks of Ebola, Zika and yellow fever.

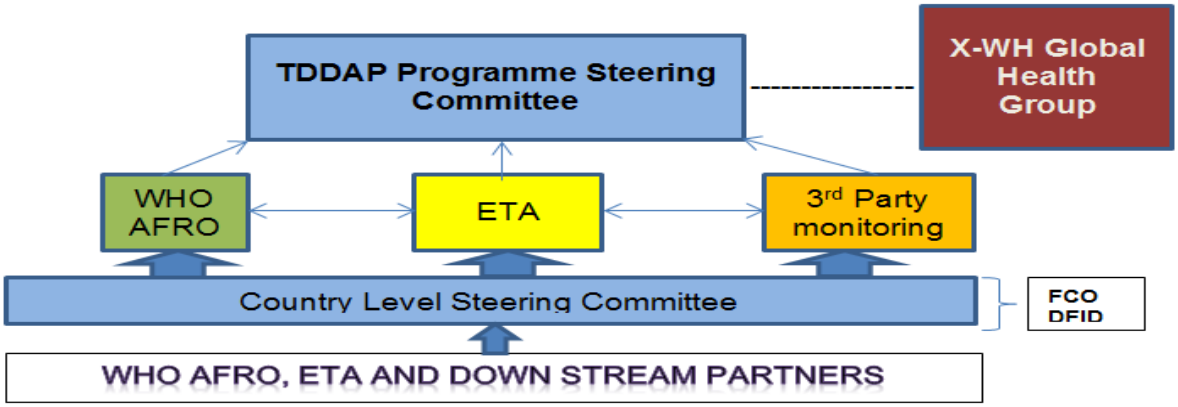
Governance

104. The governance of TDDAP will ensure that the programme is coherent at the global level and managed effectively at both regional and national levels. Overall progress on the programme will be presented to the global health oversight group to ensure alignment of HMG objectives and deliverables for global health security. The ETA will set up TDDAP programme and country-level steering committees involving WHO AFRO and where possible use existing country coordination mechanisms. The TDDAP programme committee will bring together the DFID team, ETA including consortium partners, independent monitoring agency, PHE, DH, international disease preparedness experts and representative sample of partner country institutions to steer overall programme direction. The ETA will be technically accountable to the TDDAP programme Committee, on which DFID is represented. The TDDAP programme committee will meet biannually. Its role will be:

- To review progress against milestones and identify any measures required to reach targets;
- To review disbursements, expenditure, and review the forecast for future disbursements;
- To share evidence and knowledge emerging from the programme; and
- To ensure coordination of activities under the programme with broader planning in the health sector.
- To review safeguarding processes and procedures.

105. The country level steering committee will be set up in each country to oversee the programme direction at that level. The committee will consist of the main implementing partners and where relevant include members from partner country government both national and regional, beneficiaries, DFID and FCO post holders. The committee will play a critical role in ensuring that both national and regional issues are taken forward to the TDDAP programme steering committee and raised in the Global Health Oversight Group for overall coherence on global health security. This committee will meet quarterly in the first year after which the frequency of meeting will be reviewed.

Figure 4: Proposed governance structure



106. At national level, existing oversight structures, such as those present in the prime ministers' or presidents' offices for multi-sectoral approaches will be engaged for their leadership in coordinating and monitoring overall progress.

Monitoring and Evaluation

107. The log frame will be the monitoring tool for the programme, but it is not all-encompassing. It will be revised following the commercial tender and selection of successful bidder, as the content of the log frame will be dependent on their proposed approach. During the start-up phase there will be a process of defining 'methodology notes' and each of the log frame indicators will be refined. Country log frames (nested log frames) will underpin the overall log frame. The programme will be monitored through data generated by the contractor/lead partner, the third-party monitoring/verification body, national data and global data. The log frame will be aligned with the overall WHO core voluntary contribution log frame managed by DFID's GFD.

108. DFID will hold quarterly progress meetings with the ETA to oversee overall implementation and progress. This will comprise the core DFID programme team, representatives from DFID country offices/regional programmes as relevant and the contractor/consortium. It will review progress towards delivery of outputs, the budget, results achieved, forecasts and risk mitigation.

Independent results verification

109. DFID will commission an independent third party monitor to ensure independent monitoring and quality assurance of programme delivery, documentation of lessons and robust tracking of results. Findings will be reported to DFID and subsequently the steering committee. The third-party monitor will:

- Verify activities and results reported, especially of milestones and key performance indicators, including those reported by WHO AFRO

- Verify results through sampling and spot checks of records and stakeholder interviews
- Check on fraud and fiduciary risk through regular inspections, data verification and interviews with staff and clients
- Assess data trends and emerging issues, including contextual issues, needing attention
- Provide qualitative insights into the implementation and progress of programme delivery
- Evaluate programme performance

110. It will be critical to have a close understanding of the political economy of each country and the risks and opportunities on the ground. **Providers will be required to have a country engagement strategy** within the overall programme that the monitor can use to track progress. The third-party monitoring supplier will engage and seek advice from specialists based in those countries where DFID has a presence before and during implementation and may commission separate analysis for any target countries (e.g. in the Sahel) where DFID does not have an office. This will help ensure the programme remains grounded in the realities of the operating environment.

Annual Reviews and Reporting

111. The Implementing partners will provide quarterly progress and an annual report. DFID will undertake mandatory annual reviews which will measure progress against annual milestones and VfM metrics. It will also look at budget execution and all aspects of implementation arrangements, as well as governance structures. The annual review process will provide recommendations to enhance delivery on activities and milestones that are facing challenges or slower to deliver.

Risk management

112. Risks have been identified and classified under the following areas: external context, delivery, operational, safeguards, fiduciary, reputational and overall risk. The programme attempts to address a range of complex issues identified in the strategic case. Key risks around political and technical commitment are already partly mitigated by IHR process. Technical risks include adequate capacity for preventing and responding to health emergencies. The involvement of country health advisers, links to steering committee and maintaining pressure through advocacy will support greater attention and investment in this area. The Risk Assessment matrix is in Annex F. Partners will also be required to provide a risk register which will be reviewed on a quarterly basis.

113. We are managing delivery risk through WHO AFRO through our x-HMG approach to monitoring performance led by GFD and calibrating resources accordingly. The independent evaluation of WHO performance under our regional preparedness programme, has shown improvements in WHO AFRO through increased capacity and resources. Through DFID's existing support, WHO AFRO has enhanced capacity in 21 countries, in the momentum to transition to the WHO Health Emergencies Programme, with one budget, one accountability and one results framework. WHO HQ provides support ensure coherence and bridge any competency gap as the Africa office expands its technical scope.

Table 5: Overall Risk

External Context	Delivery	Operational	Safeguards	Fiduciary	Reputational	Overall
Major	Moderate	Moderate	Minor	Minor	Minor	Moderate

Annex A: Key processes and publications related to lesson learning from the Ebola outbreak

Process, Publication, Event	***Outline***
WHO Interim Assessment (the Stocking Report)	Considers the roles and responsibilities of WHO during the outbreak and assesses the strengths and weaknesses of those actions. Makes recommendations to guide the Ebola response and inform future responses, including strengthening organisational capacity and establishing a contingency fund.
UN Secretary-General's High-Level Panel on the Global Response to Health Crises	Recommendations to strengthen national and international systems to prevent and manage future health crises (taking into account lessons learned from the outbreak of Ebola)
Lessons learned study of the UN Mission for Ebola Emergency Response (UNMEER)	Identifies the innovative approaches and strategies on crisis management undertaken by UNMEER that are transferable to other missions and contexts. Findings to be channelled into the High-Level Panel on the Global Response to Health Crises
WHO IHR Review Committee	Assesses the effectiveness of the IHR (2005) in facilitating the Ebola response, including what was implemented and what was not from the previous IHR Review Committee in 2011.
Harvard Global Health Institute and London School of Hygiene and Tropical Medicine (LSHTM) Independent Panel on the Global Response to Ebola	Analysis of the major weakness in the global health system exposed to the Ebola outbreak and offering of workable recommendations for medium to long-term institutional changes required to address them. Thematic areas include: leadership, coordination and advocacy; international rules; financing; operational response and operational research; and health technology R&D.
Chatham House - Centre on Global Health Security	Evolution of WHO response to infectious disease outbreaks, 1976 – 2014.
Save the Children, Oxfam, MSF, GOAL	NGO reports on Ebola response and lessons for future responses.

Annex B: Multi Criteria Decision Analysis

Option **Criteria**	Option 1: Core Contributions to WHO	Option 2: Support WHO AFRO and national health systems	Option 3: Support strengthening governance and accountability, data and evidence and rapid response	Option 4: Support to WHO AFRO, national health systems, governance and accountability, data and evidence and rapid response
a.Maximising the public health impact and minimising global health security risk	2	3	3	5
b. Support health systems strengthening across Africa	2	4	1	4
c.Strengthen accountability for service delivery	1	1	4	4
d.Provide data and evidence to inform decisions	1	1	4	4
e.Strengthen capacity of WHO AFRO	2	4	1	4

f.Maximising UK's influence and leverage Cross Whitehall working to strengthen disease preparedness	1	2	2	5
Weighted Total	**1.5**	**2.5**	**2.5**	**4.3**

Annex C: Roles, Responsibilities and Coordination

Work stream	WHO HQ	WHO AFRO	External Technical Agency
Output 1 – WHO AFRO reform	Supportive and QA functions	This is delivered through WHO AFRO's workplan for the Transformation Agenda.	-
Output 2 – IHR capacities	QA functions, backstopping TA, coherence, ensuring different teams work together e.g. health systems. Guidance on national action planning and costing.	Scaling up existing support to countries including on JEE, National Action Planning, and implementation (training, QA, and ensuring cross-sectoral working). Supporting governments to prioritise and cost plans.	Technical assistance in four to six focus/most vulnerable countries based on demand and needs identified by WHO AFRO, countries and INFORM tool. Assist countries in systems strengthening particularly at sub-national level and engage with communities.
Output 3 – Governance and accountability	Share best practices to support a coherent approach in the programme. Ensure support to AFRO on multi-agency collaboration ensuring support at headquarters of relevant agencies.	Work at regional and national levels to facilitate civil society engagement but it is not the core of their engagement as they will also be held accountable. Facilitate coherence, cross-border and One Health approaches and ensure various agencies/Governments work together. E.g. World Organisation for Animal Health (OIE), Economic Community of West African States (ECOWAS), Food and Agriculture Organisation (FAO), Africa CDC, etc.	Strengthen Civil Society Networks and Governments, similar to ALMA model to use data for accountability e.g. use of JEE scores, publicising and tracking progress; civil society networks able to engage in GHS dialogue get Governments to work better on IHR and cross-border approaches.
Output 4 – data, surveillance, evidence	TA support and coherence – as One WHO. Support to global health observatory. Capacity building of WHO AFRO/country offices. Explore links with WHO Blueprint (e.g. testing vaccines in phase 2 trials in contextually relevant settings). Ensuring linkages to other initiatives.	Build on existing work on risk mapping, ensuring country offices able to support strengthening of national integrated disease surveillance and response mechanisms, RSiS and DHIS2. Strengthen Africa and National Health Observatories. Continue risk mapping and assisting country governments and regional	Scaling up capacity building in focus countries to ensure evidence is translated to tangible actions. Work at sub-national levels to support operationalisation of data and surveillance systems including at community level.

		institutions allocate resources and interventions matched to risk.	Feed into operational research.
Output 5 – Rapid response	Responds at emergency levels. Backstop to regional office. No extra funding as this is through Core Voluntary Contribution and WHE funding to HQ.	Establish and strengthen emergency operations centres (Number to be confirmed) – follow-on from regional preparedness programme.	Use any intel from working on the ground to inform rapid response (links with Outputs 2, 3, 4).
3rd Party M&E			

Annex E: TDDAP coordination with GFD on WHO accountability and managing risk

TDDAP has been developed in close coordination with GFD as DFID lead for WHO. GFD (working with DH as overall HMG lead) have put in place a strong framework for cross-DFID and cross-HMG coordination on WHO.

The UK's strategic priorities for WHO are clearly articulated in the publicly available, Secretary of State-approved, UK-WHO Performance Agreement. Reform objectives are further articulated in CMO-approved cross HMG position papers – on both WHO organisational reform and WHO emergencies reform. TDDAP has been specifically designed to align with and reinforce these objectives. It is clear that only if HMG speaks to WHO with one clear voice can we influence satisfactory reform and progress. The nature of WHO's three organisation levels (HQ, Regional/ AFRO,

Risks: (Minor, Moderate, Major and Severe)	Probability	Impact	Mitigation	Residual risk
External Context				
Country governments do not sustain the programme	Major	Severe	A central focus of the programme is to establish the right approaches in countries, working closely with the national Government, and strengthening health and other systems through a multi-sector approach. It will also compel Governments to increase funding for preparedness and health systems.	Moderate
Political economy around disease preparedness is complex and context specific, and needs to be worked with to ensure outcomes are achieved	Major	Severe	WHO well established in countries of support and will use their understanding and relationships to deliver the programme effectively. ETA will need to have local technical expertise with strong relationships and understanding in focus countries. Partners will ensure political economy analysis used to adapt the programme in different contexts.	Moderate
Political unrest/conflict destabilises efforts	Severe	Severe	The project maintains information channels with security networks and emergency procedures to minimise the disruption to activities and apply Duty of Care. This is challenging to mitigate.	Major
Investment on health security decreases as donor landscape changes	Major	Major	Policy Division and DH working to influence the international architecture and to coordinate efforts. Investments are forthcoming from World Bank and influence on G7.	Moderate.
Deadly diseases resistance to drugs undermines current strategies.	Severe	Severe	The programme will play an important role in monitoring the future challenges to tackling deadly disease. This will contribute to regional responses to contain resistance linking with the work on AMR, although will not guarantee that strategies will be successful.	Major
Delivery				
Breakdown of relationship between ETA partners	Moderate	Major	Management capacity will be tested during evaluation of commercial tenders and during inception phase.	Moderate
Planned efficiency gains are not achieved within the project lifespan	Moderate	Minor	WHO and the ETA will be responsible for keeping control over the costs and demonstrating credible outcomes and VfM by end of programme, although full realisation of efficiency gains may take longer than 3 years.	Moderate
High staff turnover for WHO and ETA slows down planned activities.	Major	Major	Procurement of ETA ensures adequate capacity. Incentivise staff retention. Ensure good transition between existing programme with WHO and TDDAP. Support to WHO HQ allows for backstopping regional office.	Moderate
Over-reliance of countries on donor funding	Major	Major	WHO programme is strengthening the system and ETA will accelerate actions in underserved countries. We need to	Moderate.

resulting in lack of exit strategy and sustainability			recognise what is feasible in this timeframe and ensure that strengthened national and sub-national capacities are being used by country governments for longer-term change.	
Ineffective coordination and collaboration to achieve outcomes	Severe	Major	Incentivise collaboration and coordination amongst all partners and agree ways of working.	Moderate
Operational				
Country health systems and governments not effective or strong enough to deliver	Major	Major	ETA a) builds partnership with relevant others early to support uptake needs b) has links to global/regional/national and other relevant policy actors and c) support joined up implementation research to inform and underpin evidence and identify risk areas and gaps.	Moderate
National and sub-national capacities weak especially at community level where good surveillance and responses need to start	Major	Major	Programme strengthens sub-national capacities. ETA provides local expertise to ensure accelerated capacity building efforts in high risk, low resource settings. Programme strengthens rapid response and surveillance at all levels.	Moderate
One Health and cross-border approach dependent on effective multi-sectoral working, which varies by context.	Moderate	Major	Programme focus is to ensure that this works through strengthening IHR capacities. WHO have been defining One Health and cross-border approaches with country governments and other stakeholders in the existing programme.	Minor
WHO lack capacity to effectively lead, co-ordinate and adapt reform process	Moderate	Moderate	Coordinate dialogue with WHO through GFD. WHO are undergoing a reform process and this programme will support it. WHO have evaluated the first phase of their reform process and results are positive.	Minor
High burden of humanitarian emergencies and outbreaks detracts efforts from longer term system strengthening efforts	Major	Major	WHO and ETA will ensure they are resourced to ensure capacity available for preparedness systems strengthening and emergencies (WHO through existing WHE funding).	Moderate
Safeguards				
Mistrust of communities around disease preparedness activities	Major	Severe	Programme is designed and delivered ensuring community engagement and contextually relevant with local expertise.	Moderate

Accountability efforts by CSOs threaten to demotivate and demoralise providers who, with inadequate supervision and resources, will resent feeling under greater scrutiny.	Moderate	Moderate	TDDAP aims to avoid blame and shame approaches and use of positive deviance to highlight good practice and learning to counterbalance examples of poor performance and outcomes.	Minor
Fiduciary				
Fraud involving DFID funds	Moderate	Moderate	ETA has strong fraud and financial management practices, rigorous due diligence, annual reviews, financial audits and open ongoing dialogue with partners. WHO have strong systems in place which is monitored through GFD. DFID ensure delivery chain mapping is completed and monitored. The third-party monitoring agent will also provide fiduciary verification.	Minor
Reputational				
TDDAP unable to deliver on results.	Moderate	Severe	DFID will engage in dialogue and harmonisation x-HMG and apply learning and best practice from Ebola and Zika to maintain a faster approach through improved evidence sharing. DFID will remain flexible in its ability to partner and respond as new diseases emerge. It is designed to ensure lives are saved, systems are strengthened and protects UK nationals.	Minor

Country Office) is clearly highlighted as a major reform challenge in GFD's approved core voluntary contribution business case – with mitigation measures noted.

Specific actions to ensure TDDAP remains firmly aligned with HMG's overall WHO reform agenda:

- GFD representatives sit on the TDDAP and UK-WHO AFRO Framework Board
- TDDAP SRO attends the quarterly DFID meeting chaired by GFD and attended by all SROs for DFID funded WHO programmes and projects. This group ensures coherence of approach across DFID.
- WHO AFRO – as a key reform priority – already has KPIs included in GFD's core voluntary contribution log frame. This represents real cross-DFID integration of WHO programmes
- TDDAP's log frame will align with the CVC log frame, specifically reinforcing for the African context top UK asks. E.g. the CVC log frame requests the WHO HQ produces an organisation-wide new VFM plan. TDDAP's log frame will direct WHO AFRO to support the creation of this plan and pioneer new VFM approaches in AFRO to support the plan's implementation.
- Led by the CMO, the UK has now instigated annual UK-WHO Strategic Dialogues with WHO HQ where a deep-dive is performed with senior WHO

management (including the DG) on four top UK priorities. At the upcoming Dialogue (18-19 October 2017) one priority will be effective working between

- AFRO and HQ. Clear actions to improve performance will flow from this and be included in a revised and re-published second edition of the UK-WHO Performance Agreement.
- The election for the new DG of WHO takes place in May 2017. In our direct advocacy with the new DG we will press the vital importance to the UK of AFRO reform and a “one WHO” approach
- Feedback and concerns on TDDAP performance will be directly fed into GFD’s advocacy and interventions at the WHO’s supreme governing body, the World Health Assembly
- Additionally, the UK has now secured observer status at WHO AFRO’s Regional Committee. GFD and the TDDAP SRO will jointly prepare our advocacy for the Regional Committee, prioritising reform and the need for a “one WHO” approach and alignment with WHO HQ
- WHO HQ has identified a senior accountable person within WHO HQ who will be responsible for liaising with WHO AFRO on TDDAP and maintaining coherence
- The UK’s support for WHO’s Health Emergencies Programme (WHE) likewise sits under the UK-WHO Performance Agreement. Expected funding through CHASE to WHE supports WHO HQ’s global leadership role. Support through TDDAP builds WHO AFRO’s emergencies capabilities, and more importantly preparedness. The two are aligned and mutually reinforcing.

Annex B: Log frame

See separate excel sheet.

Annex C: Theory of change for the preferred option

INPUTS

£3.5m to fund WHO AFRO's Transformation Agenda

£xm technical assistance to support national and cross-border IHR capacities

£xm support to national civil society to track health budgets and monitor public health service delivery and preparedness

£xm to strengthen data and surveillance systems

£xm rapid response capacity/simulation/EOC's

Up to £20m potential contingency mechanism

Africa health adviser: 0.6 FTE, evaluation adviser 0.2 FTE
Regional governance adviser: 0.1 FTE
Programme manager: 1 FTE
Country office support: 0.2 FTE
PHE/DH technical support £1.5m 3rd party M&E

Inputs to Outputs: Assumptions

- DFID funding sufficient to implement scope of planned activities.
- DFID, WHO and supplier staff time sufficient to ensure high quality leadership and oversight of the programme.
- Strong partnership with DH/PHE continues and programmes identify opportunities for leverage and coordination.
- Good quality and value for money implementing partners identified.

OUTPUTS

WHO AFRO's internal reform enhances its capacity as premier authority on public health

African countries improve adherence to IHR standards

African governments and WHO AFRO accountable for IHR and quality of public health services at all levels

Accurate data and evidence for preparedness, speedy response and accurate decision-making.

Rapid Response capacity to reduce the magnitude of disease outbreaks

Outputs to Outcome: Assumptions

- WHO AFRO remains an important technical and policy partner in Africa.
- WHO AFRO reforms achieved and performance improves. WHO AFRO reforms align and mutually inform WHO HQ reforms
- Multi-sectoral approach effectively operationalises One Health commitments
- Technical capacity to prevent disease outbreaks improves in partner countries.
- Civil society and other actors show adequate will and capacity to engage with holding governments and other institutions to account
- Communities and districts are engaged effectively through culturally and contextually relevant approaches at scale.

OUTCOME

African health systems and institutions are strengthened to prevent outbreaks and epidemics of deadly communicable diseases

Outcome to Impact: Assumptions

- WHO AFRO respond postively to structural and capacity reform initiatives.
- Emergency health preparedness and response to cover risks adequately financed by UK Government and other international and national actors.
- African Governments show adequate engagement in improving capacity and quality of health services.
- Improvements in disease prevention and preparedness have knock-on effects on wider welfare and growth indicators (household income, GDP etc).
- Effects of climate change, drought, food crises, natural disasters and civil unrest are mitigated

Impact

Communicable disease outbreaks and epidemics have a reduced impact on African populations

Annex D: Duty of Care

The TPM 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 TPM Supplier must ensure they (and their Personnel) are up to date with the latest position.

This Procurement may require the TPM Supplier to operate in a seismically active zone and is considered at high risk of earthquakes. Minor tremors are not uncommon. Earthquakes are impossible to predict and can result in major devastation and loss of life. There are several websites focusing on earthquakes, including http://geology.about.com/library/bl/maps/blworldindex.htm. The TPM Supplier should be comfortable working in such an environment and should be capable of deploying to any areas required within the region in order to deliver the Contract (subject to travel clearance being granted).

This procurement may require the TPM Supplier to operate in conflict-affected areas and parts of it are highly insecure. Travel to many zones within the region will be subject to travel clearance from the UK government in advance. The security situation is volatile and subject to change at short notice. The TPM Supplier should be comfortable working in such an environment and should be capable of deploying to any area required within the region in order to deliver the Contract (subject to travel clearance being granted).

The TPM 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 seismically active, dangerous, fragile and conflict-affected environments). The TPM Supplier should ensure their personnel receive the required level of training and, if appropriate, complete a UK government approved hostile environment training course (SAFE)[1] safety in the field training prior to deployment.

As the countries/areas of work involved in this intervention are currently undetermined, DFID is not in a position to be able to provide a Duty of Care assessment at this point. On this basis, DFID assumes that this programme will be rated as ‘Medium/High’ risk. Therefore, as part of their Tender response, bidders will be asked to submit a ‘generic’ response to provide assurance to DFID that they can manage DoC responsibilities in even the most challenging of environments.

During the programme, it is DFID’s expectation that any contracted TPM Supplier will provide a full Duty of Care assessment for each potential country/area of work where in-country ground work is expected to be necessary. If the programme activities take place in medium or high-risk locations, DFID will share available information with the TPM Supplier on security status and developments in-country where appropriate.

Tenderers must develop their PQQ Response and ITT response (if invited to Tender) on the basis of being fully responsible for Duty of Care in line with the details provided above and should confirm that:

- They fully accept responsibility for Security and Duty of Care.

- They understand the potential risks and have the knowledge and experience to develop an effective risk plan
- They have the capability to manage their Duty of Care responsibilities throughout the life of the contract.

If bidders are unwilling or unable to accept responsibility for Security and Duty of Care as detailed above, or if DFID deems the arrangements proposed by bidders to be materially insufficient, the Tender will be viewed as non-compliant and excluded from further evaluation. The list below is wider than TDDAP countries.

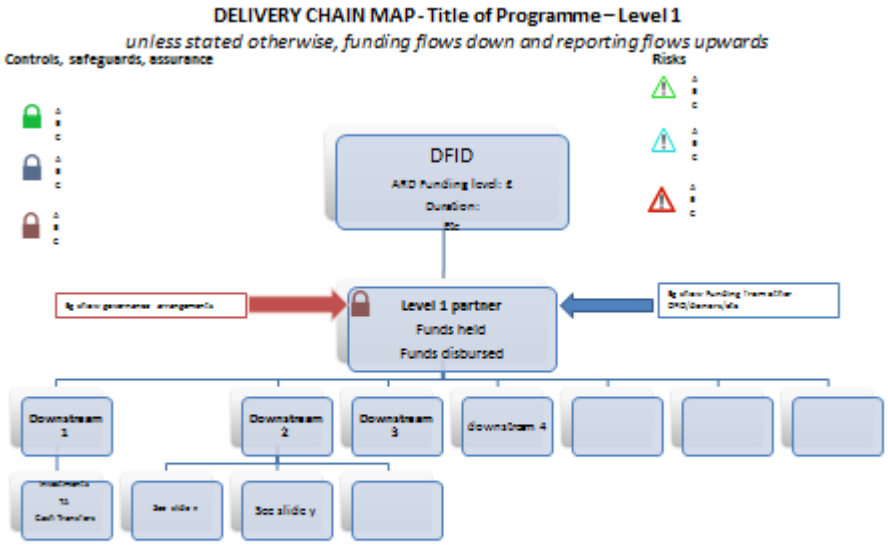
1 Very Low Risk	2 Low Risk	3 Medium Risk	4 High Risk	5 Very High Risk
Low		Medium	High Risk	

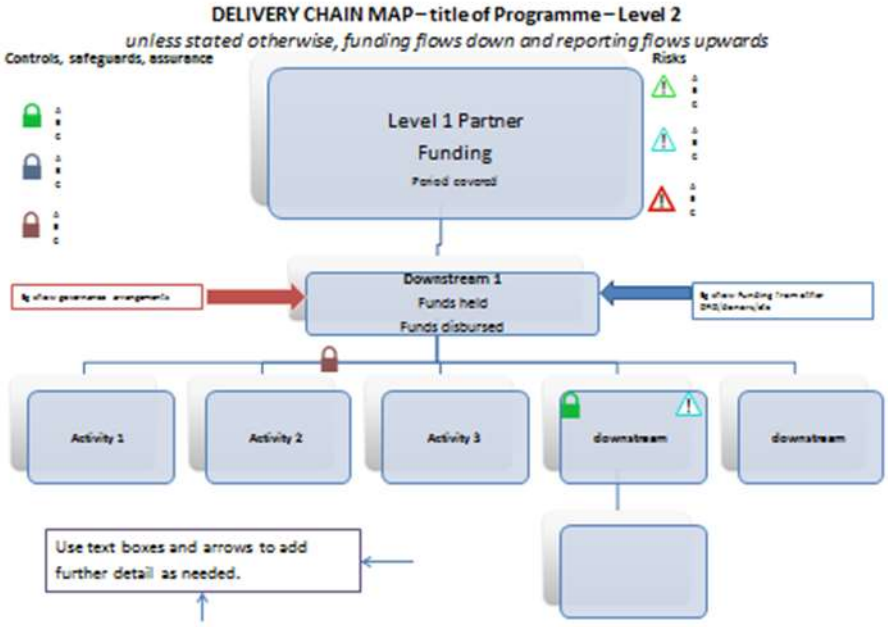
Country	City	Overall Security	Violent Crime	Civil Disorder	Terrorism	Espionage
Afghanistan	Kabul (Capital)	5	4	4	5	-
Bangladesh	Dhaka (Capital)	3	3	3	4	-
Botswana	Gaborone (Capital)	3	3	3	2	-
Burkina Faso	Ouagadougou (Capital)	4	4	4	4	-
Cambodia	Phnom Penh (Capital)	2	2	2	2	-
Cameroon	Yaoundé (Capital)	3	3	3	3	-
Central African Republic	Bangui (Capital)	4	5	5	3	-
Chad	N'Djamena (Capital)	4	4	4	4	-
Democratic Republic of the Congo	Kinshasa (Capital)	4	5	5	2	-
Cote d' Ivoire	Abidjan (Capital)	3	3	3	2	-
Djibouti	Djibouti City (Capital)	3	2	2	3	-
Equatorial Guinea	Malabo (Capital)	2	2	2	1	-
Eritrea	Asmara (Capital)	2	1	1	2	-
Ethiopia	Addis Ababa (Capital)	3	2	2	3	-
Gabon	Libreville (Capital)	2	2	2	1	-
Gambia	Banjul (Capital)	2	2	2	2	-
Ghana	Accra (Capital)	3	3	3	2	-

Iraq	Baghdad (Capital)	5	5	4	5	-
Jordan	Amman (Capital)	4	2	2	4	-
Kenya	Nairobi (Capital)	4	5	5	4	-
Kyrgyzstan	Bishkek (Capital)	2	2	2	2	-
Laos	Vientiane (Capital)	2	2	2	2	-
Lebanon	Beirut (Capital)	4	3	3	4	-
Lesotho	Maseru (Capital)	4	4	4	1	-
Liberia	Monrovia (Capital)	3	3	3	1	-
Libya	Tripoli (Capital)	4	3	3	4	-
Madagascar	Antananarivo (Capital)	3	3	3	2	-
Maldives	Malé (Capital)	2	2	2	1	-
Mauritius	Port Louis (Capital)	2	1	1	2	-
Mozambique	Maputo (Capital)	3	3	3	2	-
Namibia	Windhoek (Capital)	3	3	3	1	-
Nigeria	Abuja (Capital)	4	4	4	4	-
Pakistan	Islamabad (Capital)	5	4	3	5	Specific security concern
Rwanda	Kigali (Capital)	2	2	2	2	-
Senegal	Dakar (Capital)	3	2	2	3	-
Seychelles	Victoria (Capital)	3	3	3	2	-
Sierra Leone	Freetown (Capital)	3	3	3	2	-
South Africa	Cape Town (Capital)	4	4	4	2	-
South Sudan	Juba (Capital)	4	5	5	3	-
Sri Lanka	Colombo (Capital)	3	3	2	3	-
Sudan	Khartoum (Capital)	4	3	3	4	-
Swaziland	Lobamba (Capital)	2	2	2	1	-

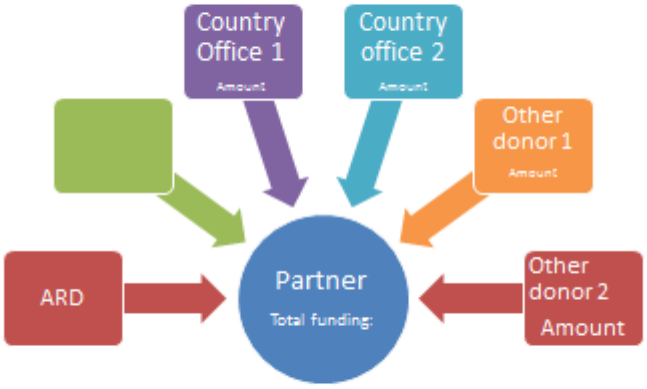
Tajikistan	Dushanbe (Capital)	3	2	2	3	Specific security concern
Tanzania	Dar es Salaam (Capital)	4	4	4	3	-
Thailand	Bangkok (Capital)	3	3	3	3	-
Togo	Lomé (Capital)	4	4	4	1	-
Turkey	Ankara (Capital)	4	2	2	4	-
United Arab Emirates	Dubai (Capital)	3	1	1	3	-
Uganda	Kampala (Capital)	3	3	3	3	-
United States of America	Washington DC (Capital)	2	2	2	2	-
West Bank and Gaza	Jerusalem	4	3	3	4	Specific security concern
	Gaza City (Capital)	4	3	4	4	-
Yemen	Sana'a (Capital)	5	3	3	5	-
Zambia	Lusaka (Capital)	3	3	3	1	-
Zimbabwe	Harare (Capital)	3	3	3	1	-

Annex E: Delivery Chain Map





Optional relationship chart could be used to simplify funds into partner (and reverse available for funds out)



Acronyms

DAC	**Development Assistance Committee**
DFID	**Department for International Development**
DOC	**Duty of Care**
EOC	**Emergency Operations Centres**
ETA	**External Technical Agency**
IHR	**International Health Regulations**
KPI	**Key Performance Indicators**
OECD	**Organisation for Economic Cooperation and Development**
PHE	**Public Health England**
TDDAP	**Targeting Deadly Diseases in Africa Programme**
TOC	**Theory of Change**
TPM	**Third Party Monitor**
WHO	**World Health Organisation**
WHO AFRO	**WHO Regional Office for Africa**