Department for International Development

UKaid from the British people

Section 4 Appendix A

CALLDOWN CONTRACT

Framework Agreement with: **IPE Global Ltd., B-84 Defence Colony, New Delhi, 110024, India**

Framework Agreement for: **Global Evaluation Framework Agreement (GEFA)**

Framework Agreement Purchase Order Number: PO 5859

Call-down Contract For: Health Partnership Scheme Summative Evaluation

Contract Purchase Order Number: PO 7323

I refer to the following:

1. The above mentioned Framework Agreement dated **14th August 2012**;

2. Your proposal of **5th November 2015 and subsequent technical clarifications on 14th December 2015 and 28th January 2016**

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 **23rd February 2016** ("the Start Date") and the Services shall be completed by **31st October** 2016 ("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 **Department for International Development** ("the Recipient").

3. Financial Limit

3.1 Payments under this Call-down Contract shall not, exceed £ **293,345** ("the Financial Limit") and is exclusive of any government tax, if applicable as detailed in Annex B**.**

Payments shall be made on a 'Milestone Payment Basis. The following Clause 28.1 shall be substituted for Clause 28.1 of the Framework Agreement.

28. Milestone Payment Basis

28.1 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 to clause 28.1 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:

4.2 The Contract Officer is:

5. Key Personnel

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

All personnel named under Annex B of the contract.

6. Reports

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

7. Duty of Care

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:

I. 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.

II. 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:

II.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;

II.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.

III. 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.

IV. 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.

V. 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.

8. Call-down Contract Signature

8.1 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: 22nd February 2016
For and on behalf of IPE Global Ltd.	Name: Position: Signature: Date:

Terms of Reference

(Call Down Contract)

Title:	Health Partnership Scheme - 2011-2017 - Summative Evaluation

INTRODUCTION

DFID's Health Services Team is seeking to commission an evaluation of the Health Partnership Scheme (HPS) implemented by the Tropical Health and Education Trust (THET). The HPS supports partnerships between UK health institutions and those in low income countries. The Scheme uses the expertise of UK health professionals and institutions to build capacity of their counterparts in developing countries and is also intended to bring back benefits to UK institutions, with NHS volunteers returning with enhanced skills, motivation and confidence. Since it began in 2011, over 1,000 NHS health workers have volunteered with projects across 26 countries in Africa and Asia.

The evaluation will contribute to DFID's oversight of this programme and also contribute to strengthen and adjust approaches that THET is deploying in this programme as necessary. In addition, the evaluation is also intended to contribute to better understanding, decision-making and design of health partnerships through the identification of best practice and other lessons learned.

PURPOSE AND OBJECTIVES

The purpose of this evaluation is to examine the health partnership model that has been implemented in the HPS programme. The focus will be on the effectiveness of the programme as a whole, plus learning about what works and what does not work in the current programme's approach. The evaluation will inform wider lesson learning about building health worker capacity in developing countries, and reciprocal benefits of partnerships in the UK.

The evaluation will also inform monitoring approaches to health partnership programmes like the HPS.[1]

- The evaluation will provide evidence of the effectiveness of HPS as a whole, as well as progress towards outcomes and, when possible to assess, impacts.
- The evaluation will recommend how to strengthen the programme M&E, based on the conclusions of the evaluation. This will contribute to robust monitoring in the remaining programme implementation and for possible future partnership programmes.

The current HPS programme Theory of Change provides a conceptual framework of the intervention logic, and states assumptions about the 'logical progression from inputs to impact on health'[2].

- Learning - The evaluation will describe key ways the HPS model has or has not evolved in three years of implementation and adaptation, and whether this has been consistent with the intervention logic.

[1] HPS programme outputs are monitored against the programme logframe through annual reviews. However, the great diversity of projects funded by the HPS presents huge challenges for assessing output at programme level. The most recent annual review, conducted in July 2014, found that 'some of the outcomes and indicators contained in the logframe are problematic', rendering the 'meaning of the results for some indicators… difficult to assess.'

[2] DFID Project Memorandum, DFID Health Partnership Scheme, November 2010, p.28.

- Future programming - The evaluation will critically appraise the HPS theory of change and the assumptions it makes.

The evaluation questions to be answered are below. These will be further refined during the inception stage.

1. **Is the programme achieving its stated outcome: "more effective and efficient health systems, with an emphasis on the performance of the health workforce"?**

   This should include the benefit to both developing country and UK health workers and institutions.

2. **Is there any evidence of programme impact: "more effective and efficient health service provision (with a special interest in MDG 4,5,6 and rural and under-served populations)"?**

For questions 1 and 2:

What has happened and how?

Who is benefitting - systems, practitioners, service users? Is the reach equitable -- eg, men and women, those who are underserved, very poor and those living in rural areas, health workers and service users?

What are the benefits being realised – with particular focus on outcome and impact indicators specified in the log frame , and health services related to MDGs 4, 5, 6?

3. **What types of partnership have been most successful and which have been most challenging?**

   What form have the partnerships taken (a descriptive typology[3] -- who, what, when, how long, special features)?

   What worked and what did not in terms of achieving improvements in health systems?

   Are there examples of partnerships overlapping, aligning or reinforcing each other?

   Is the programme building social capital for global health work, and is this contributing to outcome and impact?

4. **Is the programme and its partnerships responding to needs and priorities of host countries, districts and institutions?**

5. **How can a programme of this scale and diversity be monitored and evaluated?**

   How can future M&E include impact as well as outcomes and VFM?

   What approach is recommended for aggregating data from numerous, diverse health partnerships, and for drawing conclusions at the programme level?

   What is a realistic level of detail and investment for M&E in this programme?

   What VfM metrics and analyses are suitable to monitor the programme?

   What VfM metrics and analyses are suitable to monitor individual health partnerships?

[3] THET has separately commissioned operational research that is also developing a typology of partnerships. This is is a lengthier and more detailed undertaking than the evaluation is expected to deliver. The evaluator is encouraged to draw upon this work, keeping the typology for the evaluation to 2-3 pages, and to use it as a main criteria and reference for selecting sites to visit.

6. Is the programme delivering VfM?

Are some types of partnerships (or features of them) better VfM than others, in terms of economy, efficiency, effectiveness or equity

Is THET's management of the programme supporting VFM work by the funded health partnerships?

The contracted management agent has been expected to have a commitment to gender equity in all its operations, with particular attention to gender roles and sensitivities in diverse cultural settings, whilst ensuring that partnerships promote gender-based rights. In addition to equitable access to gender-sensitive and appropriate health services, there is the gender dimension to health worker career options and career trajectories in developing countries (eg, women trained as nurses, men as doctors, men progressing to more senior, better-paid managerial and leadership roles).

RECIPIENT

The recipient of this work is the programme participants and health service users. The evaluation deliverables will be provided to DFID and the implementing partner THET.

Relevant communications will need to be developed for each of these audiences as part of the communication and learning strategy of evaluations (responsibility of DFID and THET).

SCOPE

This evaluation will cover the duration of the HPS programme, which has been operational since 2011. .

The evaluation will visit several countries, and visit a range of sites and programmes that reflect the variety of HPS partnerships. However, the evaluation is not expected to visit all partnership sites. It is preferable that there is a gender balance in the evaluation team undertaking the qualitative work.

The evaluation will focus on the following target groups:

- Health workers directly involved in the programmes, including heath managers and educationalists from the UK and developing countries;
- Users of health facilities and services that have participated in the programme
- Implementing partner - THET

As relevant and when it is feasible, the evaluation will include:

- Administrators and other representatives of developing country partner organisation or associations (strategies, protocols, curricula)

The evaluation is expected to include:

- Review of relevant, current literature about health partnership programmes.
- Development and use of a descriptive typology of HPS partnerships (drawing on research that is currently being commissioned by THET).
- Assessment of outcomes and, when possible, the impact of the programme
- Gathering participant and beneficiary feedback, including constructive criticism
- Analysis of VFM using existing M&E data, and recommendations for possible VFM measures
- Producing recommendations for strengthening future M&E.

METHODOLOGY

Starting with a desk-based evaluability assessment, the evaluator would determine the specific methodology of the evaluation[4]. A theory-based approach is to be considered for this summative evaluation.

It is expected that a mixed methods design combining analysis of secondary data with the collection and analysis of primary quantitative and qualitative data will be appropriate to respond to the evaluation questions.

Quantitative data may be derived from a range of sources including but not limited to partner facility institutional records[5], project monitoring records and surveys. Qualitative data may be derived from sources such as interviews, focus groups, and participant and non-participant observations.

The framework used to analyse both quantitative and qualitative data should be determined by the evaluator. It should be rigorous and sufficiently robust in order to identify changes that may be plausibly associated with the programme and that may contribute to the desired outcomes and impact.

The analytical framework should identify pathways through which these changes have and could happen.

The following data collection methods are encouraged:

- document review (HPS documents, partnership reports and monitoring)
- case studies
- focus groups discussions (FGDs) (of country participants, as appropriate)
- key informant interviews (KIIs) (of country participants and UK partners, as appropriate)

An outcome mapping/harvesting exercise in the FGDs and KIIs would be useful to explore what has happened and how those involved in the intervention think it contributed to observed change(s). The final assessment about the suitability of this methodology rests with the evaluator.

The project has reported positive feedback thus far but needs to ensure that both positive and constructive feedback is captured during monitoring and evaluation especially from developing country partners and recipients of training.

Detail any limitations likely to impact on the scope (eg, geographical, political, administrative issues)

Geographical - Due to the Ebola epidemic in West Africa, evaluators will not be expected to visit some countries where Ebola is present.

Administrative - Some partnerships may have completed activities by the time of the fieldwork, while others may be in initial phases. Evaluators are encouraged to consider including them in the evaluation and site visits.

[4] This timing is to inform the specific design of the evaluation that has been planned. It would examine evaluability in practice, that is, data availability to carry out the evaluation and the systems able to provide it, as well as the likely usefulness of an evaluation.

[5] These are a source of verification in the programme logframe.

Travel - Will be limited by budget and logistical feasibility. It is desirable that evaluators conduct country visits, preferably to countries where they can visit more than one partnership to explore potential synergies, as well as efficiency.

Representativeness, generalizability - The HPS is a £30 million programme which includes a range of partnership sizes and intervention activities, operating in diverse social, political and health contexts. The evaluation will only be able to look at a relatively small portion of this work making generalizability difficult. This TOR also anticipates that the evidence of both outcomes and impacts will vary in strength across the programme. It expected that, using the descriptive typology that has been suggested, the evaluation will include a strategic selection that reflects the range of partnerships and activities. Nevertheless, drawing conclusions about the programme as a whole will be difficult.

Resources that will be available - The Evaluator will have access to THET programme monitoring data and subsequent analysis.

Data about health workers involved in the projects is disaggregated by gender and cadre; data about health services and health systems strengthening is disaggregated by health theme and level of healthcare; data about health institutions is disaggregated by population served; data about patients is disaggregated by gender.

Once the evaluator has identified their preferred partnerships and sites to visit, THET will introduce them to the relevant UK partners, who will liaise / put them in touch with their overseas partners, to agree visit dates, schedules and in-country support. Support may include facilitating meetings and providing or booking transport and accommodation, but this will depend on the resources of the specific partners visited.

Who will be responsible for compiling initial documentation
THET will prepare programme documentation for the Evaluator. The suitable documentation will be discussed and agreed with DFID's Health Services Team and the Evaluation Steering Group.

Ethics
The evaluator will be expected to adhere to the DFID Ethics Principles for Research and Evaluation (Appendix B). This will include but not be limited to the following: Information about specific partnerships and MOUs will be treated confidentially. Individual respondents (NHS volunteers, country health workers and health service uses) will be informed of the purpose of the research and have the option to voluntarily participate in the evaluation.

Evaluation code of conduct
The evaluation of DFID assistance is guided by the core principles of independence, transparency, quality, utility and ethics. The evaluator will be expected to work according to these principles[6].

Fieldwork
The evaluator is encouraged to gather data directly from programme partners and beneficiaries, including observing the institutions.

GOVERNANCE ARRANGEMENTS
The evaluation will be managed by DFID's Health Services Team.

[6] See DFID Evaluation Policy 2013, pp6-7.

There will also be guidance from a Steering Group including internal (DFID) and external stakeholders. The purpose of the Steering Group will be to guide the design of the evaluation and quality assure the evaluation outputs. The group's input should ensure that the evaluation has credibility across the range of stakeholders.

Inception, work-planning and review meetings
Meetings with evaluators and the steering group will take place as required to ensure that the provider has all the necessary advice and guidance they require and that key stakeholders are satisfied with the work being done.

Commenting on study outputs (including timescales)
DFID leads will provide comment on all study outputs (see below). The Steering Group will be invited to comment on the evaluation workplan and inception report (at month 1 or 2), the interim progress report (months 3-4) and the final report. THET/partner organisations will be invited to comment on all study outputs and will provide feedback within 2 weeks.

Quality assurance of study outputs (including timescales)
Quality assurance will be conducted, in accordance with DFID evaluation policies: DFID evaluations are QA'd at 'entry' and 'exit'. Entry QA is of the two outputs - the evaluation TOR (this document) and the evaluation design including data collection protocols/instruments. Exit QA - evaluation final draft report.

Quality Assurance is currently conducted by SEQAS, a contracted service. There is a 10 working day turnaround, provided that the programme team is able to notify them in advance about the delivery of the outputs.

REQUIREMENTS
The evaluation provider will be commissioned through a competitive tendering process/using DFID evaluation frameworks.

The following capacities are required/desirable:

- Experience in conducting assessments and evaluations of health sector development programs, with emphasis on developing health worker and institutional capacity, in developing countries.
- Knowledge of partnership-based approaches to developments, including the concept of social capital.
- Knowledge of good practice and literature about developing health worker and institutional capacity, in developing countries.
- Experience constructively critiquing and developing log frames and theories of change.
- Experience in primary qualitative and quantitative data collection and analysis.
- Strong analytical skills and ability to think strategically and concisely analyse and integrate information from a diverse range of sources into practical and realistic recommendations.
- Effective communication skills, written and spoken, in English required.

The successful provider will coordinate and work closely with the implementers of the HPS to ensure the full utilisation of technical outputs of this programme, to contribute to project course correction where relevant, and to work towards closing gaps in evidence, both nationally and internationally.

OUTPUTS

1. Work Plan: Evaluation workplan including an outline of data collection instruments, and relevant ethics procedures that will be used - (to be reviewed and approved by Steering Committee
2. Inception Report, Design & Evaluability Reports:
    - Inception report covering a desk-based evaluability assessment that outlines evaluation options, with their strengths and limitations, concluding with recommendations for evaluation approach.
    - Literature review and descriptive typology of partnerships (who, what, when, how long, special features)
    - Evaluation methodology, supported by the literature review, with data collection instruments, including sampling based on partnership typology, analysis plan, coding framework for primary data (surveys, interviews, focus groups), and reporting/dissemination plan (to be QA'd following DFID Evaluation policies)
3. Three progress reports (1-2 pages) referring to work-plan
4. Draft final report (to be QA'd following DFID Evaluation policies) with updated theory of change, lessons learned and recommendations
5. Communication Tools and Final Report, incorporating Steering Group comments, and, upon completion, primary data cleaned, labelled and with identifying information removed

CONSTRAINTS AND DEPENDENCIES

The evaluation will start in February 2016.The duration is expected to be approximately six months from start to submission of first draft of final report and eight months to final completion of all requirements.

Interwork with other suppliers
It is not expected that the evaluator will need to work with other evaluation or M&E suppliers. The evaluator will be expected to engage closely with the implementing partner THET and grant-holders.

Interface with other organisations' IT systems
The evaluator will have access to THET programme monitoring databases and the data contained in them.

Stakeholder/recipient schedules and availability
The evaluator will have to plan field trips in collaboration with THET and grant-holders to ensure that the scheduling is appropriate for all parties.

Management of risks/challenges
The evaluator will perform appropriate risks assessments for the project including field visits. THET will provide information on risks and risk management at country level as requested by the evaluator.

TIMEFRAME
The final report will be completed (including QA) within 8 months of the contract start date. No extension is anticipated, but there will be an option to extend for 3 months.

DFID CO-ORDINATION
The following people will support the development of this evaluation and its requirements: Policy Division Health Services Team Programme Manager, Health Adviser, and Economic Adviser.

BACKGROUND

The Health Partnerships Scheme is a £30 million programme linking health institutions in the UK with counterparts in developing countries. The programme, which began in 2011, aims to use the expertise of UK health professionals to build human resources for health in DFID priority countries. It works across more than 20 countries.

The Health Partnership Scheme (HPS) supports partnerships between UK health institutions and those in low income countries. Its aims are:

- Improving health services in developing countries through sharing skills and capacity development
- Bringing benefits back to the UK through volunteer NHS staff returning with stronger skills

The scheme has two main components: a grant for partnership projects, as well as activities to support and develop the health partnership community in the UK and overseas.

The original grant provided £20 million over 4 years (July 2011 – June 2015) but was extended until 2017 with a further £10 million of funding announced in 2014.

The project enables a wide variety of projects ranging from individual mentoring and training of clinical workers to developing systems of training and strengthening professional associations.

The project's results have consistently exceeded expectations. In the first two years the project took time to get established and to award grants. After grants were awarded, it took time for partnerships to establish themselves. In its third year, the programme shifted away from start-up and grant awarding activities and into the core business of partnership activity and advocacy. The groundwork laid in previous years had come to fruition in the third year, and the momentum that had been built up in previous years yielded very high results.

Since the inception of the programme, the HPS has delivered training (directly or indirectly) to over 26,500 health workers in the developing countries and over 84% (~22,000) of these training results were achieved in the third year. Partnerships have also continued to show strong performance in the development of policies, protocols and educational curricula. They have also made strong contributions to improving equipment and ICT within institutions, often going beyond their original project plans to the improve systems necessary for health care.

In 2014/15 many projects are winding down, as many grants expire in March 2015. The time taken for partnerships to build their work up to full capacity is a lesson which can be applied in setting milestones for the extension period.

In April 2014 an extension of HPS was announced providing another £10 million to extend the programme to 2017. This extension will include a new round of grants to be awarded in the next year and should enable many of the best-performing partnerships to continue as well as allowing others to scale-up or establish new partnerships.

Detail on existing key initiatives and studies within the area

- 2013: VFM assessment of the International Health Links Funding Scheme (precursor to the HPS)
- 2014: HLSP conducted a mid-term review of the HPS 'mega-grants' (Multi-Country Partnerships and Long Term Volunteering grants) examining them against Development Assistant Committee and value for money criteria.
- 2015 (commissioned): How the health partnership approach contributes to the delivery of programme outcomes: phase 1 of a research project (TORs available).
- 2015 (commissioned): 2–3 case studies of health partnership value for money, for publication by THET; outline systems for more rigorous VFM monitoring (TORs available)

DUTY OF CARE[7]

The Supplier is responsible for the safety and well-being of their Personnel (as defined in Section 2 of the Contract) and Third Parties affected by their activities under this contract, including appropriate security arrangements. They will also be responsible for the provision of suitable security arrangements for their domestic and business property.

DFID will share available information with the Supplier on security status and developments in-country where appropriate. DFID will provide the following if required:

- All Supplier Personnel will be offered a security briefing by the British Embassy/DFID on arrival. All such Personnel must register with their respective Embassies to ensure that they are included in emergency procedures.
- A copy of the DFID visitor notes (and a further copy each time these are updated), which the Supplier may use to brief their Personnel on arrival.

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

This Procurement may require the 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 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 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 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).

[7] See Smart Guide_Procurement - http://insight/Smart-Rules/Documents/Smart Guide_Procurement.docx

The Supplier is responsible for ensuring that appropriate arrangements, processes and procedures are in place for their Personnel, taking into account the environment they will be working in and the level of risk involved in delivery of the Contract (such as working in dangerous, fragile and hostile environments etc.). The Supplier must ensure their Personnel receive the required level of training and if required complete a UK government approved hostile environment training course (SAFE)8 or safety in the field training prior to deployment.

Tenderers must develop their Tender on the basis of being fully responsible for Duty of Care in line with the details provided above and the initial risk assessment matrix developed by DFID (see Appendix A of this ToR). They must confirm in their Tender 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.

Acceptance of responsibility must be supported with evidence of capability (no more than [2] A4 pages and DFID reserves the right to clarify any aspect of this evidence. In providing evidence Tenderers should consider the following questions:
a) Have you completed an initial assessment of potential risks that demonstrates your knowledge and understanding, and are you satisfied that you understand the risk management implications (not solely relying on information provided by DFID)?
b) Have you prepared an outline plan that you consider appropriate to manage these risks at this stage (or will you do so if you are awarded the contract) and are you confident/comfortable that you can implement this effectively?
c) Have you ensured or will you ensure that your staff are appropriately trained (including specialist training where required) before they are deployed and will you ensure that on-going training is provided where necessary?
d) Have you an appropriate mechanism in place to monitor risk on a live / on-going basis (or will you put one in place if you are awarded the contract)?
e) Have you ensured or will you ensure that your staff are provided with and have access to suitable equipment and will you ensure that this is reviewed and provided on an on-going basis?
f) Have you appropriate systems in place to manage an emergency / incident if one arises?

Further information on Duty of Care is provided in the Supplier Instructions (Volume 1 of the Mini-Competition Invitation to Tender Pack).

SECURITY
Security arrangements are described above and will depend on the selection of field visit sites.

QUALITY STANDARDS/PERFORMANCE REQUIREMENTS
The evaluation of DFID assistance is guided by the core principles of independence, transparency, quality, utility and ethics. Quality pertains to personnel, process and product in evaluation. Independent quality assurance is mandatory during the 'entry' design phase and at the 'exit' (draft final report) stages. In addition to quality

[8] UK Government approved hostile environment training course is known as SAFE (Security Awareness in Fragile Environments). The course should be booked through DFID and factored into the commercial tender.

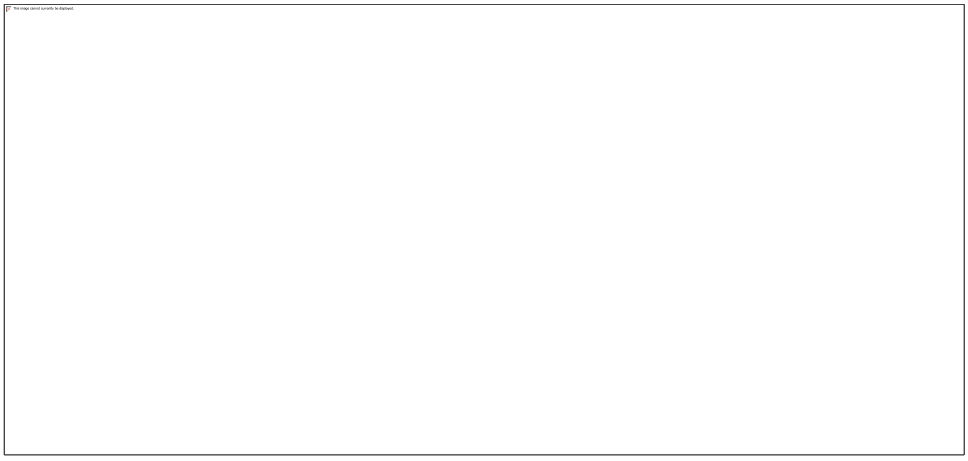
assurance requirements, a formal management response to all findings, conclusions and recommendations from an evaluation is required, and should be published with the evaluation.

The Evaluator's services and performance will be assessed using DAC Quality Evaluation Standards.

BUDGET
The budget for this evaluation is [£300,000] (excluding VAT) and it is expected to cover the costs of evaluation staff, primary data collection, secondary analysis, field visits, analysis and reporting.

APPENDIX A - DUTY OF CARE RISK ASSESSMENT MATRIX

	Country	Threats		
		Overall Security	Violent Crime and Disorder	Terrorism
1	Afghanistan	5	4	5
2	Bangladesh	3	3	3
3	Barbados	2	2	1
4	Burma	2	2	1
5	China	2	2	1
6	Democratic Republic of the Congo	5	5	2
	Egypt	3	3	4
	Ethiopia	3	2	3
	Ghana	3	3	1
	Guyana	4	4	1
	India	2	2	3
	Indonesia	3	3	3
	Iraq	5	5	5
	Jamaica	3	4	1
	Jordan	3	2	4
	Kenya	5	5	4
	Lebanon	3	3	4
	Lesotho	2	2	1
	Libya	3	3	4
	Malawi	3	3	2
	Morocco	3	2	3
	Mozambique	3	3	2
	Nepal	2	2	1
	Nigeria	4	4	4
	Pakistan	4	2	5
	Palestine	3	3	4
	Rwanda	3	4	3
	Sierra Leone	3	3	2
	Somalia	5	4	5
	South Africa	4	5	3
	South Sudan	4	4	4
	Sudan	3	3	4
	Syria	4	3	4
	Tajikistan	3	2	2
	Tanzania	3	4	3
	Tunisia	3	3	3
	Ukraine	3	2	3
	Uganda	3	3	3
	Vietnam	2	2	1
	Yemen	5	3	5
	Zambia	3	3	1
	Zimbabwe	3	3	1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APPENDIX B - DFID ETHICS PRINCIPLES FOR RESEARCH AND EVALUATION

DFID expects the research and evaluation it funds to adhere to the highest standards of integrity. To facilitate this it has drawn up these Principles on ethical practice in research and evaluation. All research and evaluation conducted or funded by DFID (wholly or partially) is expected to uphold these Principles. These Principles should be read in conjunction with DFID's Ethics Guidance for Research and Evaluation.

PRINCIPLES

1. Researchers and evaluators are responsible for identifying the need for and securing any necessary ethics approval for the study they are undertaking. This may be from national or local ethics committees in countries in which the study will be undertaken, or other stakeholder institutions with formal ethics approval systems.

2. Research and evaluation must be relevant and high quality with clear developmental and practical value. It must be undertaken to a sufficiently high standard that the findings can be reliably used for their intended purpose. Research should only be undertaken where there is a clear gap in knowledge. Evaluations might also be undertaken to learn lessons to improve future impact, or in order to meet DFID's requirements for accountability.

3. Researchers and evaluators should avoid harm to participants in studies. They should ensure that the basic human rights of individuals and groups with whom they interact are protected. This is particularly important with regard to vulnerable people. The wellbeing of researchers/ evaluators working in the field should also be considered and harm minimised.

4. Participation in research and evaluation should be voluntary and free from external pressure. Information should not be withheld from prospective participants that might affect their willingness to participate. All participants should have a right to withdraw from research/ evaluation and withdraw any data concerning them at any point without fear of penalty.

5. Researchers and evaluators should ensure confidentiality of information, privacy and anonymity of study participants. They should communicate clearly to prospective participants any limits to confidentiality. In cases where unexpected evidence of serious wrong-doing is uncovered (e.g. corruption or abuse) there may be a need to consider whether the normal commitment to confidentiality might be outweighed by the ethical need to prevent harm to vulnerable people. DFID's fraud policy will apply if relevant.

6. Researchers and evaluators should operate in accordance with international human rights conventions and covenants to which the United Kingdom is a signatory, regardless of local country standards. They should also take account of local and national laws.

7. DFID funded research and evaluation should respect cultural sensitivities. This means researchers need to take account of differences in culture, local behaviour and norms, religious beliefs and practices, sexual orientation, gender roles, disability, age and ethnicity and other social differences such as class when planning studies and communicating findings. DFID should avoid imposing a burden of over-researching particular groups.

8. DFID is committed to publication and communication of all evaluations and research studies. Full methodological details and information on who has undertaken a study should be given and messages transmitted should fully and fairly

reflect the findings. Where possible, and respecting confidentiality requirements, primary data should be made public to allow secondary analyses.

9. Research and evaluation should usually be independent of those implementing an intervention or programme under study. Independence is very important for research and evaluation; in fact evaluations in DFID can only be classified as such where they are led independently. Involvement of stakeholders may be desirable so long as the objectivity of a study is not compromised and DFID is transparent about the roles played. Any potential conflicts of interest that might jeopardise the integrity of the methodology or the outputs of research/ evaluation should be disclosed. If researchers/ evaluators or other stakeholders feel that undue pressure is being put on them by DFID officials, such that their independence has been breached, this should be reported to the Head of Profession for Evaluation who will take appropriate action

10. All DFID funded research/ evaluation should have particular emphasis on ensuring participation from women and socially excluded groups. Consideration should be given to how barriers to participation can be removed.